Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 09.30 on Wednesday 25 October 2023
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
09.30	1.	**Employee of the Month Film (October 2023)** *Purpose: To **note** the Employee of the Month film for October 2023*	Verbal	Chair *(10 mins)*
09.40	2.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	3.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	4.	**MWL TB23/041 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 27 September 2023*	Report	
	5.	**MWL TB23/042 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
09:50	6.	**MWL TB23/043 Integrated Performance Report** 6.1. Quality Indicators 6.2. Operational Indicators 6.3. Workforce Indicators 6.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report for assurance*	Report	 S Redfern L Neary A-M Stretch G Lawrence *(20 mins)*
Committee Assurance Report				
10.10	7.	**MLW TB23/044 – Committee Assurance Reports** 7.1. Executive Committee 7.2. Quality Committee	Report	 A Marr G Brown

		7.3. Strategic People Committee 7.4. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports for assurance*		L Knight J Kozer *(30 mins)*
Other Board Reports				
10.40	8.	**MWL TB23/045 Clinical Strategy** *Purpose: To **approve** the Clinical Strategy*	Report	P Williams *(15 mins)*
10.55	9.	**MWL TB23/046 Corporate Risk Register** *Purpose: To **note** the Corporate Risk Register for assurance*	Report	N Bunce *(10 mins)*
11.05	10.	**MWL TB23/047 Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	Report	N Bunce *(10 mins)*
11.15	11.	**MWL TB23/048 Aggregated Incidents, Complaints and Claims Report (Quarter 1 2023/24)** 11.1. STHK 11.2. S&O *Purpose: To **note** the Aggregated Incidents, Complaints and Claims Report for assurance*	Report	S Redfern *(15 mins)*
11.30	12.	**MWL TB23/049 Learning from Deaths Quarterly Reports (Quarter 1 2023/24)** 12.1. STHK 12.2. S&O *Purpose: To **note** the Learning from Deaths Quarterly Reports for assurance*	Report	P Williams *(20 mins)*
11.50	13.	**MWL TB23/050 Infection Prevention and Control Annual Report 2022/23** 13.1. STHK 13.2. S&O *Purpose: To **note** the 2022/23 Infection Control Annual Reports*	Report	S Redfern *(20 mins)*
12.15	14.	**MWL TB23/051 Safeguarding Annual Report 2022/23 (Adults and Children)** 14.1. STHK 14.2. S&O *Purpose: To **approve** the STHK 2022/23 Safeguarding Annual Report (Adults and Children) and the S&O 2022/23 Safeguarding Annual Report*	Report	S Redfern *(20 mins)*

12:35	15.	**MWL TB23/052 Workforce Reports** 15.1. STHK Workforce Race Equality Standard Report (WRES) (including MWL action plan) 15.2. STHK Workforce Disability Equality Standard Report (WDES) (MWL including action plan) *Purpose: To **note** the Workforce Reports for assurance and to **approve** the MWL action plan*	Report	AM Stretch *(15 mins)*

Concluding Business

12.50	16.	**Effectiveness of Meeting**	Report	Chair *(5 mins)*
12.55	17.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 29 November 2023 at 09:30		**13.00 close**

15 minutes lunch break

Chair: Richard Fraser

Minutes of the Trust Board Meeting
Held at Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 27 September 2023
(Approved by Trust Board on Wednesday 25 October 2023)

Name	Initials	Title
Richard Fraser	RF	Chair
Ann Marr	AM	Chief Executive Officer
Anne-Marie Stretch	AMS	Deputy Chief Executive Officer & Director of Human Resources
Geoffrey Appleton	GA	Non-Executive Director & Deputy Chair
Gill Brown	GB	Non-Executive Director
Nicola Bunce	NB	Director of Corporate Services
Ian Clayton	IC	Non-Executive Director
Rob Cooper	RC	Managing Director
Paul Growney	PG	Associate Non-Executive Director
Lisa Knight	LK	Non-Executive Director
Jeff Kozer	JK	Non-Executive Director
Gareth Lawrence	GL	Director of Finance and Information
Lesley Neary	LN	Chief Operating Officer
Rani Thind	RT	Associate Non-Executive Director (via MS Teams)
Christine Walters	CW	Director of Informatics
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Abigail Butler	AB	Stroke Nurse Clinician *(Agenda Item 2)* (via MS Teams)
Kate Clark	KC	Director of Strategic Clinical Reconfiguration *(Agenda Item 9)*
Michelle Kitson	MK	Matron, Patient Experience *(Agenda Item 2)* (via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Angela Ball	AB	Halton Council Representative (Stakeholder Representative)
Sue Redfern	SR	Director of Nursing, Midwifery and Governance

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**

1.1. The Employee of the Month for August 2023 was David Taylor, Maintenance Supervisor at Ormskirk Hospital and the Board watched the film of NB reading the citation and presenting the award to David.

1.2. The Employee of the Month for September 2023 was Jenny Hardaker, Matron, Sanderson Suite, St Helens Hospital, and the Board watched the film of SR reading the citation and presenting the award to Jenny.

RESOLVED:
The Board **noted** Employee of the Month films for August and September 2023 and congratulated the winners.

2. Patient Story

2.1. RF welcomed MK and AB to the meeting and introduced them to the Board.

2.2. MK and AB then presented the patient story video, which focused on the story of Rhys, a 16-year-old who suffered a stroke and the care that he received as part of the new North Mersey stroke pathway. It was noted that the story was told by his mother, Alison.

2.3. Rhys and his mother attended Accident and Emergency (A&E) at Southport Hospital and following several tests including a Computerised Tomography (CT) scan were transferred to the Hyper Acute Stroke Unit at Aintree Hospital for further assessment and treatment. Once Rhys had been stabilised, he was transferred back to Southport Hospital and Alison was allowed to stay with him whilst he was on the ward. The Stroke Consultant met with Alison and Rhys and explained what had happened and discussed treatment with them. Alison noted that there was daily contact with the Stroke Consultant and members of the Stroke team as well as twice daily visits from members of the occupational therapy team whilst Rhys was on the ward.

2.4. Alison spoke about the emotional impact on both Rhys and herself of receiving the diagnosis and noted that psychological support had been arranged for Rhys. Alison advised that following additional tests Rhys required surgery to repair a hole in his heart.

2.5. Alison commended the staff at both Southport and Aintree Hospitals for the care that the whole family had received.

2.6. RF thanked MK and AB for presenting the story and Rhys and Alison for being prepared to share their experiences and wished Rhys well in his continued recovery. RF also reflected that this story illustrated the benefits of the new stroke pathway and how it could improve outcomes.

2.7. LK asked if Rhys' heart surgery had been successful, and AB advised that they had not received an update on this. LK commented on the importance of touchpoints with key staff along a patient's journey and this story

demonstrated that, with the daily contact with the consultant that Rhys and Alison had found so comforting.

2.8. LN commented that 12 to 18 months ago the Stroke Service had been listed as a fragile service and to hear about the seamless care that a patient received made her immensely proud of the team's achievements in improving this service.

2.9. GB commented that she was with a friend who knew Alison and there had been a discussion about the issues within the NHS and Southport Hospital and Alison had commented that the care that they had received was excellent and agreed to share their story. GB congratulated the hard work of everyone involved in the establishing the Stroke Services pathway.

2.10. GA commented that he and RT had spent time on the Stroke unit shortly after the new pathway was implemented and was impressed with the staff and the teamwork that they demonstrated with the other providers to deliver seamless care.

2.11. AM reflected on the challenges that arose during the negotiations for the stroke pathway with system partners and suggested that the story be shared with everyone involved to demonstrate the improvements made to the service. Following a brief discussion around these challenges IC suggested that further discussion about stakeholder engagement and mapping take place at the Board Away Day.

RESOLVED:
The Board **noted** the Patient Story

3. Chair's Welcome and Note of Apologies

3.1. RF welcomed all to the meeting.

3.2. RF acknowledged the following Awards and Recognition that the Trust had recently received:

3.2.1. The St Helens and Knowsley Preceptorship Team were awarded a Cavell Nurses' Trust star for their work championing preceptorship, particularly for the effective and supportive integration of newly registered nursing and midwifery professionals into the workforce.

3.2.2. The Equality and Diversity Team at St Helens and Whiston hospitals, were shortlisted for the Excellence in Employee Engagement category.

3.2.3. The annual Care Quality Commission Adult Inpatient Survey 2022 ranked three of the Trust's hospitals amongst the best in the NHS.

3.2.4. Three teams had been shortlisted for the Nursing Times Workforce Summit Awards.

3.2.5. Best Workplace for Learning and Development, the Critical Care Team at Southport Hospital were shortlisted for the Senior Staff Nurse Role Enhancement Programme.

3.2.6. The Critical Care Team have also been shortlisted in the Best Employer for Staff Recognition and Engagement category for their innovative "What 3 Words" campaign.

3.2.7. The Preceptorship Team covering St Helens and Knowsley were shortlisted in the Preceptorship Programme of the Year category for their Preceptorship Pathway which supported our newly qualified clinicians.

3.3. Apologies for absence were **noted** as detailed above

4. Declaration of Interests

4.1. There were no declarations of interests in relation to the agenda items.

5. Minutes of the previous meeting

5.1. The meeting reviewed the minutes of the meeting held on 26 July 2023 and approved them as a correct and accurate record of proceedings subject to the following amendments:

5.1.1. *Min ref MWL TB (23)018a STHK 23.4 – IC requested additional information around the infringement order be included in the minutes. CW agreed to provide an update.* ***(action)***

5.1.2. MWL TB(23)019a (STHK) and 019b (S&O) - the spelling of trysts to be amended to trusts.

RESOLVED:
The Board **approved** the minutes from the meeting held on 26 July 2023 subject to minor amendments

6. Action Log and Matters Arising

6.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions.

RESOLVED:
The Board **approved** the action log

Performance Reports

7. MWL TB23/030 Corporate Performance Reports

GL introduced the combined Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL Corporate Performance Report for August 2023.

7.1. Quality Indicators

7.1.1. RC presented the Quality Indicators and advised that the Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) targets for the majority of the metrics in the Corporate Performance Reports (CPR) had now been agreed and would be included in future reports. Additionally, RC advised that

the top 30 metrics featured could be amended to include any metrics that the Board felt were more pertinent and following a discussion, it was agreed to include neonatal deaths as a metric in future reports.

7.1.2. The latest available Hospital Standardised Mortality Ratio (HSMR) was for May 2023, and it was noted that the year-to-date (YTD) position for the Trust was at 87.2 which showed that the Trust has fewer deaths than expected given the age and comorbidities of patients. PW advised that both Southport and Ormskirk Hospital NHS Trust (S&O) (78) and St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) (92) had demonstrated a lower than expected number of in-hospital deaths. The S&O historic figures were particularly low, and PW reported that he was working with Business Intelligence (BI) and the Learning from Deaths teams to understand this, and a report of this review would be presented at a future Executive Committee.

7.1.3. The Trust remained within the tolerance levels for Clostridium difficile (C.Diff) infections with eight cases reported in month and 40 cases reported YTD and it was noted that several cases were still being investigated to see if they could have been avoided and if there is any learning.

7.1.4. The recommendation rates for the Friends and Family Test (FFT) were above 90% for all areas excluding Accident and Emergency (A&E) and it was noted that the main reason cited for not recommending the service was the long waiting times, when the departments were very busy. RC advised that work was ongoing to improve patient flow across all hospital sites and to ensure that patients who had to wait in A&E for long periods of time were cared for appropriately.

7.1.5. There were six falls with moderate or greater harm reported in July 2023 and improvement work continued as part of the Trust's Strategic Falls improvement work for the wards.

7.1.6. There were six category 2 pressure ulcers reported YTD and improvement and awareness work was in progress. Additionally, RC advised that this was a focus area as part of the Trust's objectives from a service quality perspective. It was noted that the Root Cause Analyses (RCA) for Category 2 and above pressure ulcers were being reviewed and validated.

7.1.7. LK asked whether the benchmark of 50% for the FFT meant that the Trust was in the bottom 50% of all Trusts and RC confirmed that this was correct and noted that, following a question raised at a previous Quality Committee the overall performance across the country was reviewed and all trusts had scored very high and performance for MWL was at 95.2% which was above target.

7.1.8. LK asked about the decline in the number of complaints responded to in the agreed timescale and RC advised that this was due to the combining of the two trusts and the setting of a standard target for MWL which was shorter

than the former STHK's target response time. RC noted that an improvement plan was in place.

7.1.9. PG asked about the recording of palliative care as part of the HSMR and PW advised that patients who were coded as receiving palliative care were not included in the HSMR calculation. It was this point that PW was investigating to understand the impact of removing these patients.

7.1.10. AMS commented that the demographic for HSMR at Southport Hospital was an elderly population and that the Trust also worked closely with Queens Court Hospice to deliver palliative care for patients who needed it. PW noted that Queens Court would be a factor but going forward it would be important to ensure there was a consistent coding methodology across MWL.

7.2. Operational Performance Indicators

7.2.1. LN presented the operational performance indicators and provided an update on the actions taken to mitigate some of the performance risks. LN highlighted the following:

7.2.1.1. The A&E overall 4hour performance was 71.3% for August against national performance at 73% and Cheshire & Merseyside (C&M) overall performance at 73.4%. MWL was the best performing acute Trust in the C&M region for all attendance types and second behind East Cheshire NHS Trust for Type 1 performance at 60.6% compared to the C&M region at 58.1%.

7.2.1.2. Bed occupancy remained an issue for Whiston and Southport Hospitals sites and MWL averaged 102.6% occupancy across all sites in August 2023 (the equivalent of 40.3 extra patients) and peaked at an extra 88 patients which included patients in general and acute beds, escalation areas and those waiting for admission from A&E.

7.2.1.3. The Trust was working with system partners on winter plans and several solutions were being reviewed which included creating additional bed capacity at Whiston Hospital and the implementation of a model similar to that of Ward 11a at the Southport site. Additional elective capacity at Ormskirk Hospital was also being reviewed. Additionally, escalation beds were being reviewed across the Trust with surge plans being developed and risk assessed to ensure safe escalation when necessary. LN advised that a new OPEL framework would be implemented, and all escalation plans would be tied into the new framework triggers.

7.2.1.4. For Southport Hospital discussions were underway to take over the additional 14 beds at Chase Heys and capacity at Ormskirk Hospital was also being assessed as potential step-down capacity.

7.2.1.5. Elective Activity and Long Waits had been impacted by the recent periods of industrial action and annual leave in August 2023 and this would continue into September 2023. The 52-week waiters had increased to 3% of the waiting list for MWL and to 5% for Cheshire and Merseyside (C&M) Integrated Care Board (ICB). LN noted that this position was mirrored nationally. There were five 78-week waiters which was in line with plan.

There were 397 65+week waiters which was better than plan (predicted 869).

7.2.1.6. Performance against the two-week Cancer standards was 80.3% against a target of 93% (nationally performance was 75.7%) with S&O sites at 92.6% and STHK sites at 71.2%.

7.2.1.7. Performance against the 62-day Cancer standard was 72.6% against a target of 85% (nationally performance was 62.6%). LN noted that STHK (81.5%) performed better than S&O (58.7%) for this metric and there were lessons to be shared.

7.2.2. IC was concerned that the performance targets for providing discharge letters were not being met and there had been no improvement for a long time. IC requested that a narrative about the discharge letters performance be included in future reports.

Action
The Operational Indicators of the Corporate Performance Report to be updated to include discharge letters performance.

7.2.3. LN advised that the Patient Flow Focus Groups held at Southport and Whiston Hospital sites to support winter planning had been well attended and there had been lots of suggestions made, that were being evaluated.

7.2.4. PG reflected on the A&E long waits and bed pressures and the effect that this had on patient flow as well as the dependency on system partners and asked what the Trust could do about the system partners not attending meetings. LN advised that she had written to the system partners non-attenders and noted that the 92% bed occupancy was a PLACE objective agreed with the ICB. LN commented that whilst system partners advised that they had the bed capacity, it seemed that this was not the right capacity to cater for the patients being discharged and noted that each PLACE still had a different process to be followed.

7.2.5. AM asked whether the PLACE directors were aware of the information and LN advised that she shared this information at the Patient Tracking List (PTL) and Ready for Discharge (RFD) meetings.

7.3. Workforce Indicators

7.3.1. AMS presented the Workforce Indicators and highlighted the following:

7.3.1.1. The appraisal compliance rate was 75.9% against a target of 85% and AMS noted that this was partially due to the legacy system of completing appraisals at the two trusts and reminded members that the window for recording appraisals for legacy STHK staff was due to close at the end of the month, whereas for S&O staff appraisals could be undertaken throughout the year.

7.3.1.2. Core Mandatory training was 86.2% against a target of 85%.

7.3.1.3. Overall sickness was at 5.6% with stress and anxiety remained the highest cause for sickness. AMS noted that a MWL Trust sickness target of 5% had been agreed following a national, North West and C&M region benchmarking exercise.

7.3.2. PG asked if the Trust was experiencing any impact from the reported increase in Covid-19 cases and AMS advised that, whilst there had been an increase in Covid-19 staff absence, this had not impacted the overall sickness performance as yet.

7.3.3. RT commented on recent national reports related to maternity services and queried whether these impacted sickness and stress in Maternity, and asked what the Trust was doing to support staff. AMS advised that Health and Wellbeing (HWB) offered a range of services to support staff and monitored the data for sickness hotspots. AMS noted that there was a high incidence of sickness in the Community Midwives team and the HWB team was working with staff and listening events with the midwives were held at regular intervals. AMS noted that stress was a big reason for absence. RT asked if the Trust was able to provide interventions before staff went off sick and AMS advised that a deep dive into sickness absence attributed to stress and anxiety had highlighted that issues at home, rather than work were the predominant cause, however, HWB still provided interventions to all staff regardless of the origin of the stress and anxiety.

7.3.4. LK commented that the HWB team used to contact staff members who had been signed off after a couple of weeks to offer support, however, interventions were now offered at the start of a period of absence to try and get staff back to work as soon as possible.

7.4. Financial Indicators

7.4.1. GL presented the Financial Indicators and highlighted the following:

7.4.1.1. The final approved MWL financial plan for 2023/24 (combined agreed STHK and S&O plans) was to achieve a surplus of £7.6m and assumed:

- Full achievement of Commissioning for Quality and Innovation targets (CQUINs)
- Delivery of £31.8m recurrent Cost Improvement Plans (CIP) as well as the delivery of £7.0m non-recurrent CIP

7.4.1.2. The Trust reported a YTD deficit of £1.4m which was £2.2m adverse to plan and this related to the impact of industrial action leading to activity underperformance and additional pay costs. GL noted that the ICB still needed to confirm the Trust's allocation of the reported funding to cover months 1 and 2 industrial action (2% of Elective Recovery Funding). Inflation above the NHS assumptions was also adding pressure to the financial position.

7.4.1.3. The cash balance at the end of Month 5 was £6m and the Trust had submitted a request for a £10m cash loan in line with the transaction support agreed with NHSE and C&M ICB.

7.4.1.4. Capital expenditure at Month 5 was £5m.

7.4.2. RF commented that despite the pressures the financial performance remained strong.

RESOLVED:
The Board **noted** the Corporate Performance Report for assurance

Committee Assurance Reports

8. MWL TB23/031 Committee Assurance Reports

8.1. Executive Committee

8.1.1. AM presented the Executive Committee Assurance reports for July and August and highlighted the following:

July 2023

8.1.1.1. Patient moves between wards continued to be a cause for concern. The Executive had agreed that the S&O dashboard which showed the number of times that a patient had been moved and allowed for the allocation of 'keep me here' flags would be adopted across MWL, and quarterly reports would be presented to the Committee to track the impact of these changes.

8.1.1.2. The Committee had received an update on the outcome of the discussions with the external auditors about the treatment of transaction reconfiguration funding in the S&O 2022/23 accounts.

August 2023

8.1.1.3. The Committee approved the following business cases:

8.1.1.4. Nurse Staffing Establishment Business Cases for Wards 3E and 4A

8.1.1.5. Electronic Patient Records (EPR)

8.1.2. The report was noted

8.2. Audit Committee (including approval of Audit Letters)

8.2.1. IC presented the Audit Committee Assurance Report and advised that the only material issue identified in the audits for both trusts had been the treatment of assets under construction and the adjustments to the financial statements if the treatment was changed. Following various discussions with the external auditors that had been ongoing since June the amended financial statements were reviewed by the Committee with a recommendation to Board to approve the annual report and accounts, however, IC noted that the final audit letters remained outstanding although the auditors had attended the Committee and presented their audit findings.

8.2.2. The Committee had reviewed the actions being taken to improve the compliance with the low levels of Conflict of Interest declaration-requirements for S&O, noting that compliance was similarly low for the

legacy STHK Trust, and the Committee had requested a more detailed breakdown of compliance by staff group.

8.2.3. GL advised that based on the auditors' verbal reports the Annual General Meetings (AGMs) could go ahead and the Annual Reports and Accounts for the two legacy trusts would then be published as soon as the audit letters were received, to meet the 30 September publication deadline.

8.2.4. The report was noted

8.3. Quality Committee

8.3.1. GB presented the Quality Committee Assurance report and highlighted the following:

8.3.1.1. The meeting received the detailed MWL Quality Committee Performance Report (CPR) and it had been noted that this report was a work in progress as several targets and metrics were still to be finalised for MWL. GB thanked the BI team for the work completed to provide an overview of performance for the new organisation.

8.3.1.2. The Committee had been assured by a report which detailed the actions taken as a result of the two Category 3 pressure ulcers with lapses in care and the learning that had been shared.

8.3.1.3. The Committee had received a detailed report on the Trust's assessment of the recommendations made in the letter from the NHSE following the Lucy Letby verdict and had reviewed the current processes for raising concerns and escalating incidents. Plans for further improvements to enhance the MWL systems were also discussed.

8.3.1.4. The Committee had reviewed the Terms of Reference (ToR) and GB noted that comments had been incorporated into the updated version being recommended to Board.

8.3.2. The report was noted.

8.4. Strategic People Committee

8.4.1. LK presented the Strategic People Committee Assurance report and highlighted the following:

8.4.1.1. The proposed MWL HR Governance arrangements which detailed the Council structure reporting to the Strategic People Committee (SPC) were presented.

8.4.1.2. The Committee approved the annual work plan, which was based on the draft ToR.

8.4.1.3. The Workforce dashboard/People Committee Performance Report had been reviewed, and the Committee requested a detailed analysis of the reasons for the increased Allied Health Professionals (AHP) vacancies and the actions required to improve retention.

8.4.1.4. The Committee had received a briefing on the new Fit and Proper Persons Test Framework.

8.4.2. The report was noted.

8.5. Finance and Performance Committee

8.5.1. JK presented the Committee assurance report and highlighted the following points:

8.5.1.1. The Committee had reviewed the Finance and Operational Performance reports, noting the financial position at month 5 and the risks to delivery of the 2023/24 financial plan. Agency costs were £7.8m year to date and mitigating actions were being taken to address this.

8.5.1.2. CIP targets were on track to be delivered.

8.5.1.3. The Better Payment Practice Code (BPPC) compliance has reduced as a result of the merger of the ledger, but mitigation plans were in place and improvements were expected over the next few months.

8.5.1.4. The Committee had approved the costing processes for the 2022/23 National Cost Collection (NCC) submission.

8.5.1.5. The Committee had received an update on the business case benefits realisation tracker, and it had been reported that 93% of planned benefits were on track to be fully delivered.

8.5.1.6. The Committee reviewed the Elective Recovery assessment against the declaration required by every Trust and noted compliance against seven of the 11 key areas. The actions being taken to support further compliance against the four areas rated as partially compliant were noted. Additionally, it was noted that two requests for additional funding had been submitted to support this activity.

8.5.1.7. The Committee had reviewed the proposed Finance and Performance (F&P) Committee Terms of Reference and agreed an amendment to reflect that the new Estates and Facilities and IT Councils would report to the F&P Committee.

8.5.2. The remainder of the report was noted.

RESOLVED:
The Board **noted** the Committee Assurance Reports

Other Board Reports

9. MWL TB23/032 Medical Revalidation Annual Declaration

9.1. STHK

9.1.1. PW presented the 2022/23 Medical Revalidation Report for STHK and advised that the report covered the period 01 April 2022 to 31 March 2023. PW highlighted the following:

9.1.1.1. On 31 March 2023, 528 doctors had St Helens & Knowsley Teaching Hospitals NHS Trust as their registered Designated Body.

9.1.1.2. In 2022/23 474 doctors completed their medical appraisals in line with the General Medical Council (GMC) guidance. 54 doctors had not completed appraisals of which 45 were approved 'missed appraisals' and nine were unapproved.

9.1.1.3. A total of 38 revalidation recommendations were made to the GMC with 32 doctors being positively recommended for revalidation.

9.1.1.4. During 2022/23 one doctor was referred to the GMC for further action and one was referred to the Practioner Advice Service for support. It was noted that no doctors had been excluded from practice during 2022/23.

9.1.1.5. In March 2023, the Medical Director became the Responsible Officer to cover the unexpected long-term absence of the substantive Responsible Officer.

9.1.1.6. In July 2023, as a result of the transaction MWL became a new designated body, and PW became the Responsible Officer

9.1.1.7. Following the approval of a business case in 2022, the Medical Appraisal and Revalidation team was expanded and now consisted of a full-time Medical Appraisal, Revalidation and Governance Lead, and a full-time Medical Workforce Administrator. The expansion of the team had helped to increase appraisal compliance and provided more support to doctors during the appraisal and revalidation processes.

9.1.1.8. Section 6.2 of the report referred to how information was collated, analysed, and shared with the Board. PW advised that the method of collation would depend on the process that a concern had been raised through and the number, type and outcome of concerns raised would be reported to the Employee Relations Scrutiny Group for analysis. Additionally, PW advised that the Equality, Diversity, and Inclusion (EDI) information would also be reported to the Employee Relations Scrutiny Group as part of this analysis.

9.1.2. AM asked about the outcome of the doctors who had not completed their appraisals as well as the 38 revalidation recommendations that were made to the GMC. PW advised that there was an agreed process that the Medical Appraisal and Revalidation team worked through with the doctors that had not engaged with the appraisal process.

9.1.3. AM asked about the nine doctors who had not completed their appraisals and PW advised that these had not been completed by the 2022/23 deadline but had now been completed. PW advised that the six doctors who had not met the criteria would receive a referral and their appraisal would be deferred for 12 months.

9.1.4. IC asked about the referral to the GMC and asked whether the individuals were fit to practice. PW advised in this case several patient safety concerns had been raised and following a number of meetings and restrictions being placed on the doctor's ability to practice, the individual had left the Trust, and the GMC had been notified so that a Healthcare Professional Alert could be raised to other potential employers so they would be made aware of the restrictions. PW noted that as Responsible Officer, he could also be contacted for additional information.

9.1.5. RT commented that if an appraisal was deferred for a legitimate reason a certificate which reflected the revalidation and new date would be issued

and asked whether a doctor who had not been revalidated was allowed to continue to practise. PW advised that the individual could continue to practice, and a communication would be received from the GMC to this effect with the revalidation date.

9.1.6. In response to RT's question about the selection of appraisers and whether the appointment of Medical Managers as appraisers was a conflict of interest, PW responded that he did not feel this was the case, and that Medical Managers could be appointed as appraisers. LK noted that the Employee Relations Oversight Group reviewed cases and trends across any concerns raised and work was ongoing with NHSE to develop a training programme to ensure that all appraisers understood the revalidation process.

RESOLVED:
The Board **approved** the 2022/23 Medical Revalidation Annual Declaration for St Helens and Knowsley Teaching Hospitals NHS Trust

9.2. S&O

9.2.1. KC presented the 2022/23 Medical Appraisal and Revalidation Annual Report for S&O and advised that the report covered the period 01 April 2022 to 31 March 2023. KC highlighted the following:

9.2.1.1. On 31 March 2023, 245 doctors had Southport and Ormskirk (S&O) Hospital NHS Trust as their registered Designated Body, and this reflected an increase in the medical workforce.

9.2.1.2. In 2022/23 204 doctors completed their medical appraisals in line with the GMC guidance. There were 40 approved 'missed appraisals' and one unapproved missed or late appraisal. KC noted that the individual has subsequently completed an appraisal but due to the number of ongoing issues has been referred to the GMC.

9.2.2. KC noted that there were a few differences between the two organisations with regards to policies and processes and advised that due to workforce resources, the appraisal cycle at S&O ran from March 2022 to March 2023. It was noted that this would be reviewed as MWL worked towards a single system. The Appraisal Support Group, which provided support to the appraisers, was re-introduced during 2022/23 and provided an opportunity to discuss cases and challenges.

9.2.3. KC thanked the Director of Medical Education for her contribution.

RESOLVED:
The Board **approved** the 2022/23 Medical Revalidation Annual Declaration for Southport and Ormskirk (S&O) Hospital NHS Trust

10. MWL TB23/033 Emergency Planning Response and Resilience (EPRR)

10.1. STHK Emergency Preparedness, Resilience and Response (EPRR) Annual Report (April 2022 to March 2023)

10.1.1. LN, on behalf of SR, presented the STHK 2022/23 Emergency Preparedness, Resilience and Response (EPRR) Annual Report and noted that the S&O Annual Report had been presented at the Board meeting in July 2023. Additionally, LN advised that once the annual report was approved it would be retained as evidence for the Core Standards Self-Assessment process.

10.2. Statement of Compliance with national core standards for Emergency Planning Response & Resilience (EPRR) for 2023/24

10.2.1. LN on behalf of SR, presented the Statement of Compliance with national core standards for Emergency Planning Response & Resilience (EPRR) for 2023/24 and advised that as a Category 1 responder, the Trust was required to meet the NHSE Core Standards for EPRR.

10.2.2. LN advised that as a new organisation, MWL had undertaken a self-assessment of the revised EPRR core standards and noted that 52 core standards were fully compliant, six were partially compliant and four were non-compliant. LN advised of the actions that had been put in place to achieve compliance with all standards.

10.2.3. IC asked if the Statement of Compliance with national core standards should be included on the internal audit programme of work and NB advised that the compliance self-assessment would be audited by the ICB EPRR team, and in the past had formed part of the S&O internal audit programme. It was agreed that this would be discussed outside of the meeting.

RESOLVED:
The Board **approved** the STHK Emergency Preparedness, Resilience and Response (EPRR) Annual Report (April 2022 to March 2023 and the Statement of Compliance with national core standards for Emergency Planning Response & Resilience (EPRR) for 2023/24

11. MWL TB23/034 Protecting and Expanding Elective Capacity Declaration

11.1.1. LN presented the Protecting and Expanding Elective Capacity Declaration and advised that the report had been reviewed in detail at the Executive Committee and presented to the Finance and Performance Committee.

11.1.2. LN advised that in May 2023 NHSE communicated the priorities for elective and cancer recovery for 2023/24 to all acute trusts and noted that this was reiterated in a letter in July 2023 in relation to winter planning. In August 2023 acute trusts received a further communication from NHSE which

outlined the requirement to protect and expand elective and outpatient capacity and implement transformation including:

11.1.2.1. Revisiting the Trust's plan for reducing follow up outpatient appointments.
11.1.2.2. To set an ambition for zero patients waiting 65-week
11.1.2.3. To maintain an accurate and validated waiting list by ensuring that at least 90% of patients who had been waiting over 12 weeks were contacted and revalidated.

11.1.3. LN advised that the Trust was fully compliant with seven of the 11 elements and partially compliant with four elements.

11.1.4. LN advised that the Trust had submitted a bid for additional funding to support the validation of data and communication with patients on the waiting list (expected to be £7,000 per 1,000 patients) but noted that the Trust had only been offered £35,000 funding in total which equated to £7,000 per 10,000 patients. It was noted that the Trust would not be able to achieve the deadline of 31 October 2023 to validate the waiting list without the anticipated funding. LN advised that based on the funding received the Trust would only be able to complete the validation by March 2024. It was noted that this had been referred to Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) as it appeared that the funding received was incorrect. AM asked if any other trusts had been affected and LN advised that the allocations to other trusts had not been shared.

RESOLVED:
The Board **approved** the Protecting and Expanding Elective Capacity Declaration

12. MWL TB23/035 Patient Safety Incident Response Framework (PSIRF) – Priorities for 2023/24

12.1. PW, on behalf of SR, presented the Patient Safety Incident Response Framework (PSIRF) Plan and Priorities for 2023/24 and noted that PSIRF replaced the current Serious Incident Framework. PW advised that the Patient Safety Incident response plan set out how MWL would respond to patient incidents for the period 2023/24 and the plan consisted of two elements:

12.1.1. national guidance which set priorities for which safety incidents must be investigated in-depth, and
12.1.2. a local plan, which has been developed by MWL and detailed the additional patient safety incidents for investigation. This plan also detailed how the Trust would respond to patient safety incidents as well as how and when investigations would be carried out.

12.2. PW explained that the plan had been developed in collaboration with a wide range of stakeholders across the Trust and that patient safety incident risks for the Trust had been profiled using organisational data on safety and existing improvement projects. It was noted that the plan would be supported by the Patient Safety Incident Response Framework and Trust policy.

12.3. PW highlighted the following:

12.3.1. PSIRF was a contractual requirement under the NHS Standard Contract and as such was mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers.

12.3.2. PSIRF supported the development and maintenance of an effective patient safety incident response system that integrated four key aims:

12.3.2.1. Compassionate engagement and involvement of those affected by patient safety incidents.

12.3.2.2. Application of a range of system-based approaches to learning from patient safety incidents.

12.3.2.3. Considered and proportionate responses to patient safety incidents.

12.3.2.4. Supportive oversight focused on strengthening response system functioning and improvement.

12.3.3. Whilst some events and issues would arise that would require a special type of response as dictated by policies or regulations (such as the Never Events or learning from deaths criteria), the PSIRF was designed to help organisations conduct investigations relevant to their context and the populations they served. Under PSIRF investigation into incidents would not be based on the harm caused in the event, but by the potential for learning and improvement. PW noted that the Trust currently conducted 50 to 70 incident investigations per year, some of which resulted in significant learning and change of practice.

12.3.4. It was noted that the requirement to report incidents on the Strategic Executive Incident System (StEIS) would cease with the adoption of the PSIRF.

12.3.5. The time frame for an investigation would be negotiated with the patient or family members and the aim was to complete an investigation within three months, however, more complex incidents could take a maximum of six months.

12.3.6. All staff members involved in an incident would be required to provide statements to support the investigation and would also be included in the structured interviews.

12.3.7. The governance for the PSIRF would be delegated to the PSIRF Executive Lead with an overarching responsibility for quality or patient safety. MWL has established a weekly Patient Safety Panel chaired by the Medical Director and the Director of Nursing, Midwifery and Governance and regular reports would be provided to the Quality Committee and Trust Board.

12.4. GB referenced the roles and responsibilities listed in the Patient Safety Incident Response Plan and noted that the Non-Executive Directors (NEDs) were not listed as having a formal role in the process and suggested that the plan should reflect the oversight and assurance role of the NEDs.

12.5. GB and RF asked about the inclusion of the patient and family members in the drafting of the Terms of Reference (ToR) for an investigation and GB commented that family members might be more interested in learning what

happened rather than what could be learned from the incident and therefore the Patient Liaison role would be crucial. PW commented that the wishes as well as questions from the patient and family members were already taken into account as part of the current investigations into an incident.

12.6. NB asked if it was possible the focus from PSIRF on learning might have unintended consequences for increased litigation. PW advised that local department-led investigations and reviews would still take place to provide patients and families with information about the cause of an incident.

12.7. GB commented that procedural errors had not been included as a Trust Priority and asked what process would be followed if an incident occurred during a procedure. PW advised that this would depend on the incident and would either be a never event (a nationally mandated priority) or would be investigated at a departmental level. GB asked if there was a possibility that an incident might be missed if it had not been included as a priority and PW advised that any trends or themes would be covered under the areas of emerging risks.

12.8. RT reflected on the high-profile risks for maternity and neonatal deaths and asked where these would be included in PSIRF. PW advised that this was a national priority and would receive an automatic review and was therefore not included in the Trust's priorities.

12.9. It was noted that the PSIRF would be discussed at the Board Away Day to provide the Board with a more detailed briefing.

RESOLVED:
The Board **approved** the Patient Safety Incident Response Framework (PSIRF) Trust priorities for 2023/24

13. MWL TB23/036 Cheshire & Merseyside Pathology Network (CMPN) Outline Business Case (OBC) for a Laboratory Management Information System (LIMS)

13.1. CW presented the Cheshire & Merseyside Pathology Network (CMPN) Outline Business Case (OBC) for a shared Laboratory Management Information System (LIMS) on behalf of the C&M region and advised that there were five other trusts included in the joint procurement for the system. CW highlighted that the programme timeline was incredibly tight to ensure that the allocated capital was utilised by March 2024.

13.2. CW noted that the Board was asked to:

13.2.1. support and enact system approval for this direction of travel which included LIMS market testing and engagement.

13.2.2. note the LIMS OBC as presented endorsing the aims and objectives of the approach which included the acknowledgement of the 'system' wide benefit of the proposals and the need to develop system responses on risk and gain

share alongside this process to support the management of risk and opportunities.

13.2.3. support the next step in the development of options for a consolidated C&M approach to LIMS and to delegate decision making and oversight for the process of market testing and engagement to CMAST Leadership Board (who would in turn report to Trust Boards).

13.3. GA commented on the complexity and asked how the different systems of the various trusts involved in the bid would tie in and whether the ICB would select the system that met most of the requirements. CW advised that MWL would be the first trust to transition to the new system and noted that the supplier for the current MWL system had given notice that the system was to be sunset. Additionally, CW advised that she was a member of the Executive Directors project board which would oversee the procurement and implementation of the new system at all five sites.

13.4. IC asked whether patients outside of the area who received treatment in the C&M area would have the same access to their records. CW advised that currently out of area patients did not automatically have visibility of their hospital patient records, however C&M did have a shared care record and information is shared with Lancashire and South Cumbria GPs.'.

RESOLVED:
The Board **approved** the Cheshire & Merseyside Pathology Network (CMPN) Outline Business Case (OBC) for a Laboratory Management Information System (LIMS)

14. MWL TB23/037 Gender Pay Gap Report

14.1. AMS presented the annual Gender Pay Gap report for 2023 in accordance with the legal regulations and noted that the report provided a snapshot for STHK and S&O as well as a theoretical calculation for MWL based on the merger of both data sets.

14.2. AMS highlighted the following:

<u>STHK</u>

14.2.1. Mean Gender Pay Gap is 30.4%
14.2.2. Median Gender Pay Gap is 13.7%
14.2.3. Mean Bonus Pay Gap is 17.8%
14.2.4. Median Bonus Pay Gap is 0.0%

<u>S&O</u>

14.2.5. Mean Gender Pay Gap is 20.6%
14.2.6. Median Gender Pay Gap is 5.9%
14.2.7. Mean Bonus Pay Gap is 8.5%
14.2.8. Median Bonus Pay Gap is 0.0%

<u>MWL</u>

Based on the merging of 2 data sets, a theoretical MWL pay gap would be:
14.2.9. Mean Gender Pay Gap is 27.0%
14.2.10. Median Gender Pay Gap is 11.7%
14.2.11. Mean Bonus Pay Gap is 14.8%
14.2.12. Median Bonus Pay Gap is 10.6%

14.3. AMS advised that several key factors influenced the gender pay gaps and these included the number and location of men and women within the pay structure (vertical segregation), and the number of men and women in specific types of roles (horizontal segregation) which showed a higher proportion of men occupying higher paid roles in comparison to women.

14.4. GB asked why there was a difference between STHK, and S&O and AMS advised that this was likely because STHK outsourced estates, domestic and portering services which were part of the PFI, so the workforce profiles were different. As a result, S&O employed a higher proportion of men in lower paying agenda for change bands than STHK.

14.5. LK noted that the relative likelihood of men or women being employed in certain roles was societal and not a Trust specific issue. AMS advised that another contributing societal factor related to doctor's pay. The medical staffing pay spine was based on the length of service, and it was noted that as a result there were currently more men in senior medical positions. However, there were now more newly qualified females taking up roles than men so it would take several more years to reduce the pay gap in this area. AMS advised that she had requested the Equality, Diversity, and Inclusion (ED&I) team to review the staff groups to gain a better understanding of quartile one and quartile four.

14.6. RT commented that similar discussions had taken place in previous years on the gender pay gap and noted that it was important to review the historical figures to determine if any improvements had been made. AMS advised that the gender pay gap had remained similar year on year and noted that this demonstrated the difficulty involved in changing and influencing this.

14.7. RF commented on the importance of the questions raised and AMS suggested that, as this was an issue, a deep dive be undertaken by the Strategic People Council (SPC) around the gaps in quartile 1 and quartile 4 and assurance be provided to the Board via a future SPC Chair's Assurance Report.

Action
The Strategic People Council to undertake a deep dive and assurance to be provided to Board via a future Chair's Assurance Report.

RESOLVED:
The Board **noted** the Gender Pay Gap Report for assurance

15. MWL TB23/038 Freedom to Speak Up - Response to the NHSE Letter

15.1. AMS, on behalf of SR, presented the Freedom to Speak Up, Response to the NHSE Letter report and noted that this had been discussed at the Quality Committee and would also be discussed at the Board Away Day. AMS advised that the report detailed the arrangements in place across MWL against each point raised in the letter as well as recommendations for future actions.

15.2. AMS highlighted that the initial self-assessment indicated that there were established systems and processes in place, however, it had been recognised that more work was required to create a single Freedom to Speak Up (FTSU) and safety culture for MWL. It was noted that an additional FTSU guardian role was already out to advert to strengthen visibility across the Trust and the network of champions would be increased.

15.3. RT asked whether the North West Assembly Framework (Black, Asian and Minority Ethnic Framework) would be referenced as part of the partnership with ED&I leads and AMS advised that she would request that this be included in the action plan.

RESOLVED:
The Board **noted** the Freedom to Speak Up, Response to the NHSE Letter

16. MWL TB23/039 Staff Vaccination Campaign 2023/24

16.1. AMS presented the Staff Vaccination Campaign for 2023/24 and noted that the Executive Committee had approved the additional funding for a vaccination team to assist Health and Wellbeing with the rollout. Additionally, AMS advised that one of the quality indicators in the 2023/24 Commissioning for Quality and Innovation (CQUIN) is to vaccinate healthcare workers for seasonal influenza, with a vaccine uptake between 75% to 80% of staff.

16.2. The Board approved the completed self-assessment check list to be published on the Trust's website in accordance with the Department of Health and Social Care (DHSC) and NHSE guidance to provide assurance to the public.

RESOLVED:
The Board **noted** the Staff Vaccination Campaign 2023/24 and approved the publication of the self-assessment checklist on the Trust's website

17. MWL TB23/040 Committee Terms of Reference

17.1. NB presented the Terms of Reference (ToR) for the for the Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Board and its committees and noted that Committees had reviewed the ToR to ensure that the aligned with the Board's agreed governance structure as well as the NHS code of governance. Additionally, it was noted that the ToR for Councils would be reviewed and presented at the relevant Committees for approval.

17.2. NB acknowledged that the governance structure for the new organisation was still evolving and would be subject to an annual effectiveness review for the 2023/24 annual governance statement and amendments could be made where required at that time.

17.3. GB requested that the Trust Board ToR be amended to refer to the Strategic People Council (SPC) and not the Workforce Committee.

RESOLVED:
The Board **approved** the Board and Committee Terms of Reference, subject to the amendment agreed

Concluding Business

18. Effectiveness of Meeting

18.1. No comments were received, and a formal review was not undertaken due to time constraints due to the scheduled Annual General Meeting (AGM).

19. Any Other Business

19.1. RF thanked the Executive members and staff who were working hard to mitigate the impact of the ongoing industrial action and reflected on the difficulty of balancing patient needs and the rights of staff .

19.2. RF commented that he had attended a ceremony at Lakeside Church at which the Trust was awarded a Love Southport Award in appreciation of the work done by the Trust and noted that the Police, Fire and Ambulance Services had also been recognised for their service to the community.

19.3. There being no other business the meeting closed at 13.57.

The next Board meeting would be held on **Wednesday 25 October at 09.30**

Meeting Attendance 2023/24

Members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Richard Fraser (Chair)				✓		✓						
Ann Marr				✓		✓						
Anne-Marie Stretch				✓		✓						
Geoffrey Appleton				✓		✓						
Gill Brown				✓		✓						
Nicola Bunce				✓		✓						
Ian Clayton				✓		✓						
Rob Cooper				✓		✓						
Paul Growney				A		✓						

Lisa Knight				✓		✓						
Jeff Kozer				✓		✓						
Gareth Lawrence				✓		✓						
Lesley Neary				✓		✓						
Sue Redfern				✓		A						
Rani Thind				✓		✓						
Christine Walters				✓		✓						
Peter Williams				✓		✓						
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Angela Ball				✓		A						
Richard Weeks				✓		✓						
✓ = In attendance A = Apologies												

Trust Board (Public)

Matters Arising Action Log

Action Log updated 20 October 2023

Mersey and West Lancashire Teaching Hospitals NHS Trust

Status	
Yellow	On Agenda for this Meeting
Red	Overdue
Green	Not yet due
Blue	Completed

Agenda Ref	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
9	27/09/2023	**MWL TB23/030 Corporate Performance Reports (CPR) / Operational Indicators**	CPR Operational Indicators to include the Discharge Letters performance	LN	October	October	

Completed Actions

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
5	27/09/2023	**MWL TB23/028 Minutes of Previous meeting** Information Governance and Freedom of Information Annual Reports 2022/23 (MWL TB(23)018a (STHK)	IC requested additional information regarding the period of time that the infringement notice from the ICO would be active for.	CW	October	02/10/2023 - The ICO will issue an infringement notice if it believed that there was an infringement of the UK GDPR, but the infringement was not serious enough to warrant a fine or enforcement notice. The notice itself does not have a time limit. After the incident in question, the Trust advised the ICO of all the steps that had been and would be taken to prevent a reoccurrence in the future. The ICO thanked the Trust for the information and informed us that they would keep the information on file, as per their policy. If there is a similar incident in the future, then they will review all previous correspondence to see if there is a trend. If they believe there is a trend, then the latest incident would be viewed in a more serious light by the ICO. We have checked the ICO website, where all enforcement and decision notices are published. There isn't any information on the website that covers any notices relating to the Trust. **Action completed**	Completed

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
11	27/09/2023	**MWL TB23/034 Protecting and Expanding Elective Capacity Declaration**	Finance and Performance Assurance Report to be updated to reflect that this report was discussed at the F&P committee and recommended to the Board for ratification	GL	September	**17/10/2023** - The Finance and Performance Report was updated to reflect the discussion at the F&P Committee and the recommendation to Board for ratification. **Action completed**	**Completed**
14	27/09/2023	**MWL TB23/037 Gender Pay Gap Report**	A deep dive to be undertaken by the Strategic People Council (SPC) around the gaps in quartile 1 and quartile 4 and assurance provided to the Board via a future Chair's assurance report.	AMS	October	**05/10/2023** - Action referred to the SPC. **Action completed**	**Completed**
17	27/09/2023	**MWL TB23/040 Committee Terms of Reference**	The Trust Board ToR to be amended to refer to the Strategic People Committee rather than the Workforce Committee.	NB	September	**17/10/2023** - Trust Board ToR updated. **Action completed**	**Completed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	**25 October 2023**
Agenda Item	**MWL TB23/043**			
Report Title	Integrated Performance Report			
Executive Lead	Gareth Lawrence, Director of Finance and Information			
Presenting Officer	Gareth Lawrence, Director of Finance and Information			
Action Required		**To Approve**	X	**To Note**

Purpose

The Integrated Performance Report provides an overview of performance for MWL across four key areas:
1. Quality
2. Operations
3. Workforce
4. Finance

Executive Summary

Performance for MWL is summarised across 30 key metrics. Quality has 10 metrics, Operations 13 metrics, Workforce 4 metrics and Finance 3 metrics.

Financial Implications

The forecast for 23/24 financial outturn will have implications for the finances of the Trust.

Quality and/or Equality Impact

The 10 metrics for Quality provide an overview for summary across MWL

Recommendations

The Trust Board is asked to note the Integrated Performance Report for assurance.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care – Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Overview

Mersey and West Lancashire 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.

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	May-23	90.4	100	90.6	Top 30%
FFT - Inpatients % recommended	Sep-23	94.1%	90.0%	95.0%	Bottom 50%
Nurse Fill Rates	Aug-23	97.0%	90.0%	97.0%	
C.difficile	Sep-23	9	85	49	Top 50%
E.coli	Sep-23	16	121	103	Top 40%
Hospital Acq Pressure Ulcers per 1000 bed days	May-23	0.0	0.0	0.1	
Falls ≥ moderate harm per 1000 bed days	Aug-23	0.1	0.0	0.1	
Stillbirths (intrapartum)	Sep-23	0	0	0	
Neonatal Deaths	Sep-23	1	0	3	
Never Events	Sep-23	0	0	0	
Complaints Responded In Agreed Timescale %	Sep-23	76.9%	90.0%	69.8%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-23	70.3%	75.0%	69.4%	Bottom 30%
Cancer 62 Days	Aug-23	69.6%	85.0%	70.2%	Top 30%
% Ambulance Handovers within 30 minutes	Sep-23	63.8%	95.0%	69.0%	
A&E Standard (Mapped)	Sep-23	74.7%	76.0%	76.0%	Top 30%
Average NEL LoS (excl Well Babies)	Sep-23	3.9	4.0	4.1	Top 30%
% of Patients With No Criteria to Reside	Sep-23	30.0%	10.0%	26.4%	
Discharges Before Noon	Sep-23	16.9%	20.0%	17.8%	
G&A Bed Occupancy	Sep-23	89.8%	92.0%	89.4%	Bottom 50%
Patients Whose Operation Was Cancelled	Sep-23	1.0%	0.8%	0.9%	
RTT % less than 18 weeks	Sep-23	59.7%	92.0%	61.5%	Top 50%
RTT 65+	Sep-23	466	0	466	Top 30%
% of E-discharge Summaries Sent Within 24 Hours	Sep-23	63.3%	90.0%	63.5%	
OP Letters to GP Within 7 Days	Aug-23	40.4%	90.0%	39.9%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Sep-23	81.4%	85.0%	81.4%	
Mandatory Training	Sep-23	86.0%	85.0%	86.0%	
Sickness: All Staff Sickness Rate	Sep-23	6.0%	5.0%	5.6%	
Staffing: Turnover rate	Sep-23	1.3%	1.1%	1.1%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Sep-23		7,000	6,300	
Cash Balances - Days to Cover Operating Expenses	Sep-23	1.5	10		
Reported Surplus/Deficit (000's)	Sep-23		629	629	

Board Summary - Quality

Quality

Complaints - Operational pressures continue to impact on capacity to respond to requests for statements, drafting and quality checking responses. Measures to support teams include training and guidance on getting statement right first time and ensuring a high quality response is drafted at the initial stages.

Infection - The Trust is within the tollerance levels for C. Difficile. In Aug the Trust had a total of 8 cases, giving a YTD total of 40.

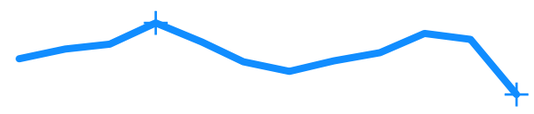
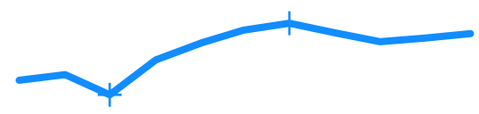
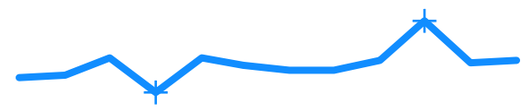
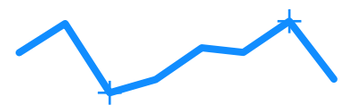
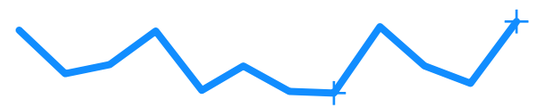
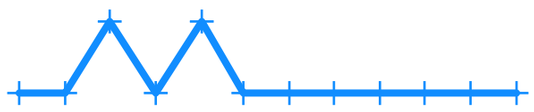
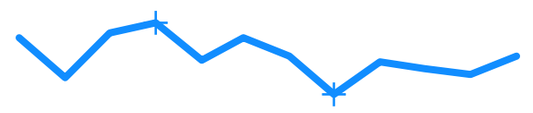
FFT - Recommendation rates were above 90% for all areas in September, other than ED, where long waiting times features frequently in the comments for patients who wouldn't recommend the service. Work continues to improve flow throughout the hospital and to ensure that patients who are in ED for longer periods are cared for appropriately.

Falls - There were 3 falls (moderate or greater) in August and 4 in September (SO) . For August, there were 1 Severe harm falls reported, for Ward 5B and the other 2 moderate harm falls reported from ward 1A and ED . There were 4 Moderate harm and above category falls reported from SO sites. Improvement works in progress as part of Trust Strategic Falls Improvement work as well as bespoke programmes for the wards.

Pressure Ulcer - YTD 7 Patients with Category 2+ Pressure Ulcers with lapse in care. Improvement and awareness work in progress. Significant education and monitoring are place. Trust wide prevalence audit completed. RCA for Category 2 and above pressure ulcers being reviewed and validated including for May.

Mortality - The latest available Hospital Standardised Mortality Ratio (HSMR) data is for May-23. The YTD position (90.6) shows the Trust has less deaths than expected given the age, comorbidities etc of our patients.

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	May-23	90.4	100	90.6	Top 30%	
FFT - Inpatients % recommended	Sep-23	94.1%	90.0%	95.0%	Bottom 50%	
Nurse Fill Rates	Aug-23	97.0%	90.0%	97.0%		
C.difficile	Sep-23	9	85	49	Top 50%	
E.coli	Sep-23	16	121	103	Top 40%	
Hospital Acq Pressure Ulcers per 1000 bed days	May-23	0.0	0.0	0.1		
Falls ≥ moderate harm per 1000 bed days	Aug-23	0.1	0.0	0.1		
Stillbirths (intrapartum)	Sep-23	0	0	0		
Neonatal Deaths	Sep-23	1	0	3		
Never Events	Sep-23	0	0	0		
Complaints Responded In Agreed Timescale %	Sep-23	76.9%	90.0%	69.8%		

Board Summary - Operations

Operations

Bed occupancy across MWL averaged 104.3% in September equating to an additional 48 patients - an increase from 102.6% in August. There was a peak of 108 more patients than beds (46 at S&O, 60 at StHK), escalation areas and those waiting for admission in ED. There is an increased number of admissions sustaining this high occupancy level, with admissions 7% higher than last September driven mainly by a 22% increase in 0-day LOS activity. Average length of stay for emergency admissions is similar across both main sites with an overall average of 8.1 days. . 4-Hour performance deteriorated slightly in September achieving 69.6% (all types), national performance 71.6% and Cheshire & Merseyside 71.3%. Plans for winter with system partners and internally continue to be developed to support further escalation and mitigate the bed occupancy challenge.

The Trust had 2,480 52-week waiters at the end of September (307 S&O and 2,173 StHK), The Trust reported 14 x 78+ week waiters (S&O - 2 (T&O & Gen Sur) and StHK - 12 (5 in T&O, 3 Vascular, 2 Plastics, 1 ENT & Urology)). The Trust remains below the current planned levels of 65+ week waiters but this has been impacted as a result of industrial action.

The 52 week position has increased from August and is above plan but this is a picture that is mirrored across C&M and nationally due to the impact of industrial action and annua leave. In the week ending 30th September C&M had 5.31% of patients on a waiting list waiting over 52 weeks, for MWL this is 3.4%.

Cancer performance for MWL in August was 74.4% for the 14-day standard (target 93%) and 69.6% for the 62-Day standard (target 85%). St Helens performance being 61.7% for 14-day and 78.4% for 62 Day - both a drop from last month. Southport achieved 90.8% for the 14 -day standard and 55% 62-day, also seeing a drop from last month. MWL ranked 3rd best acute performer against the 62 day standard and seen the 2nd highest number of patients on a 62 day pathway.

Whilst a slight improvement, challenges continue with the production of letters following an outpatient appointment. Whist there continues to be delays overall, urgent letters are being produced within 48 hours of appointment. A recruitment open day has taken place and there have been a number of posts successfully recruited to. There are also a number of apprenticeship posts that have been secured. Further work being undertaken around Speech Recognition and opportunities.

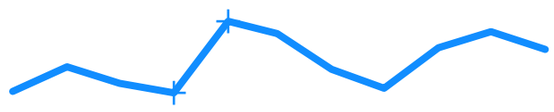
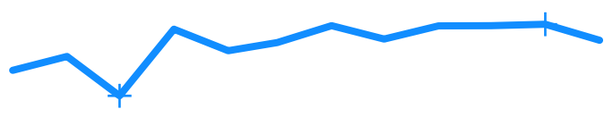
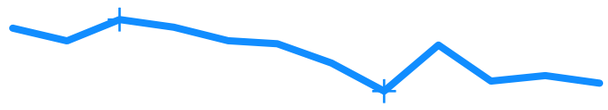
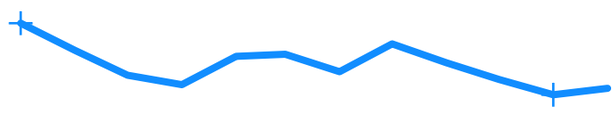
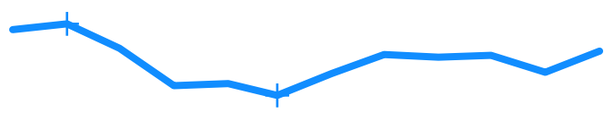
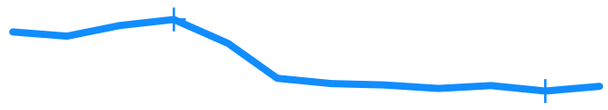
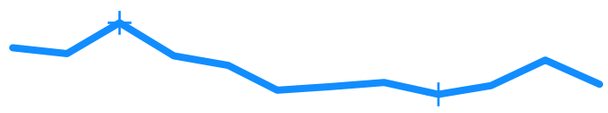
There were 4 days of industrial action in September for Junior Doctors and Consultants, 3 days for the Junior doctors and 2 for the consultants with 1 day of overlap this impacted upon elective activity.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Aug-23	70.3%	75.0%	69.4%	Bottom 30%	
Cancer 62 Days	Aug-23	69.6%	85.0%	70.2%	Top 30%	
% Ambulance Handovers within 30 minutes	Sep-23	63.8%	95.0%	69.0%		
A&E Standard (Mapped)	Sep-23	74.7%	76.0%	76.0%	Top 30%	
Average NEL LoS (excl Well Babies)	Sep-23	3.9	4.0	4.1	Top 30%	
% of Patients With No Criteria to Reside	Sep-23	30.0%	10.0%	26.4%		
Discharges Before Noon	Sep-23	16.9%	20.0%	17.8%		
G&A Bed Occupancy	Sep-23	89.8%	92.0%	89.4%	Bottom 50%	
Patients Whose Operation Was Cancelled	Sep-23	1.0%	0.8%	0.9%		
RTT % less than 18 weeks	Sep-23	59.7%	92.0%	61.5%	Top 50%	
RTT 65+	Sep-23	466	0	466	Top 30%	
% of E-discharge Summaries Sent Within 24 Hours	Sep-23	63.3%	90.0%	63.5%		
OP Letters to GP Within 7 Days	Aug-23	40.4%	90.0%	39.9%		

Board Summary - Workforce

Workforce

Sickness Absence
The top reason for absence is Anxiety, Stress and Depression. This is consistent with the top reason for absence across the NHS. The Trust continues to focus supporting all employees who are absent due to Anxiety/Stress/Depression by ensuring that all supportive actions have been undertaken. Further targeted work has also been undertaken as part of our overall absence management approach:

- Ensuring that welcome-back conversations (renamed from return to work), welfare meetings and trigger meetings are being undertaken
- Carrying out internal audits of areas to ensure the processes are being followed and providing support and training to line managers
- Delivering Attendance Management training sessions to new and existing managers
- Holding bi-weekly review of Trust absences by HR Operations Team and HWWB Team
- Facilitating early engagement of all employees who are absent due to musculoskeletal problems

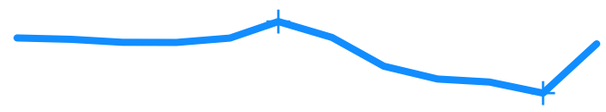
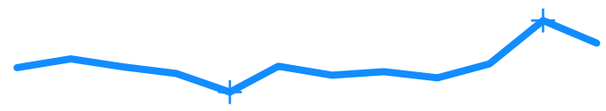
Appraisal - The Trust has not achieved the appraisal target, achieving 81.4% against a target of 85%.
ADOs have been requested to improve compliance throughout the rest of October, ahead of the Winter period. Increase in the number of virtual training events regarding appraisals and how to ensure successful completion of paperwork and upload into ESR. Weekly compliance updates identifying staff who do not have a completed appraisal recorded in ESR.
Mandatory Training - The Trust is exceeding its mandatory target at 86% against a target of 85%.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Sep-23	81.4%	85.0%	81.4%		
Mandatory Training	Sep-23	86.0%	85.0%	86.0%		
Sickness: All Staff Sickness Rate	Sep-23	6.0%	5.0%	5.6%		
Staffing: Turnover rate	Sep-23	1.3%	1.1%	1.1%		

Board Summary - Finance

Finance

The final approved MWL financial plan for 23/24 (combining agreed STHK and S&O plans) gives a surplus of £7.6m, which assumes:
- Full achievement of CQUINs
- Delivery of £31.8m recurrent CIP
- Delivery of £7.0m non-recurrent CIP
- Delivery of the 23/24 activity plan, in order to achieve planned levels of income including ERF/API variable funding

Surplus/Deficit – At Month 6, the Trust is reporting a year to date surplus of £0.6m, in line with plan. This position includes YTD industrial action costs of £3.7m which are assumed to be fully funded. The position also includes ongoing pressures currently being mitigated internally, including £4.0m non pay inflation above plan and a £1.9m YTD pay award pressure.
CIP - The Trust's 2023/24 CIP target is £38.8m, of which £31.8m is to be delivered recurrently and £7.0m non-recurrently. As at Month 6, schemes delivered or at finalisation stage totalled £26.0m in year (67%) and £16.9m (53%) recurrently.
Cash - At the end of M6, the cash balance was £3m, with a forecast of £12m at the end of the financial year. The Trust has submitted a request for £10m revenue cash, and £14m capital cash, in line with the transaction support agreed with NHS England and C&M ICS. The year end forecast assumes the application is successful.
Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £6.3m. No PDC funding (provided by Department of Health & Social Care) has been used.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Sep-23		7,000	6,300		
Cash Balances - Days to Cover Operating Expenses	Sep-23	1.5	10			
Reported Surplus/Deficit (000's)	Sep-23		629	629		

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Southport & Ormskirk

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	May-23	108.7	100	100.7	
FFT - Inpatients % recommended	Sep-23	93.8%	90.0%	94.9%	
Nurse Fill Rates	Aug-23	96.6%	90.0%	95.3%	
C.difficile	Sep-23	5	39	18	
E.coli	Sep-23	7	48	44	
Hospital Acq Pressure Ulcers per 1000 bed days	May-23	0.0	0.0	0.5	
Falls ≥ moderate harm per 1000 bed days	Sep-23	0.3	0.0	0.1	
Stillbirths (intrapartum)	Sep-23	0	0	0	
Neonatal Deaths	Sep-23	0	0	1	
Never Events	Sep-23	0	0	0	
Complaints Responded In Agreed Timescale %	Sep-23	82.4%	90.0%	70.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-23	71.1%	75.0%	68.9%	
Cancer 62 Days	Aug-23	55.0%	85.0%	56.7%	
% Ambulance Handovers within 30 minutes	Sep-23	68.1%	95.0%	76.5%	
A&E Standard (Mapped)	Sep-23				
Average NEL LoS (excl Well Babies)	Sep-23	4.7	4.0	5.0	
% of Patients With No Criteria to Reside	Sep-23	18.4%	10.0%	17.7%	
Discharges Before Noon	Sep-23	18.9%	20.0%	19.5%	
G&A Bed Occupancy	Sep-23	80.1%	92.0%	79.6%	
Patients Whose Operation Was Cancelled	Sep-23	0.3%	0.8%	0.6%	
RTT % less than 18 weeks	Sep-23	59.9%	92.0%	60.4%	
RTT 65+	Sep-23	19	0	19	
% of E-discharge Summaries Sent Within 24 Hours	Sep-23	81.5%	90.0%	78.4%	
OP Letters to GP Within 7 Days	Aug-23	70.8%	90.0%	69.9%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Sep-23	73.4%	85.0%	73.4%	
Mandatory Training	Sep-23	91.1%	85.0%	91.1%	
Sickness: All Staff Sickness Rate	Sep-23	6.0%	6.0%	5.6%	
Staffing: Turnover rate	Sep-23	1.2%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Sep-23				
Cash Balances - Days to Cover Operating Expenses	Sep-23				
Reported Surplus/Deficit (000's)	Sep-23				

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

St Helens & Knowsley

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	May-23	82.7	100	86.5	
FFT - Inpatients % recommended	Sep-23	94.3%	90.0%	95.1%	
Nurse Fill Rates	Aug-23	97.6%	90.0%	98.9%	
C.difficile	Sep-23	4	46	31	
E.coli	Sep-23	9	73	59	
Hospital Acq Pressure Ulcers per 1000 bed days	May-23	0.0	0.0	0.1	
Falls ≥ moderate harm per 1000 bed days	Aug-23	0.1	0.0	0.2	
Stillbirths (intrapartum)	Sep-23	0	0	0	
Neonatal Deaths	Sep-23	1	0	2	
Never Events	Sep-23	0	0	0	
Complaints Responded In Agreed Timescale %	Sep-23	72.7%	90.0%	69.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-23	69.7%	75.0%	69.8%	
Cancer 62 Days	Aug-23	78.4%	85.0%	78.8%	
% Ambulance Handovers within 30 minutes	Sep-23	60.2%	95.0%	62.9%	
A&E Standard (Mapped)	Sep-23				
Average NEL LoS (excl Well Babies)	Sep-23	3.6	4.0	3.7	
% of Patients With No Criteria to Reside	Sep-23	35.9%	10.0%	31.2%	
Discharges Before Noon	Sep-23	15.0%	20.0%	16.2%	
G&A Bed Occupancy	Sep-23	97.0%	92.0%	96.8%	
Patients Whose Operation Was Cancelled	Sep-23	1.4%	0.8%	1.0%	
RTT % less than 18 weeks	Sep-23	59.7%	92.0%	61.9%	
RTT 65+	Sep-23	447	0	447	
% of E-discharge Summaries Sent Within 24 Hours	Sep-23	59.3%	90.0%	60.1%	
OP Letters to GP Within 7 Days	Aug-23	23.7%	90.0%	22.4%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Sep-23	85.9%	85.0%	85.9%	
Mandatory Training	Sep-23	83.9%	85.0%	83.9%	
Sickness: All Staff Sickness Rate	Sep-23	6.2%	5.0%	5.7%	
Staffing: Turnover rate	Sep-23	1.4%	1.1%	1.1%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Sep-23				
Cash Balances - Days to Cover Operating Expenses	Sep-23				
Reported Surplus/Deficit (000's)	Sep-23				

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 October 2023
Agenda Item	**MWL TB23/044 (7.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in September 2023		
Committee Chair	Ann Marr, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were four Executive Committee meetings held during September 2023. At every meeting bank or agency staff requests that breach the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded.		
07 September 2023		
September Trust Board Agendas	• The Director of Corporate Services presented the draft Trust Board agendas for October for review. • The nominations for the Employee of the Month received in August were also discussed.	Assurance
Protecting Elective Capacity – Draft Board Checklist	• The Chief Operating Officer presented the Trust's proposed responses to the NHSE Board Checklist for protecting elective capacity that was due for submission by 14 September 2023. • The Committee reviewed the Board Checklist and agreed amendments in relation to validation and communication with patients. • It was agreed the checklist would be presented at the Finance and Performance Committee and the final version would be presented to Board, in line with NHSE requirements.	Approval
Non-Elective Business Cases	• The Managing Director introduced the report which provided background information and context for proposed business cases to address the pressures being experienced in Urgent and Emergency care at Whiston Hospital.	Assurance
MWL Culture Programme	• The Director of Staff Engagement and Inclusion presented the proposals for a two-year programme based on the King's Fund guidance to	Approval

	develop a shared culture across Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). • The initial phase was a “big conversation” to engage with staff to create the values for the new organisation. • The Committee supported of the plan, although reservations were expressed about the timescales.	
14 September 2023		
Freedom to Speak Up (FTSU)	• The Director of Nursing, Midwifery and Governance presented the review of the Trust Freedom to Speak Up arrangements and Whistleblowing Policies considering the additional guidance from NHSE following the Lucy Letby verdict. • The Committee discussed the review and agreed some amendments. The revised version would be presented to the Quality Committee to provide assurance that the Trust processes were fit for purpose.	Assurance
Trust Objectives aligned to Quality Committee	• The Committee received and reviewed the update on Quarter 1 progress on delivering these Trust objectives which were aligned to the Quality Committee. The report included updates from both legacy Trusts. Some amendments were agreed for the reports to be updated before presentation to the Quality Committee.	Assurance
Electronic Patient Record (EPR) Outline Business Case (OBC) changes	• The Director of Informatics presented the proposed changes to the EPR OBC following the Cheshire and Merseyside ICB review. The requested changes were principally in relation to the completion of the financial model, in respect of the treatment of contingency funds and optimism bias. • The committee approved the changes and for the OBC to be re-submitted.	Approval
Patient Experience Portal Business Case	• The Director of Informatics and the Chief Operating Officer presented the business case to procure the Netcall Patient Hub system. The portal is designed to support communication with patients, allowing them to view hospital records, update their health information and amend appointments.	Approval

	• The funding for the system had been received from NHSE (capital and revenue for three years). • The portal should reduce DNA rates and improve efficiency of the booking systems, with a view to being self-funding by year 4. • Assurance was provided that the system could be linked to Careflow to ensure patient tracking lists remained accurate. • The business case was approved.	
Impact of Long Waiters	• The Director of Finance and Information briefed the Committee on some of the pressures to secure non-medical staff to support weekend waiting list initiatives and the committee discussed potential solutions. • It was agreed further exploratory work was required to understand comparisons with other trusts.	Assurance
Mandatory Training (linked to LCEA)	• The Deputy CEO/Director of Human Resources presented the report and advised that LCEAs were a contractual entitlement for consultants, but local conditions could be agreed as part of the qualifying criteria for how the LCEA funds would be allocated. • The report outlined the options for developing a competitive award scheme, following the equal distribution of LCEA funds since the start of the COVID 19 pandemic. The Committee agreed that as there was insufficient time to develop, engage about and implement a new competitive awards scheme for the 2023/24 award year, but work should commence on developing a scheme for MWL with key qualifying criteria (including completion of mandatory training) to commence in 2024/25.	Approval
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the RMC Assurance report following the meeting held on 12 September 2023 and advised that there continued to be legacy Trust reports as the Datix system was aligned to the organisational structures. Assurance was provided that risks were still being reported across the organisation and escalated to the Corporate Risk Register (CRR) through a similar process.	Assurance

	• There were 804 risks on the STHK sites risk register with 35 escalated to the CRR, with one new high/extreme risk relating to capacity to maintain the target for clinical letters to be completed in two weeks. • There were 229 risks on the S&O sites risk register with 10 escalated to the CRR, with no changes to the CRR risks in the month. • The RMC had approved the new Emergency Preparedness, Resilience and Response (EPRR) policy for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). The other supporting EPRR procedural documents had been approved virtually ahead of the annual EPRR declaration against the new core standards.	
Fit and Proper Persons Test (FPPT)	• The Deputy CEO/Director of Human Resources presented a briefing on and proposals for implementing the new NHSE Fit and Proper Person Test Framework. • The committee approved the proposals, which would also be shared with the Trust Board at the September meeting.	Approval
21 September 2023		
Safe Staffing Report	• The Director of Nursing, Midwifery and Governance introduced the report for July 2023 which provided a full overview of nursing safe staffing as well as a summary/update of staffing areas to note, potential risks and actions taken to mitigate risk. • The overall fill rate for STHK sites was 98.61% for Registered Nurses (RNs) and 124.86% for Health Care Assistants. (HCA). • The overall fill rate for S&O sites was 97.97% for Registered Nurses (RNs) and 92.07% for Health Care Assistants. (HCA). • STHK reported an average of 26.4 escalation beds per day in July 2023 and for S&O sites Ward 1 remained opened with 12 beds and a fill rate of 91.6% for the month. • It was noted that further alignment of systems was required to provide an overall MWL safer staffing position, which was being progressed. • A review of supplementary care and the criteria for requesting additional staff was underway.	Assurance

	• Committee noted that there had been an increase in medication errors noted for the neonatal ward in consecutive reports, which had occurred when there had been shortfalls in RN staffing, and agreed a more detailed review would be undertaken.	
Staff Seasonal Vaccination Campaign 2023/24 Business Case	• The Deputy CEO/Director of Human Resources introduced the report and explained that the campaign covered both flu and Covid-19 vaccinations for NHS staff. • The campaign would run from 07 October to 15 December 2023, and the CQUIN target was to achieve 75-80% of frontline staff vaccinated for flu. • The HWWB team sought additional investment for MWL to run and promote the campaign for the 16 week period. • The business case and delivery plans were approved, and it was noted that the vaccination assurance checklist would be presented to the September Board.	Approval
Gender Pay Gap Report 2023	• The Deputy CEO/Director of Human Resources introduced the reports for 2023 for both legacy trusts, based on a snapshot of information taken in March 2023, and modelling of the MWL position for each metric. • The annual gender pay gap declarations to comply with the legal requirements would be presented at the September Board. • Committee reviewed the impact of LCEAs on the gender pay gap for Medical and Dental staff in detail.	Assurance
Transition and Transformation Council (TTC) Update	• The Managing Director presented the report which included the risks that had been identified as part of the NHSE Transaction Business Case approval process and noted the progress made in establishing the governance and workstreams to deliver the recommendations received from NHSE prior to the transaction and take forward the integration of services and the Trust's input to the Shaping Care Together programme.	Assurance
Laboratory Information System	• The Director of Informatics presented the business case, on behalf of the Cheshire and	Approval

(LIMS) Business Case	Merseyside pathology network, who are seeking the support of Trust boards to progress a single procurement for a shared LIMS across the ICB. • It was noted that MWL would host the LIMS contract on behalf of the ICB, and the timetable for the procurement created some financial challenges, if there was slippage into 2024/25 • Committee agreed that having a shared LIMS was the right thing to do to promote integrated working and therefore supported the business case to be taken to the Trust Board in September for approval.	
Impact on Long Waiters (Proposal re Theatre Staff)	• The Director of Finance and Information presented the report which outlined the comparative pay rates and agency costs for undertaking Waiting List Initiatives (WLIs) for legacy STHK and S&O theatre staff and when existing agreements were due for review and how harmonised pay rates for WLI could be introduced for ASA doctors and other staff who staffed these additional sessions.	Assurance
28 September 2023		
Off Framework Agency Spend	• The Deputy CEO/Director of Human Resources provided an update on the development of a new standardised Off Framework Agency spend form and approval process for MWL.	Assurance
HCA B2-B3 Claim	• The Director of Finance and Information provided an update following a meeting with staff side representatives and the Committee agreed the next steps.	Assurance
Registered Nurse Degree Apprenticeship Programme	• The Managing Director presented the proposals to continue the programme to support assistant practitioners and nursing associates to progress to registered nurses through the apprenticeship programme. • The Trust can bid to NHSE for up to five places on the programme for 2023/24 and would need to cover the backfill costs. • The committee agreed to go forward with the maximum funded places, as this aligned with the Trust Nursing and People Strategies.	Approval

Ophthalmology Bid	• The Chief Operating Officer briefed the committee on the revised bid that had been submitted to NHSE to create an ophthalmology hub at Ormskirk Hospital. • An original bid had included proposals for a Health on the High Street scheme, but NHSE had now moved away from this model in the initial phase. • If successful, the bid would enable the development of the hub by the end of 2024/25. • Committee approved the revised bid for submission.	Approval

Alerts:

Decisions and Recommendation(s):

New investment decisions taken by the Committee during September were:

1. Patient Experience Portal Business Case
2. Staff Vaccination Campaign 2023/24 Business Case

Committee Assurance Report

Title of Meeting	**Trust Board**	**Date**	25 October 2023
Agenda Item	**MWL TB2/044 (7.2)**		
Committee being reported	Quality Committee		
Date of Meeting	17 October 2023		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Minutes of the previous meeting	Minutes of the meeting held on 19 September were approved as a correct and accurate record of proceedings, following a minor correction.	Approve
Matters arising/action log	There were no due actions.	Approve
Corporate Performance Report (CPR)	The quality metrics were discussed, noting the work taking place to align reporting across all sites. Data was reviewed in relation to pressure ulcers, falls, nurse/midwife fill rates, serious incidents, nutrition, infections, mixed sex breaches, complaints, friends and family test, mortality ratio, e-discharges and maternity indicators. The Committee noted the actions being taken to improve e-discharge compliance. The Committee discussed maternity metrics, preparation for the imminent CQC inspection, the essential role of the Maternity Voices Partnership (MVP) and reiterated the need to appoint an MVP chair at Whiston as soon as possible. The Committee requested a detailed report on the latest national maternity survey for Whiston and Ormskirk at the next meeting.	Assurance
October Patient Safety Council report	The Committee received an assurance report from October's Patient Safety Council and noted that a detailed review of sample mislabelling was taking place to identify areas for improvement. Assurance was provided that all women who had had antenatal Anti-D omitted at Whiston Maternity Unit had been followed up and would receive appropriate care. The process for monitoring blood results has been changed to further reduce the risk. The Committee requested information regarding compliance with Anti-D at Ormskirk Maternity Unit for their next meeting in November.	Assurance

	Venous thrombo-embolism (VTE) risk assessment/ pathway has now been included in clerking documentation. The benefits of pharmacy technicians in Emergency Department (ED) at Whiston were outlined with increased numbers of medicines reconciliations being completed. The Committee sought assurance that processes for managing any controlled drug incidents were robust, with any trends identified and managed and, also, that gynaecology ward was included in NEWS audits.	
Safeguarding Quarterly Reports – Quarter 2	It was noted that the contracts for both services were rated green in all areas other than training, with legacy St Helens and Knowsley Teaching Hospitals NHS Trust (StHK) compliant with 6/9 areas and Southport and Ormskirk Hospital NHS Trust (S&O) with 7. However, commissioners are assured staff are competent due to the levels of activity. No looked after children health check breaches were due to internal processes and work continues with the designated nurse to achieve compliance. St Helens Section 11 visit provided positive comments and it was noted that MIAA are to conduct an audit before the end of the year. Deprivation of Liberty Safeguard applications remain high. A learning disability (LD) patient experience event will be held quarterly, and the Committee were pleased to note that the Learning Disability and Autism Practitioner and the LD volunteer at S&O have been nominated for Time to Shine awards. In addition, two case studies from StHK have been used as examples of Gold Standard practice by NHS England. It was positive to note that Child and Adolescent Mental Health Services are now providing 4 hour response times 24 hours per day, which will reduce unnecessary admissions and provide better outcomes. The two teams have harmonised a number of policies and are aligning ways of working across the Trust.	Assurance
Maternity Services Update Report Whiston	A detailed paper was delivered, including: • Confirmation that Maternity Incentive Scheme year 4 had been achieved and that work was underway to meet the challenging target to have all evidence for year 5 signed off and submitted by 01 February 2024, including oversight by Local Maternity and Neonatal System (LMNS)	Assurance

	• Work to improve smoking indicators, including appointment of Tobacco Dependency Treatment Advisors • Assurances that processes are followed to ensure timely and thorough review of incidents, including neonates requiring cooling and perinatal mortality, noting the latest reports had identified some learning but no issues with clinical care leading directly to an adverse incident • Compliance with Saving Babies Lives version 2 was noted and ongoing work to achieve version 3, including the new element of management of pre-existing diabetes. The Committee noted the challenging timetable for this also with evidence required by 30 October 2023 • The Committee noted the ongoing work to ensure full staffing and the increase in red flags on the day a divert was put in place for 4 hours in April. Members were pleased to note that provision of a supernumerary shift co-ordinator and one to one care for women in established labour had been fully achieved in Q1 • List of training was provided • Committee requested future reports include patient experience information •	
Patient Experience Council	The Committee received an assurance report from the October meeting of the Patient Experience Council, noting the following key points: • Two patient stories highlighted the positive impact made by Patient Experience Team through the use of patient experience surveys • Ongoing invaluable contribution of the volunteer service, including new initiatives of butterfly champions for palliative care patients and support for international nurses • Progress update on delivery of equality objectives • Outcome of latest urgent and emergency care patient survey for Southport and Ormskirk sites, with improvement actions noted • Work to ensure all procedural documents are up-to-date The Council noted the challenges in reducing the time taken to respond to complaints.	Assurance
Inpatient Survey - StHK	The Committee noted the positive results of the 2022 inpatient survey for legacy StHK, with 17 questions rated somewhat better, better or much better than most trusts and none in the worse categories. The Trust	Assurance

	scored the second highest score nationally for overall inpatient experience when compared to similar trusts and the whole section score for doctors was banded better than most trusts. A detailed action plan has been developed to further improve in areas with lower or decreasing scores.	
Complaints, PALS, Claims, and Friends & Family Quarterly Report	The Committee discussed the quarter 2 report, noting a slight increase in the overall number of complaints compared to previous quarter, but a significant decrease in Patient Advice and Liaison Service (PALS) contacts. ED at Southport was noted to have a low level of complaints, with lessons learned to be shared with Whiston team. Actions taken and lessons learned were shared. The increase in activity with the Parliamentary and Health Service Ombudsman and sharp increase in pre-action claims were highlighted. Friends and Family Test results remain fairly static. The Committee noted the work ongoing to reduce the response times for complaints and the challenges faced by Whiston-based PALS team.	Assurance
Clinical Effectiveness Council	The Committee received the assurance report from October's meeting noting the following: • Review of the number of Medical Emergency Team (MET) calls to Bevan Court 1 • Sustained improvement in appropriate do not attempt cardio-pulmonary resuscitation (DNACPR) orders • Simulation training for managing trauma patients to ensure staff retain key skills and trial of silver trauma team in ED working with Frailty Team for specific cohort of patients • Care Group/Clinical Business Unit reports received • National Emergency Laparotomy Audit results noted with challenges in meeting revised better payment tariff relating to input of care of elderly consultant, with work on going to address this • Discharges direct from Intensive Care Unit and delayed discharges to wards were flagged as amber on latest national audit, with overall practice noted to be good • Improving Outcomes Group reported no undue concerning trends in surgical subspecialties. The Committee noted higher than national rates of chest infections in general surgery and received assurance that this has been highlighted	Assurance

Learning from Deaths – StHK and S&O	Assurance provided that there are comprehensive processes in place to identify any learning from deaths, with one amber case at StHK identified in April 2023, that is undergoing further review. None of the five investigations conducted at S&O highlighted deaths that were more likely than not to be attributed to problems in healthcare. Key learning from the process is shared widely.	Assurance
Alerts:		
Nothing to escalate to Trust Board		
Decisions and Recommendation(s):		
Not applicable		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 October 2023
Agenda Item	**MWL TB23/044 (7.2)**		
Committee being reported	Strategic People Committee		
Date of Meeting	16 October 2023		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Minutes of the previous meeting	The Committee reviewed the minutes of the meeting held on 18th September 2023 and approved them as a correct and accurate record of proceedings.	Decision
Action Log and Matters Arising	• The Terms of Reference for the Strategic People Committee (SPC) were amended for approval by the Trust Board • The Workforce Dashboard detailed analysis was completed at the People Performance Council with a specific deep dive into allied health professionals. Assurance was provided to the committee via the People Performance Council Assurance report.	Assurance
Workforce Dashboard	The Corporate Performance Report (CPR) dashboard was presented focusing on the key indicators for the SPC. • It was noted that work was ongoing to align the two legacy organisations appraisal approaches. • Sickness remained above target although a positive change has been identified with regards to reducing Allied Health Professionals (AHP) sickness It was noted that the Executive Committee have set a new stretch target of 5% for sickness absence following a benchmarking exercise.	Assurance
Staff story	An MWL employee shared her 25-year career journey across a number of NHS organisation. The positive impact of collaborative working across MWL teams was highlighted. The employee complimented the professional recruitment process, onboarding process and induction they experienced	Assurance

	within Community Planned Care. They felt the structure of the Community Planned Care team enabled staff to support each other and promoted team work. The employee expressed gratitude for the opportunities for learning and training provided by the Trust and expressed their passion for improving patient care. It was agreed that the positive experience and learning from the Community Planned Care department should be shared Trust wide.	
Staff Survey Action Plan	The Committee were provided with an overview of actions identified following the 2022 staff survey and given assurance on progress to date. Going forward all results from the staff survey will be discussed at the Staff survey Operational Group where bespoke action plans are developed and monitored.	Assurance
Staff Engagement/Culture Update	The Staff Engagement/Culture update informed the committee on the progress of the Big Conversation Programme. The Committee noted the following actions were being delivered: • Regular communications to all staff, including MWL News weekly issue and Trust Brief Live. • Engagement with staff via the Staff Survey events planned by the L&OD Team. • Continued support is being provided by the Trust Board and Senior Leaders to support the Big Conversation Programme.	Assurance
Workforce Race Equality Standard Report (WRES) Annual Update and Workforce Disability Equality Standard Report (WDES) Annual Update	The committee received full reports on the legacy STHK Workforce Race Equality Standards and the Workforce Disability Equality Standards. The committee received a presentation on both reports which provided an analysis of the standards and where available, comparison data was also provided for legacy S&O along with NHS national averages. The WRES data was submitted to NHSE on the 31 May 2023 and will be published on 31 October 2023 following discussion at the October Trust Board meeting. Action plans for both the WRES and WDES standards were shared.	Assurance
Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Reports from the People Performance Council and Valuing our People Council	Assurance

People Performance Council – Terms of Reference	The Strategic People Committee approved the People Performance Council terms of reference.	Assurance
Items for Escalation to Trust Board	No items to be escalated via the Assurance Report	

Alerts:

Not applicable

Decisions and Recommendation(s):

- Approval of the previous minutes
- Approval of the People Performance Council terms of reference.
- Amendments to be made the Strategic People Committee Terms of Reference to recommend to the Trust Board for approval.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board Meeting**	**Date**	25 October 2023
Agenda Item	**MWL TB23/044 (7.4)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	19 October 2023		
Committee Chair	Jeff Kozer		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Integrated Performance Report Month 6 2023/24	• Bed occupancy across MWL averaged 104.3% in September 2023. There is an increased number of 1+ day admissions, 7% higher than last September 2022. • Average length of stay for emergency admissions is an average of 8.1 days, the impact of non-Criteria to reside (NC2R) patients being 26.4% at overall trust level. • 4-hour A&E performance improved over the summer with September 2023 achieving 69.6% (all types). National performance is at 71.6% and Cheshire & Merseyside overall position at 71.3%. • The Trust had 2,480 x 52+ week waiters at the end of September 2023 with 14 x 78+ week waiters. The 52-week position is an increase on plan and 127 more than August 2023. • Cancer performance for MWL in August 2023 was 74.4% for the 14-day standard (target 93%) and 69.6% for the 62-Day standard (target 85%). • Industrial action has impacted activity in month.	Assurance
Finance Report Month 6 2023/24	• At the end of Month 6, the Trust is reporting a year-to-date surplus of £0.6m (in line with plan). • Forecast outturn for 23/24 remains in line with plan at £7.6m surplus. • This position includes £3m costs relating to Industrial action in M3-M6 which remain a risk to the planned position if national funding not realised (M1-M2 IA have now been funded). • Agency costs £9.5m year to date. This equates to 4.0% of total pay spend, against a target of	Assurance

	3.7%. Mitigating actions are being taken to address this. • CIP is on track to be delivered in line with target by the end of the year. • Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £6.3m, significant amount of capital to be spent in the second half of the year. Capital summit held to review progress and update plans for the remainder of the year. • At the end of M6, the cash balance was £3m, with a forecast of £12m at the end of the financial year. The Trust has submitted requests for cash in line with the transaction support and these are included within the forecast. • The Better Payment Practice Code (BPPC) compliance has reduced in line with expectations post ledger merge, plan in place to achieve target.	
Month 6 2023/24 CIP Programme Update Alongside: Medicine & Emergency Care (S&O) CIP Presentation Specialist & Support (S&O) CIP Presentation	• Total targets for 23/24 (including £2.8m recurrent CIP delivered by S&O during M1-M3) are £41.6m in year and £34.6m recurrently. • Schemes identified totalling £51.1m in year and £34.8m recurrently. • Delivered/low risk schemes currently total £28.8m in year (69% of target) and £19.7m recurrently (57% of target). • Trust remains on track to deliver full CIP target by end of year. • Committee noted the update and was assured by the report and presentations.	Assurance
Diagnostics Update	• Performance against the national 6-week diagnostics target of 80% is 67.9% in September 2023. • By modality, MRI and CT are exceeding this target and the remaining modalities are below (Endoscopy, Dexa and Non obstetric ultrasounds). • There are 222 patients waiting more than 26 weeks against a target of zero.	Assurance
Assurance Reports from Subgroups:	• CIP Council • Capital Planning Council • Verbal report from Estates and Facilities Council	Assurance

	• Committee noted the Council updates with nothing to escalate.	

Alerts:
Finance Report Month 6 2023/24 The financial position includes £3m costs relating to Industrial action in M3-M6 which remain a risk to the planned position if national funding not realised (M1-M2 IA have now been funded).
Decisions and Recommendation(s):
N/A

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	25 October 2023
Agenda Item	**MWL TB23/045**				
Report Title	MWL Clinical Strategy				
Executive Lead	Peter Williams, Medical Director				
Presenting Officer	Peter Williams, Medical Director				
Action Required	X	**To Approve**		**To Note**	

Purpose

To present to the Board the Final Draft of the Trust Clinical Strategy.

Executive Summary

A Clinical Strategy for the new Trust has been developed to align with the principles outlined in the Post Transaction Implementation Plan, along with Local, National and Regional priorities. The Strategy was developed in consultation with members of the medical leadership, nursing, and executive teams. It has previously been shared with the Board and is now being shared in its final draft form.

The clinical objectives outlined in the strategy are to:

- Ensure clinical governance structures are in place to continue to deliver safe and effective clinical care across the Trust
- Achieve national, regional and local NHS priorities
- Review and align pathways to enable integration of clinical services across the Trust
- Complete the stabilisation of fragile clinical services and address any inequalities and barriers to delivery of high quality and effective care to patients

The final draft has been shared with Integrated Care Board (ICB) Leaders for comment and engagement events have taken place with Patient Engagement Groups across the Trust.

Following approval the Clinical Strategy will be shared with clinical colleagues within and outside of the Trust as well as with partner organisations.

Financial Implications

None

Quality and/or Equality Impact

This does not related to a service change.

Recommendations

The Board is asked to approve the Clinical Strategy

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce

	SO7 Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Mersey and West Lancashire Teaching Hospitals NHS Trust

Mersey and West Lancashire Teaching Hospitals NHS Trust

CLINICAL STRATEGY 2023 – 2025

Draft v 18

"Delivering Five Star Patient Care"

Contents

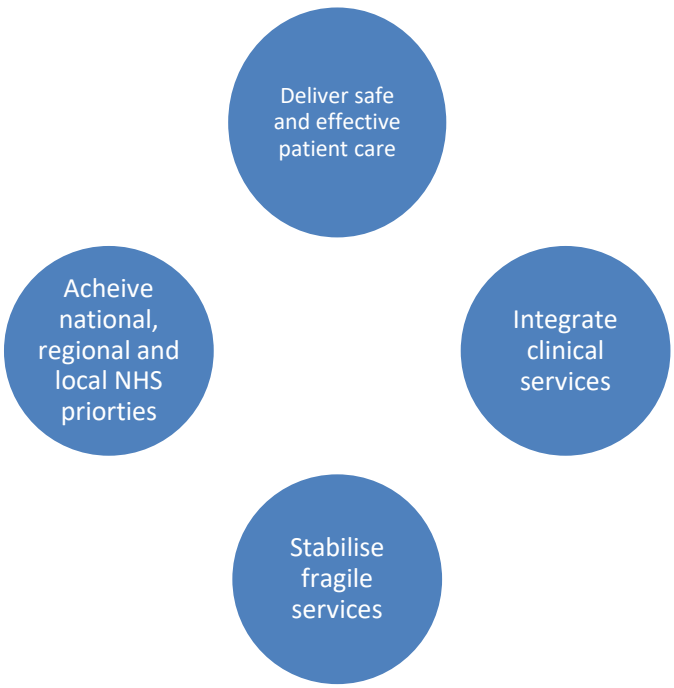
Executive Summary

This clinical strategy sets out the priorities for the new organisation combining the St Helens and Knowsley Teaching Hospitals and Southport and Ormskirk Hospital NHS Trusts to form Mersey and West Lancashire Teaching Hospitals NHS Trust. As the new Trust progresses, this strategy will guide the development of clinical services over the initial post-transaction period, allowing time for engagement with our larger workforce and our local healthcare system as the working relationship continues to evolve with Places, as part of two Integrated Care Systems (Cheshire and Merseyside ICS and Lancashire and South Cumbria ICS). As our organisation consolidates and the emerging healthcare landscape becomes clearer, the Trust will develop a long-term strategy which aligns with the new organisation and the new health and social care system.

The Clinical Priorities outlined in this strategy are based around the local, system and national healthcare challenges and our priorities for delivery of care. They reflect the strategic direction for the Trust and the patient centred care delivered by clinical staff, both of which will improve quality and safety for those using our services.

Clinical Priorities

- Ensure clinical governance structures are in place to continue to deliver safe and effective clinical care across the Trust
- Review and align pathways to enable integration of clinical services across the Trust
- Complete the stabilisation of fragile clinical services and address any inequalities and barriers to delivery of high quality and effective care to patients
- Achieve national, regional and local NHS priorities to:
  - Improve Emergency Department waiting and ambulance turnaround times
  - Reduce waiting times for elective treatments and diagnostic tests
  - Reduce the time to diagnose or exclude cancer in patients who are referred to hospital



Introduction

The formation of a new NHS Trust is a unique opportunity for both patients and staff members. As Medical Director it is my privilege to help to shape the direction of clinical services in the new Trust through the development and delivery of the Trust Clinical Strategy. This strategy document outlines the background to the transaction between the St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust as well as the national and regional context which have set the performance standards which NHS trusts must deliver. To deliver those standards while also ensuring patients receive safe, effective and compassionate patient care will be a challenge we will all work together to meet and will require us to work collaboratively with colleagues in primary care, social care, community services, mental health services and the voluntary sector. The document also explains how the strategy has been developed, the principles which will underline the way we deliver care and the clinical objectives for the first two years in the new Trust.

The delivery of clinical services in our Trust is only possible through every member of staff putting patients at the centre of what we do. I am delighted to have the chance to work with colleagues, including the medical, nursing, Allied Health Professionals and all other staff in Mersey and West Lancashire Teaching Hospitals NHS Trust and our partner Integrated Care Systems, to deliver this strategy and to provide 5-star care to everyone who uses our services.

Dr Peter Williams

Medical Director
Mersey and West Lancashire NHS Trust

1. About our new Trust

a. Background

Mersey and West Lancashire Teaching Hospitals NHS Trust is a new NHS Trust formed following the long-term collaboration between St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust.

St Helens and Knowsley Teaching Hospitals NHS Trust provided acute and community healthcare services to approximately 360,000 people living in St Helens, Knowsley, Halton and Liverpool as well as neighbouring areas including Warrington, Ormskirk and Wigan in three hospitals: elective and emergency services at Whiston Hospital, elective services at St Helens Hospital, intermediate care and community services at Newton Hospital, and Primary Care at Marshall's Cross Surgery. In addition to general and acute adult, maternity and paediatric services, the Trust also provided community services to patients in the boroughs of St Helens, Halton and Knowsley and burns and reconstructive plastic surgery services to patients across Cheshire, Merseyside, North Wales and the Isle of Man. In addition, the Trust hosts the Mid-Mersey Neurological Rehabilitation Unit at St Helens Hospital

Southport and Ormskirk Hospitals NHS Trust (S&O) provided healthcare services to approximately 258,000 people across Sefton and West Lancashire at two hospitals: Acute adult clinical services at Southport Hospital, with an adult Emergency Department and inpatient speciality facilities, and women and children's services, including obstetric-led maternity care, paediatric Accident and Emergency Department and elective adult clinical services at Ormskirk Hospital. The Trust also provided the regional spinal injuries unit at Southport Hospital.

When S&O began to struggle to provide clinical services in several specialities, an Agreement for Long Term Collaboration (ALTC) began, in order to allow these services to continue to be delivered through collaborative working and sharing of best practice. Following this period of successful collaboration, a decision was made to bring the two organisations together to form one single, new Trust through a formal transaction.

b. Our new trust and drivers for the change

The drivers for closer working and the move to become one Trust came from national, regional and local challenges which will be addressed with collaborative solutions.

National and Regional Challenges

- Increasing demand for healthcare due to an ageing population with more complex needs
- Challenges following the COVID-19 pandemic during which elective activity was reduced to prioritise acute services
- Workforce shortages across all disciplines within the NHS
- Health inequalities caused by high population levels of social deprivation

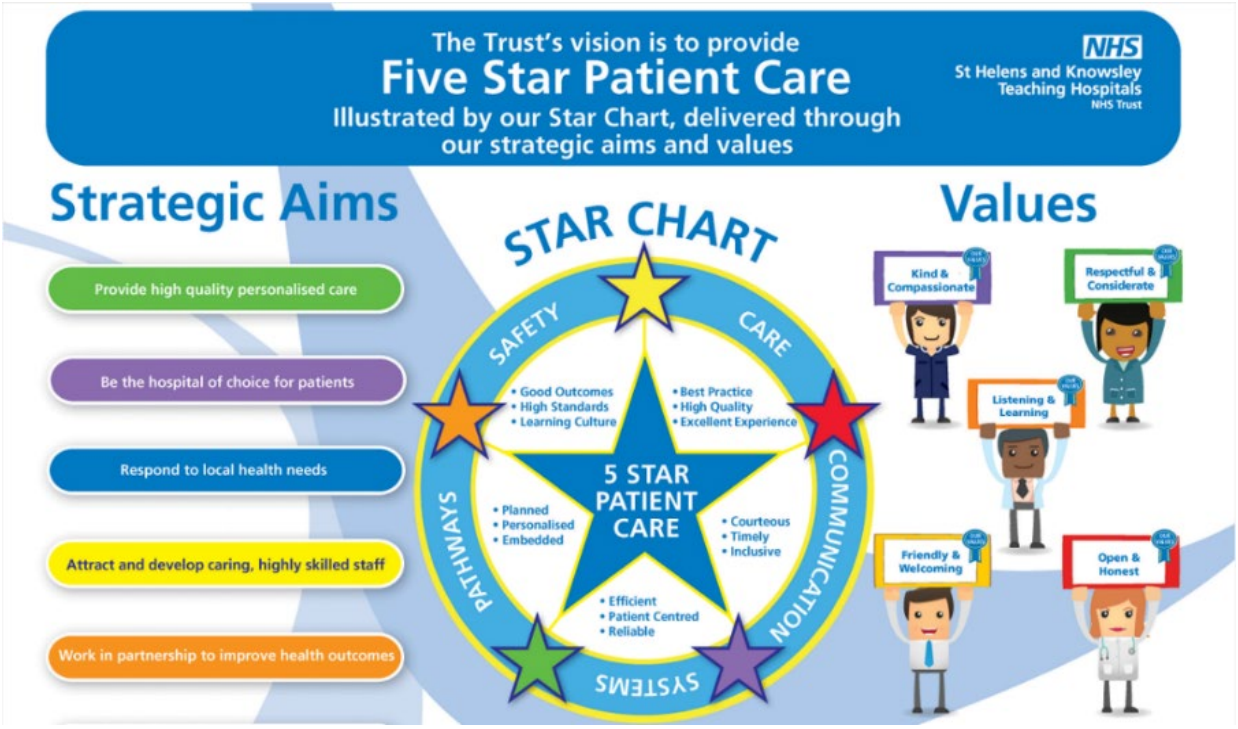
Local challenges

- Providers unable to provide required level of patient care in some specialities which may lead to reduced service to the population who require them (“Fragile Services”)
- Proliferation of Service Level Agreements between providers which may reduce individual Trusts’ ability to establish their own services.
- Financial sustainability issues and an underlying financial deficit at Southport and Ormskirk Hospital NHS Trust leading to challenges in sustainable service improvement
- High vacancy rates and agency spend reflecting a workforce recruitment and retention problem at S&O

Opportunities exist within a new, larger Trust to address a number of these issues through:

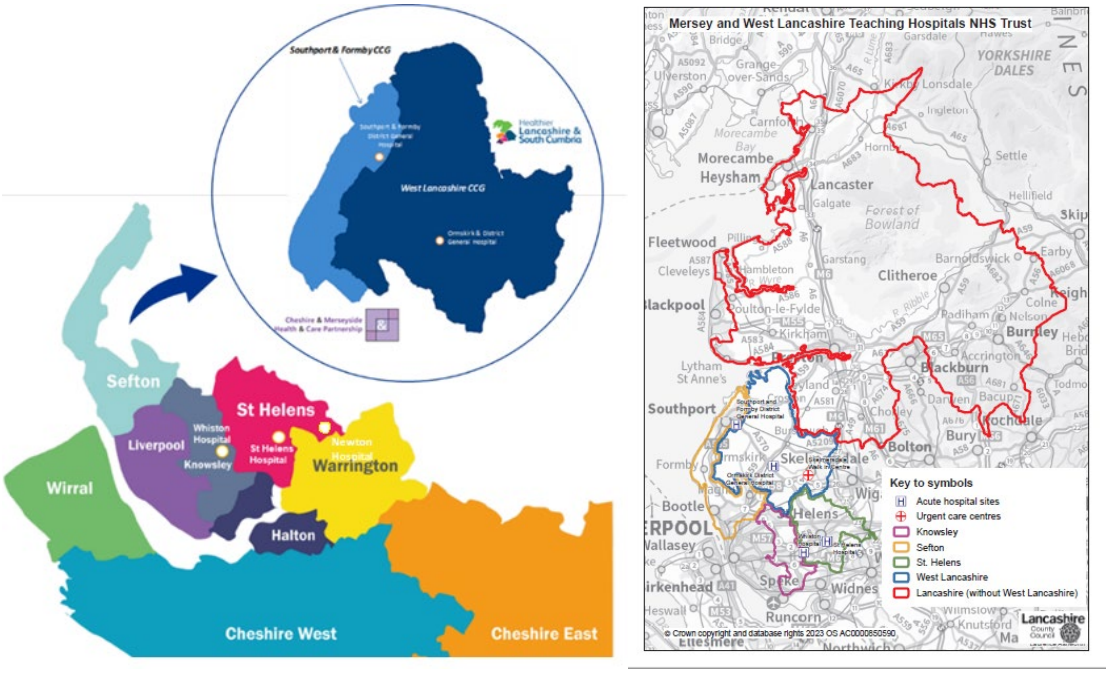
- Improvement in clinical sustainability to achieve the best possible performance across the whole Trust
- Clinical service review and alignment to achieve optimal clinical pathways and patient flow
- Workforce development and growth to attract and retain a higher number of staff
- Economies of scale allowing a larger organisation to leverage its increased scale and purchasing power (eg. during procurement)
- Improved digital services and integration will increase the Trust’s level of digital maturity

The formation of Mersey and West Lancashire Teaching Hospitals NHS Trust will ensure that patients receive the best care available across the whole area which our Trust serves based on the model of 5 Star patient care



c. The areas we serve

This infographic shows the areas covered by Mersey and West Lancashire Teaching Hospitals NHS Trust which is based directly in four of the nine Places within Cheshire and Merseyside Integrated Care System (St Helens, Knowsley, Halton, Sefton) and the Central Lancashire locality within the Lancashire Place in the Lancashire and South Cumbria Integrated Care System



Geographical area of the Trust's sites across Cheshire and Merseyside and West Lancashire

The Trust consists of five hospital sites:

- Whiston Hospital
- St Helens Hospital
- Southport & Formby District General Hospital
- Ormskirk District General Hospital
- Newton Community Hospital

Additionally, we deliver care in and from a number of community sites including:

- Lowe House Health Centre
- Marshalls Cross GP Practice
- Millennium Health Centre
- Southport Centre for Health & Wellbeing.

d. Health systems and partners

Mersey and West Lancashire Teaching Hospitals operates in two Integrated care Systems: Cheshire and Merseyside Integrated Care System (C&M ICS) and Lancashire and South Cumbria Integrated Care System (L&SC ICS).

Our new organisation covers four of the nine Places in C&M ICS and also part of the Central Lancashire locality within the Lancashire Place in L&SC ICS. In the context of integrated care systems (ICSs), "Place" refers to a smaller geographic footprint within a system which often aligns with a local authority area or patient flows for acute care. The aim of Place based care is to encourage local health and care providers to work more closely together, providing "joined up care" to improve the health of their local communities.

As our new organisation sits across two ICSs, it interacts and collaborates with multiple partners across the health and social care. The future of health care delivery is dependent upon the strengthening of pathways and care delivery models between providers, and collaboration between different organisations. The complexity of delivering care across multiple providers in different Places will be one of the key challenges faced by the new Trust.

The table below lists some of the healthcare providers which interact with the Trust and how we work together.

Provider	Relationship
Liverpool University Hospitals NHS Foundation Trust	SLA for some clinical services eg. North Mersey Stroke Alliance, Ear, Nose and Throat (ENT) services and regional specialist centre for some specialities
Merseycare NHS Foundation Trust	Delivers community and Mental Health services in some areas
Bridgewater NHS Foundation Trust	Delivers community services in some areas
Liverpool Heart and Chest NHS Trust	Regional Specialist Centre
Clatterbridge Cancer Centre NHS Foundation Trust	Regional Specialist Centre
Walton Centre NHS Foundation Trust	Regional Specialist Centre
Warrington and Halton Hospitals NHS Foundation Trust	Neighbouring trust, collaborative working through shared pathology services
HCRG Care Group	Delivers community services and urgent care services in West Lancashire
Lancashire and South Cumbria NHS Foundation Trust	Delivers mental health services in West Lancashire

Local Authorities:
St Helens, Knowsley, Halton, Liverpool, Sefton Councils, Lancashire County Council and West Lancashire Borough Council.

Additionally, we work with many private and voluntary sector organisations within each Place to supplement, support and enhance pathways of care.

e. Our patients and the population we serve

The vision of C&M ICS is “To ensure that everyone in Cheshire and Merseyside has a healthy start in life and receives the support they need to stay healthy and live longer”. A significant challenge to achieving this vision is the high levels of deprivation across the region; 33% of the population of Cheshire and Merseyside is currently in the most deprived 20% of neighbourhoods in England. The area of West Lancashire is in the Lancashire and South Cumbria Integrated Care System, and has its own specific issues and areas of inequality across its neighbourhoods. Sefton and West Lancashire both have populations which are older? higher than the national average which is often associated with increased health problems, falls, frailty and risk of hospital admission.

	Sefton	**St Helens**	**Knowsley**	**Halton**	**West Lancs**
Population	279,233	181,000	156,481	128,625	118,200
Proportion of patients aged 65+	23.6%	20.6%	17.3%	18.4%	22.1%
Deprivation	58th most deprived local authority out of 317	26th most deprived local authority out of 317	2nd most deprived local authority out of 317	23rd most deprived local authority out of 317	155th most deprived local authority out of 317
Life expectancy	Male life expectancy at birth 78.9 years Female life expectancy at birth is 82.9	Male life expectancy at birth 77.5 Female life expectancy at birth is 81.0	Male life expectancy at birth 76.2 Female life expectancy at birth is 79.7	Male life expectancy at birth 77.3 Female life expectancy at birth is 81.3	Male life expectancy at birth 78.6 Female life expectancy at birth is 82.5
Alcohol	Admissions to hospital for alcohol specific conditions is 1,187 per 100,000 population	Admissions to hospital for alcohol harm is 8th highest in the NW	Admissions to hospital for alcohol harm is 13th highest in England	Admissions to hospital for alcohol specific conditions is 995 per 100,000	Admissions to hospital for alcohol specific conditions is 749 per 100,000
Smoking	15% of adults smoke England average 14%	13% of adults smoke England average 14%	16% of adults smoke England average 14%	14.9% of adults smoke England average 14%	13.9% of adults smoke England average 14%
Obesity	Approximately 71.5% of adults in Sefton were classified as overweight or obese	Approximately 69% of adults in St Helens were classified as overweight or obese	Approximately 74% of adults in Knowsley were classified as overweight or obese	Approximately 61% of adults in Halton were classified as overweight or obese	Approximately 66% of adults in West Lancashire were classified as overweight or obese

3. Developing our clinical strategy

This clinical strategy will address key challenges faced by the new trust in providing safe, high quality patient care. Some of these relate to the challenges previously faced within Southport and Ormskirk Hospital NHS Trust while others follow national, regional and local priorities.

One key driver for the Clinical Strategy is the elective recovery programme, which addresses the impact of the COVID-19 pandemic on NHS Trusts to deliver outpatient care and elective surgery. Another is the ongoing challenge in the delivery of Urgent and Emergency Care, which will require collaborative working between providers to ensure that patients receive care quickly, safely and in the most appropriate place. Finally, cancer care, with growing numbers of referrals and the need to diagnose and treat cancer at an earlier stage is of critical importance following the reduction of patient presentation and diagnostic activity during the pandemic.

a. How this strategy was developed

As Mersey and West Lancashire Teaching Hospitals NHS Trust is a newly formed organisation, the clinical strategy has been brought together to reflect the immediate priorities in the newly formed Trust. For that reason, the clinical objectives are deliberately aimed at delivering those immediate priorities: forming a new organisation with safe, effective clinical services which work towards meeting the local, regional and national priorities. Once our new divisional structure has been created, clinical services integrated and fragile services stabilised, a longer-term clinical strategy will be developed reflecting the clinical priorities of each division.

This strategy was developed by the Medical Director in consultation with senior clinical leaders from both organisations. It has taken into account the learning and experience gained during the period of collaboration between the two Trusts which preceded the transaction and the areas identified for action in the Post-Transaction Implementation Plan submitted to and approved by NHS England.

Consultation on the completed strategy has been undertaken with representatives of local patient groups to ensure that their views are heard and incorporated into the services which they will use. It has also been shared with leaders from the Integrated Care Boards in Cheshire and Merseyside, and Lancashire and South Cumbria to ensure this strategy aligns with the wider strategy within the Integrated Care Systems.


Analysis
•Learning from collaboration between Trusts
•Indentification of key national, regional and local priorities
Synthesis
•Development of Draft Strategy
•Consulatation and feedback from patients, staff & stakeholders
Delivery
•Engagment with clinical teams
•Delivery of key priorities
Development
•Learning from integration of clinical services
•Development of next Clinical Strategy

National policy and strategic context

National NHS strategy, delivery plans and performance framework ensure that organisations provide clinical services along the same principles of access and delivery. The shared clinical access targets allow Trust performance to be benchmarked across the NHS and ensure providers are delivering care in a timely and effective way.

The NHS Delivery plans for tackling the COVID-19 backlog of elective care and for recovering urgent and emergency care services have set out the priorities for NHS organisations to the targets set out in the NHS Long Term Plan. Along with the NHS planning guidance for 2022/23, these strategies have outlined how NHS organisations will deliver the changes required to meet the healthcare needs of the population in the post-pandemic period. The alignment of clinical services and pathways will work within the planning guidance to ensure we deliver the expected performance in elective care.

The Elective Recovery Plan published in February 2022 sets out an ambitious national delivery plan to address the COVID-19 backlog through increasing staff capacity, prioritising those with greater need and transforming care settings. The COVID-19 pandemic had a significant impact on healthcare delivery, diverting resources usually used for elective care and preventing patients attending hospital for planned surgery and outpatient appointments. Closer working between providers will allow clinical teams to deal with the backlog more efficiently with better utilisation of resources. There are opportunities for the new Trust to optimise capacity and resources across both Trusts to address the backlog through initiatives such as the streamlining of pathways to increase clinical effectiveness and the implementation of a clinical prioritisation strategy to increase productivity and clinical efficiency.

The Urgent and Emergency Care Recovery Plan was published in January 2023 to help NHS Trusts meet the extreme demands on non-elective clinical services. Despite the best efforts of Trusts and Social Care partners, problems discharging patients to the appropriate care settings has seen hospital occupancy reach record levels slowing patient ‘flow’ through hospitals. To support recovery, the plan sets out a number of ambitions, including patients being seen more quickly in emergency departments and ambulances getting to patients more quickly. Delivery of these ambitions will require sustained focus on five areas:

- Increased capacity (investing in more hospital beds and ambulances and improving flow)
- Growing the workforce
- Improving discharge (working jointly with all system partners to strengthen discharge processes)
- Expanding and joining up health and care outside hospital (increasing use of Urgent Community Response and Virtual Wards)
- Making it easier for patients to access the right care

The NHS Planning Guidance for 2023/23 outlines key areas to improve patient safety, outcomes and experience: improving ambulance response and Emergency Department waiting times, reducing elective and cancer backlogs, improving performance against the core diagnostic standard, and making it easier for people to access community services, particularly general practice.

Cheshire and Merseyside ICS Priorities

Cheshire and Merseyside Integrated Care System has four key strategic objectives which align with those of the new organisation:

- Improve population health and healthcare
- Tackle health inequality, improving outcomes and access to services
- Enhancing quality, productivity, and value for money
- Helping the NHS to support broader social and economic development

These strategic objectives will be delivered by the Integrated Care Board through its Provider Collaboratives and programmes or work across a wide range of clinical and non-clinical areas in which the Trust will be involved. Several of these programmes are detailed in the table below:

Programme	Description
Ageing Well	Improving urgent community response for older patients, enhanced health in care homes and helping people with complex needs stay healthy.
Diabetes	Improving treatment targets, multi-disciplinary footcare teams, specialist nursing and flash glucose monitoring.
Diagnostics	Improving access to all diagnostic tests including, pathology, imaging, endoscopy, cardiorespiratory and neurophysiology.
Elective Recovery	Reducing waiting lists, restoring services to pre-COVID levels, and embedding sustainable services.
Respiratory	Quality assured diagnostic spirometry, pulmonary rehabilitation and psychological support to manage respiratory disease
Stroke	Reducing the number of strokes in Cheshire and Merseyside by focusing on prevention, reducing health inequalities, improving access and community rehabilitation.
Women's Health and Maternity	Transforming and improving support for women's health, improving wellbeing, life chances and outcomes for women and babies.

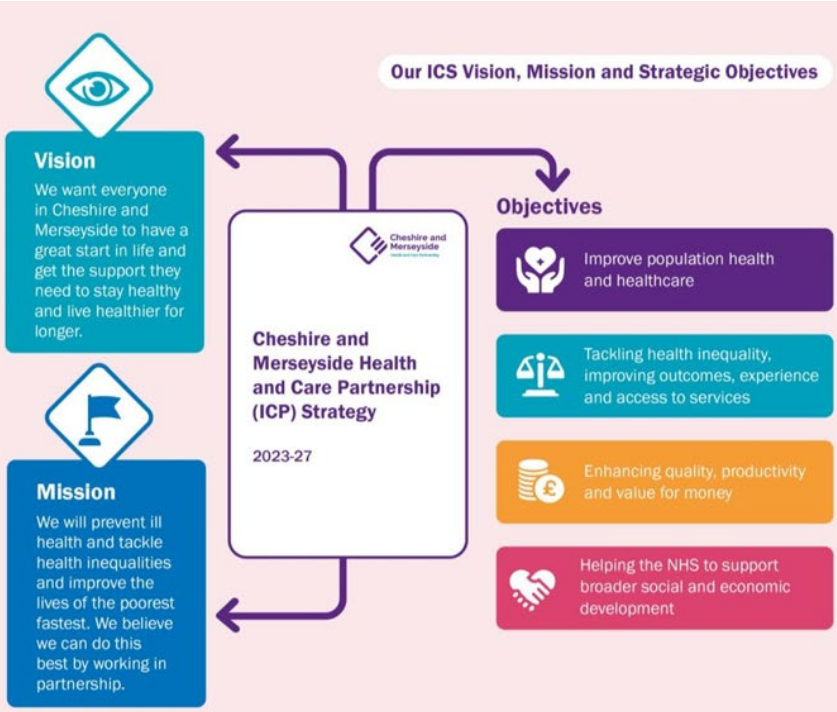
The Trust is a member of both the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative and the Community and Mental Health Provider Collaborative, due to the breadth of care which it delivers. The Provider Collaboratives bring together NHS Trusts to work collaboratively to deliver on ICB Objectives across the whole system.

The Trust is also part of the C&M Health and Care Partnership, a committee of health and care partner from across the region, working together to improve health and care outcomes, and reduce variation in experience of care. By working together across the region the health and care partnership aims to reduce health inequalities and promote wellbeing to all of our residents. The Trust is a signatory to the Prevention Pledge which has a focus on not just treating patients but preventing future admission and promoting self-care and management of an individual's health.

Cheshire and Merseyside Health and Care Partnership (ICP) is focussed on tackling the big issues that need to be addressed to improve health and reverse the widening gaps in life expectancy between the poorest and wealthiest in our population.

Particular emphasis will be placed on tackling the impact of the COVID-19 pandemic to ensure that there is not an irreversible deepening of poverty and health inequity across Cheshire and Merseyside.

The ICS footprint is broken down into nine places, which are made up of local stakeholders in the health and care system.

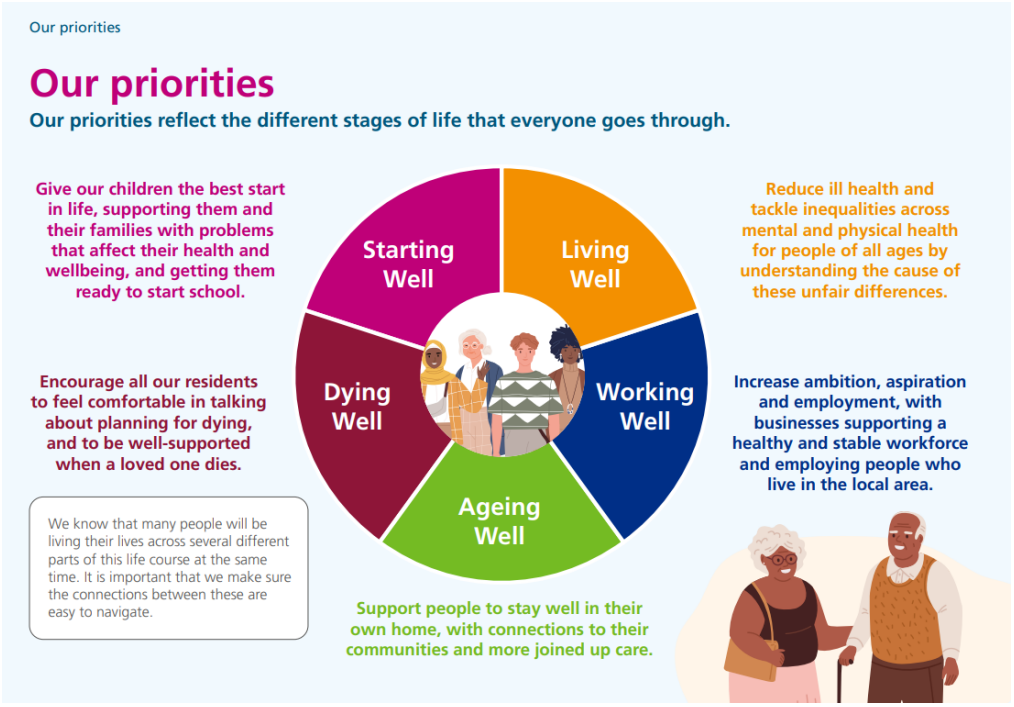


Lancashire and South Cumbria ICB Priorities

The Trust is also part of Lancashire and South Cumbria ICS and works together with partners across the whole region to help deliver the priorities which have been set out in by the ICB and the integrated care partnership. The integrated care partnership brings together healthcare providers (including Mersey and West Lancashire Teaching Hospitals NHS Trust), local government, the voluntary, community, faith and social enterprise sectors, education organisations, people that represent local businesses, Healthwatch and residents to work together to a set of common, agreed priorities to improve the lives of people in Lancashire and South Cumbria.

The priorities will be focused on the life course of residents: Starting Well, Living Well, Working Well and Ageing Well.

- Starting Well: Giving children the best start in life, supporting them and their families with problems that affect their health and wellbeing, and getting them ready to start school.
- Living Well: Reducing ill health and tackling inequalities across mental and physical health for people of all ages by understanding the cause of these unfair differences.
- Working Well: Increase ambition, aspiration and employment, with businesses supporting a healthy and stable workforce and employing people who live in the local area.
- Ageing Well: Supporting people to stay well in their own home, with connections to their communities and more joined up care.
- Dying Well: Encouraging all residents to feel comfortable in talking about planning for dying, and to be well-supported when a loved one dies.



As part of the Integrated Care Partnership, Mersey and West Lancashire Teaching Hospitals will work alongside partner organisations to help deliver these priorities for residents living in

Lancashire Place. The work to reduce health inequalities for residents sits with all providers and organisations in the ICB and the healthcare providers are uniquely positioned to be able to deliver interventions aimed at both primary and secondary prevention of ill health. The Trust will work alongside colleagues in primary and community care to work with patients to help reduce their risk of developing or worsening illnesses in the future.

b. Shaping Care Together

The Shaping Care Together (SCT) Programme began in 2021 to allow Southport, Formby and West Lancashire health and care providers to examine how they can work together to provide better and improved health and care for patients. Building on the NHS Long Term Plan, the aim of the programme is to make health and care services in the local area “seamless” and ensure that patients receive the right care in the right place, at the right time.

The founding principles of the Shaping Care Together programme are:

- Elimination of barriers to access to expertise across primary, community, secondary & tertiary care
- Maximising digital solutions to deliver diagnosis, treatment and care
- Delivering care as close to the patient’s home as possible
- Optimising pathways to enable efficient and effective access for specialist care

The Shaping Care Together Programme aims to identify the best way that clinical pathways and services can be delivered by providers across Sefton and West Lancashire to achieve the best outcomes for patients and reduce health inequalities. This will require closer collaboration between primary, secondary, community and social care providers in order to make sure the principles of the programme are delivered.

The programme was paused during the period surrounding the transaction and formation of the new Trust and has now restarted with a view to building on the work which has already taken place.

c. Fragile Services

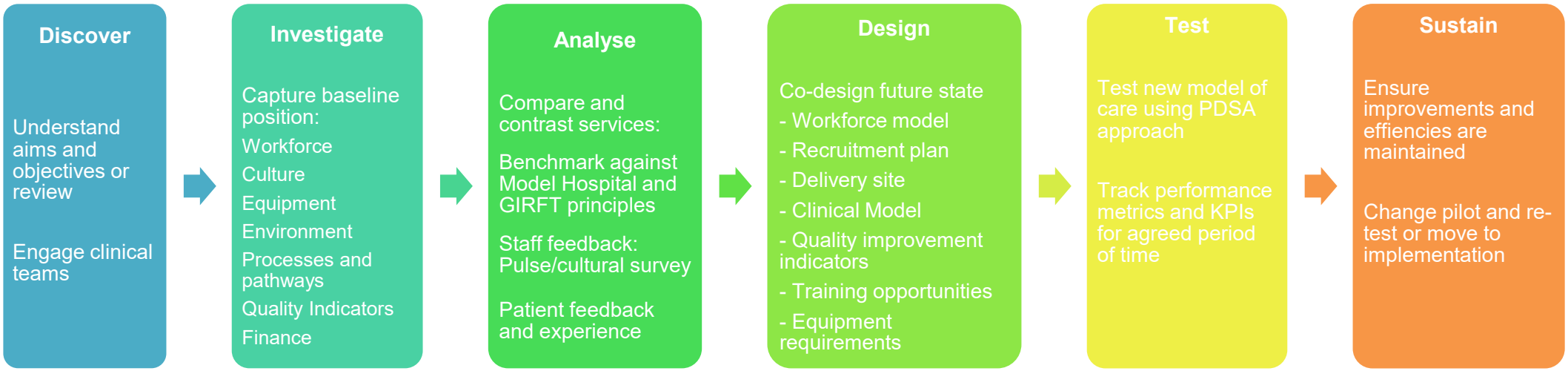
In January 2022, several clinical services provided by Southport and Ormskirk Hospital NHS Trust were identified as “fragile” due to workforce or other challenges following a quality impact assessment. This meant that they were at risk of no longer being able to deliver the level of service required to continue or had closed to new referrals. Since the Agreement for Long Term Collaboration (ALTC) several of these have been stabilised (green) whereas others still remain at risk of not being able to deliver the required standard of clinical care. Each of these services have individual challenges in their delivery and detailed plans to meet these were contained in the Post Transaction Implementation Plan (PTIP), the Trust’s plan to ensure we smoothly transition into a single organisation.

High Risk Fragile Services	Fragile Services	Stabilised Services
ENT	Oral Surgery	Haematology
Ophthalmology	Dermatology	Paediatric Dietetics
Vascular Surgery	Pain	Stroke
	Medicine for Older People	Orthodontics
	Rheumatology	
	Cardiology	
	Diabetes	
	Paediatric A&E	
	Paediatric Ophthalmology	
	Optometry	
	Clinical Physiology	

A critical objective for the new organisation is the stabilisation of the existing fragile services to ensure that patients can continue to access these services across the whole area which the Trust serves. Where possible, this will be done in the way that ensures services will continue to be delivered as close to patients as possible. Where this is not possible, they will be delivered as close to the population as is clinically viable. The stabilisation of fragile services will draw on experience and learning from the ALTC and be carried out by clinical leaders within those specialities supported by members of the senior leadership team.

Service Development Strategy

In addition to stabilisation of fragile services, the new organisation will undertake a standardised approach to integration of all clinical services, reviewing and agreeing the future delivery model of care across the organisation, in consultation with patients, local communities and partners. Using the principles of service improvement and led by clinicians, we will collaborate to understand the challenges and identify the opportunities for clinical delivery then develop a transformation plan to move the service forward. Each speciality will have their own unique journey of integration which will reflect the individual challenges for their service. This will be supported by a senior leadership team with a remit to oversee the integration of clinical services and ensure this is done in a way which maximises the effectiveness and efficiencies outlined ahead of the transaction. The diagram below outlines the principles which will underline the integration of services in a systematic way.



Model of clinical service integration

2. Our clinical ambition

a. Our principles

The following principles underpin the clinical strategy and guide the development of the clinical objectives. They are linked to the Trust's strategic aims and ensure that the clinical strategy aligns with the aims and objectives of the new organisation.

Domain	Principles	Linked Strategic Aim
Best Practice, Policy, and Guidance	• Services will operate to a common set of clinical standards, quality metrics, policies and guidelines across the new Trust, wherever they are delivered • Good practice will be shared to ensure that services achieve the best of what is currently delivered by the two Trusts and comply with standards set by national professional bodies eg. National Institute of Clinical Excellence (NICE), Getting It Right First Time Programme (GIRFT) and the Academy of Medical Royal Colleges • Closed services will re-open to referrals and enhance the care delivered to the population of Sefton and West Lancashire where this is clinically and financially viable • Utilisation of estate and clinical facilities will be optimised across the four main hospital sites if beneficial to patients • Improvement practice will be embedded in each clinical service and developments will be supported where these will enhance the health of the local population or reduce health inequalities • Participation in clinical trials and research will be supported and encouraged • Excellent opportunities for teaching, training and development will be provided throughout the new Trust	Be the Trust of choice for patients Deliver high quality, personalised care

Service Delivery and Workforce	• Clinical services will continue to be delivered as close to patients as possible • Where services cannot be delivered locally, they will be delivered as close to the population as is clinically viable • Other than the proposed strategic clinical service reconfiguration between Southport and Ormskirk Hospitals (subject to public consultation led by the ICBs), there is no intention to move services between sites. If this does occur, it should only be where there are clear patient and clinical benefits which outweigh any potential disruption and following consultation	Be the Trust of choice for patients Respond to local health needs Attract and develop caring, highly skilled staff
System and National Responsibilities	• C&M and L&SC ICS priorities will be supported including elective recovery and restoration • Sustainable solutions to the remaining fragile services at S&O will be found through collaboration with system partners where appropriate • Report performance and outcome measures as a single organisation • Provide timely and accurate information about activity, performance and outcomes to allow clinical teams to continuously improve.	Work in partnership to improve health outcomes
Clinical Leadership, Education and Research	• Clinical Leadership will feature prominently in the workforce strategy as we develop a clinical leadership programme which will focus on equipping new and aspirant clinical leaders with tools and resources to take further steps in leadership in the organisation. • Clear, visible and easily accessible reporting and escalation structures will be embedded across the new Trust with an integrated, compassionate approach to leadership • Undergraduate and postgraduate medical education will be part of every clinical service to ensure that the Trust continues to provide the developing medical workforce the knowledge and skills to deliver the best possible patient care • Research, Development and Innovation will be promoted and supported throughout the organisation and clinicians will work with University colleagues to develop relationships which promote collaboration between the Trust and academic departments	Attract and develop caring, highly skilled staff Work in partnership to improve health outcomes

b. Our Clinical Objectives

Having considered the national, regional and local context, our vision is to provide 5 Star Patient Care and deliver the following clinical objectives over the first 2 years of the new Trust.

Clinical Objectives for Mersey and West Lancashire Teaching Hospitals NHS Trust
• Ensure clinical governance structures are in place to continue to deliver safe and effective clinical care across the Trust
• Review and align pathways to enable integration of clinical services across the Trust
• Complete the stabilisation of fragile clinical services and address any inequalities, delivering high quality and effective care across to patients who use any of our hospitals
• Achieve national, regional and local NHS priorities to: o Improve Emergency Department waiting and ambulance turnaround times o Reduce waiting times for elective treatments and diagnostic tests o Reduce the time to diagnose or exclude cancer in patients who are referred to hospital

National benchmarking tools including data from the Getting It Right First Time (GIRFT) Programme and Model Hospital System will provide many of our services the information to identify where each service will focus interventions for improvement. This will be supplemented with guidance from NICE, NCEPOD and professional bodies to support the safe and efficient delivery of clinical services.

c. Our clinical services

Work will be undertaken across 2023/24 to align our services and pathways to be led and overseen by the most appropriate division. This will allow a greater focus on integration, understanding of the gap in equitable provision for our population and the mitigation of clinical risk.

Clinical services will be divided into divisions which will be led by a triumvirate of nursing, operational and medical leaders. This leadership model and the departmental leadership structure which sits beneath it will help to unify speciality delivery across the new organisation.

The services will be allocated to one of the following divisions

- Medicine and Urgent care
- Surgery
- Women and Children's Services
- Community and Clinical Support Services

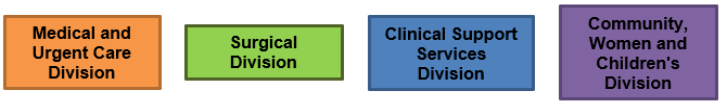
Consideration has been given within this model to factors such as

- Site management and presence
- Speciality oversight when accountable for delivery across multiple sites
- The spread of high risk and fragile services across portfolios
- The introduction of roles to improve the architecture of the leadership teams and to support career progression

The divisional structures will be kept under constant review in accordance with the clinical transformation plan to ensure that they are delivering the optimal model for clinical and operational leadership.

Corporate leadership roles will remain and report directly to the Medical and Nursing Directors as in the previous model to ensure safety and quality remains at the top of the Trust agenda and has executive oversight and accountability.

Post Transaction Operational Organisational Structure



- Bringing together services from across all of the delivery sites and grouping them into 4 Divisions.
- Future delivery models to focus on local site delivery and equity in access for populations across our footprint.
- Awareness and future focus on pathways for patients that move across all divisions.

- Triumvirate leadership model to head up each of the Divisions.
- Reflecting clinical and operational leadership in the governance, oversight and development of services in the division.
- Providing professional and operational support to services and staff e.g. business partner model form the corporate services.
- A balanced focus on clinical delivery, quality and safety, and operational efficiency across the triumvirate through challenge and support.

d. Enabling Strategies

The Clinical Strategy is only one of the strategies for the new Trust to deliver the benefits which will be realised through the transaction. It is through close, collaborative working between clinical and non-clinical services which will allow us to deliver the Trust's objectives, give patients high quality care and create a working environment which attracts and retains the best possible employees.

The Trust strategies which will enable the delivery of the clinical strategy include:

- Digital Strategy
- Workforce Strategy
- Estates Strategy
- Environmental Sustainability Strategy

e. Monitoring and review

The clinical priorities will be monitored through the regular committee and council meetings which make up the Trust's Corporate Governance Structure. Each committee will provide assurance to its Executive and Non-Executive members that teams are working safely and effectively to deliver this Clinical Strategy. As stated previously, this Trust Clinical Strategy will be reviewed and updated ahead of the publication of the next Clinical Strategy in 2025 when integration of clinical services is completed, allowing objectives to be set within individual clinical divisions to develop their services.

Delivery of the Post-Transaction Implementation Plan (PTIP), developed prior to the transaction and approved by NHS England, will be monitored by the Transaction Board to ensure that the patient and organisational benefits identified for the new Trust are realised. This will run in parallel with reporting to NHS England to provide assurance that the PTIP delivery is on track.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 October 2023
Agenda Item	**MWL TB23/046**			
Report Title	Corporate Risk Register (October 2023)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required		**To Approve**	**X**	**To Note**

Purpose

To inform the Board of the risks that have currently been escalated to the MWL Corporate Risk Registers (CRR) via the Trust's risk management systems.

Executive Summary

1. Risk Management Systems

The two legacy Trusts both utilise DATIX to capture and report risks. The two risk management frameworks embed the same best practice principles, but the reporting is aligned to the legacy organisational structures.

When the new MWL operating model is implemented the two DATIX system structures can be aligned and there are also plans to move to a single MWL system for reporting and managing risks, incidents, and complaints and a single Risk Management Policy.

This report therefore provides an overview of all the risks currently reported for MWL, via these legacy reporting systems. This was felt to be the most effective way of ensuring that all risks can continue to be reported by staff and their severity/impact assessed by local managers.

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

- Have been identified and reported
- Have been scored in accordance with the standard risk grading matrix.
- Risks initially rated as high or extreme have been reviewed by a Director for STHK sites or reviewed by the CBU Governance Groups for S&O sites
- Have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will realistically bring the risk to the target level.

2. Risk Registers and Corporate Risk Registers

This report is based reflects a snap shot of the risk registers at the end of September 2023.

STHK (appendix 1)

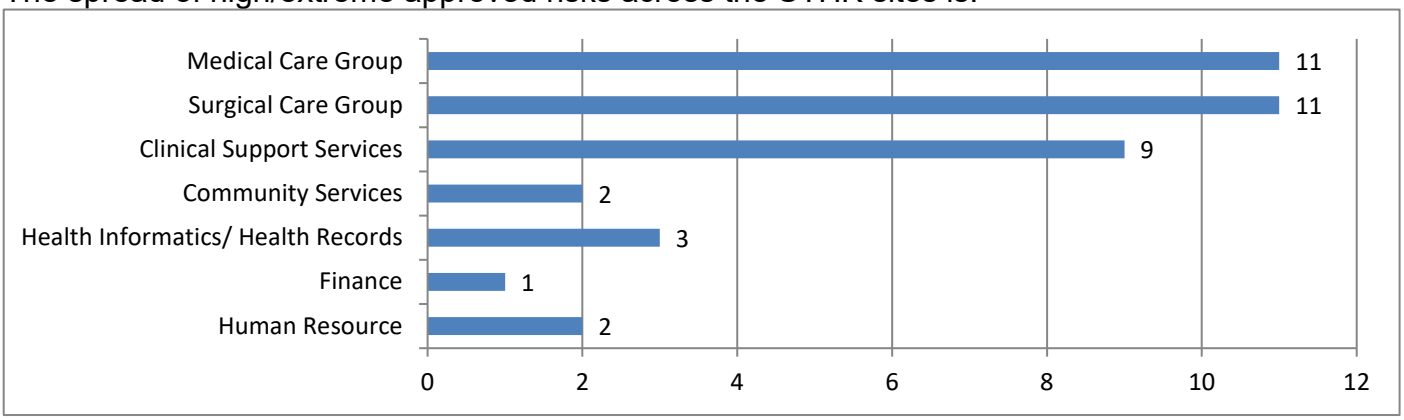
The total number of risks on the STHK risk register was 795 compared to 796 in July. 791 of the risks had been scored at the time of the report (as DATIX is a live system).

58.15% (460/791) of the Trust's reviewed risks are rated as Moderate or High compared to 56.7% in July.

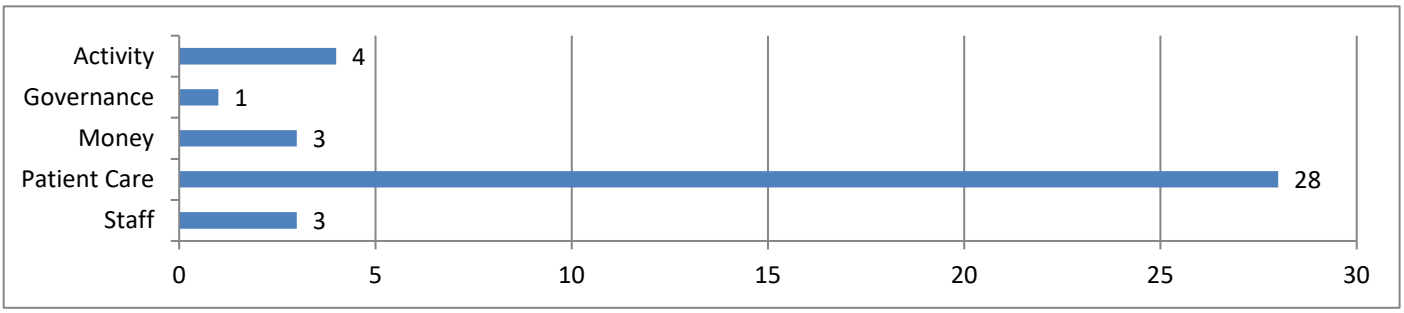
39 high/extreme risks had been escalated to the CRR (appendix 2), although 4 of these had not followed the correct escalation process and had not been approved by a director. This compared to

30 risks escalated to the CRR in July 2023. Two risks have been removed or deescalated from the CRR since July.

The spread of high/extreme approved risks across the STHK sites is:



The risk categories of the CRR risks are:



S&O (appendix 3)
225 risks are open on the S&O sites risk register at the end of September and 12 on the tolerated risk register.

34 of these risks were not approved and being reviewed via the CBU governance process.

10 risks had been escalated to the S&O sites CRR, with three further potential CRR risks awaiting approval. One risk has been removed from the S&O sites CRR since July.

Financial Implications
None as a direct result of this report
Quality and/or Equality Impact
Not applicable
Recommendations
The Board is asked to note the Corporate Risk Register Report
Strategic Objectives

X	**SO1** 5 Star Patient Care – Care

X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Appendix 1

STHK SITES CORPORATE RISK REGISTER REPORT – OCTOBER 2023

1. Risk Register Summary for the Reporting Period

This table provides a high-level overview of the "turnover" in the risk profile of the Trust compared to previous reporting periods.

RISK REGISTER	Current Reporting Period 05/10/2023	Previous Reporting Period 01/09/2023	Previous Reporting Period 03/08/2023	Previous Reporting Period 03/07/2023
Number of new risks reported	24	13	15	20
Number of risks closed or removed	30	11	15	29
Number of increased risk scores	10	3	2	4
Number of decreased risk scores	17	9	10	11
Number of risks overdue for review	66	65	84	72
Total Number of Datix risks	**795***	**804**	**803**	**796**

*791 have been approved and scored and 4 risk reported by not yet scored in DATIX. The remainder of the report is therefore based on 791 risks.

The RMC periodically monitors how many risks have missed more than one planned review date and these are escalated to the Care Group Heads of Nursing and Quality.

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
25	**38**	**17**	**82**	**9**	**160**	**62**	**155**	**32**	**172**	**18**	**11**	**10**	**0**
80 = 10.11%			**251 = 31.73%**			**421 = 53.22%**				**39 = 4.93%**			

The risk profiles for each of the Trust Care Groups and for the collective Corporate Services are:

2.1 Surgical Care Group – 203 risks reported 25.66% of the Trust total.

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
2	**13**	**3**	**12**	**3**	**34**	**21**	**46**	**12**	**46**	**7**	**1**	**3**	**0**
18 = 8.87%			**49 = 24.14%**			**125 = 61.58%**				**11 = 5.42%**			

2.2 Medical Care Group – 134 risks reported 16.94% of the Trust total.

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
7	**5**	**2**	**14**	**1**	**26**	**7**	**22**	**8**	**31**	**4**	**3**	**4**	**0**
14 = 10.45%			**41 = 30.60%**			**68 = 50.75%**				**11 = 8.21%**			

2.3 Clinical Support Care Group – 126 risks reported 15.92% of the Trust total.

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	**5**	**0**	**12**	**0**	**20**	**7**	**28**	**8**	**32**	**4**	**3**	**2**	**0**
10 = 7.94%			**32 = 25.40%**			**75 = 59.52%**				**9 = 7.14%**			

2.4 Primary Care and Community Services Care Group – 48 risks reported 6.06% of the Trust total.

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
1	**0**	**1**	**5**	**1**	**12**	**2**	**7**	**3**	**14**	**2**	**0**	**0**	**0**
2 = 4.17%			**18 = 37.50%**			**26 = 54.17%**				**2 = 4.17%**			

2.5 Corporate (Finance, Health Informatics/Health Records, Facilities, Nursing/Governance/Quality & Risk, HR, and Medicines Management) – 280 risks reported 35.39% of the Trust total.

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
10	**15**	**11**	**39**	**4**	**68**	**25**	**52**	**1**	**49**	**1**	**4**	**1**	**0**
36 = 12.85%			**111 = 39.64%**			**127 = 45.35%**				**6 = 2.14%**			

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

	High	Moderate	Low	Very low	**Total**
Health Informatics/ Health Records	3	19	12	5	**39**
Facilities (Medirest/TWFM)	0	11	13	6	**30**
Nursing, Governance, Quality & Risk	0	17	13	4	**34**
Finance	1	11	25	9	**46**
Medicines Management	0	26	24	3	**53**
Human Resource	2	43	24	9	**78**
Total	**6**	**127**	**111**	**36**	**280**

Appendix 2 - Summary of the Corporate Risk Register OCTOBER 2023

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
1	Patient Care	762	**If** the Trust cannot recruit sufficient staff to fill approved vacancies, **then** there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	29/09/2023	4 x 2 = 8	✓	Strategic People Committee
2	Money	1152	**If** there is an increase in bank and agency, **then** there is a risk to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	20/09/2023	4 x 3 = 8	✓	Finance & Performance Committee
3	Patient Care	1263	**If** the Trust cannot achieve the required numbers of patient discharges and transfers, **then** there is a risk to operational performance	3 x 3 = 9	3 x 5 = 15	18/07/2022 Rob Cooper	31/08/2023	3 x 2 = 6	✓	Executive Committee
4	Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	27/07/2023	4 x 3 = 12	✓	Executive Committee
5	Activity	1874	**If** the Trust cannot maintain 92% RTT incomplete pathway compliance, **then** it will fail the national access standard	4 x 4 = 16	4 x 5 = 20	30/03/2020 Rob Cooper	29/09/2023	4 x 2 = 8	✓	Finance & Performance Committee
6	Patient Care	2082	**If** there is no robust established daily process for review of all medical patients who remain in the ED/EAU due to the lack of an available bed on the ward, **then** this can result in patient safety and experience issues	4 x = 12	3 x 5 =15	27/05/2022 Peter Williams	15/08/2023	3 x 2 = 6	✓	Quality Committee
7	Patient Care	2083	**If** Inpatient medical bed occupancy levels are over 95% **then** there is a risk this will adversely impact the ability to admit medical patients from the ED	3 x 5 = 15	3 x 5 = 15	28/04/2020 Rob Cooper	19/09/2023	2 x 2 = 4	✓	Quality Committee
8	Patient Care	2223	**If** A&E attendances and admissions increase beyond planned levels, **then** the trust may not have sufficient bed capacity or the staffing to accommodate patients	4 x 3 = 12	4 x 5 = 20	09/12/2021 Rob Cooper	04/10/2023	2 x 4 = 8	✓	Executive Committee
9	Patient Care	2750	**If** the Trust cannot access the national PDS (spine) **then** there is an increased risk of not identifying the correct patient for diagnostic imaging results	5 x 3 = 15	5 x 3 = 15	04/09/2019 Rob Cooper	25/09/2023	5 x 2 = 10	✓	Quality Committee
10	Patient Care	2767	**If** inpatient maternity staffing shortfalls persist **then** there could be a negative impact on patient safety. It will also have an impact on patient experience. Inpatient maternity staffing shortfall	3 x 3 = 9	3 x 5 = 15	23/03/2022 Sue Redfern	03/10/2023	2 x 3 = 6	✓	Quality Committee
11	Patient Care	2963	**If** a patient does not receive a planned appointment following surgery or for histology results due to	5 x 4 = 20	5 x 4 = 20	21/10/2020	26/09/2023	5 x1= 5	✓	Quality Committee

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
			delayed treatment as a result of COVID-19 **then** the patient outcome could be worse.			Rob Cooper				
12	Patient Care	2985	**If** there is increased absence of phlebotomy staff due to COVID **then** there is a risk to the continuity of service provision	3 x 3 = 9	3 x 5 = 15	01/07/2021 Rob Cooper	31/03/2023	3 x 2 = 6	✓	Executive Committee
13	Patient Care	2996	**If** MCG is unable to maintain safe staffing levels in adult inpatient areas, **then** there is a risk to patient safety, experience and quality of care	4 x 5 =20	4 x 5 =20	27/10/2020 Sue Redfern	04/10/2023	3 x 2 = 6	✓	Executive Committee
14	Patient Care	3043	**If** suitable consultant staff cannot be recruited to the Microbiology service**, then** there would be an impact on service provision	4 x 3 = 12	4 x 4 = 16	31/07/2023 Peter Williams	06/09/2023	4 x 1 = 4	✓	Executive Committee
15	Staff	3178	**If** there are not sufficient staff in post in blood sciences, **then** there is a risk to service delivery	4 x 4 = 16	4 x 4 = 16	15/10/2021 Rob Cooper	06/06/2023	4 x 2 = 8	✓	Strategic People Committee
16	Patient Care	3199	**If** medical patients are to 'forward wait' on a medical ward **then** there is a risk to patient safety, dignity, and experience	4 x 4 = 16	4 x 4 = 16	02/11/2021 Sue Redfern	11/10/2023	4 x 1 = 4	✓	Executive Committee
17	Patient Care	3251	**If** the current end of life solution for outpatient letter printing fails before a replacement system is implemented, **then** there is a risk that letters will be delayed or could impact other EPR functionality	4 X 5 = 20	4 X 5 = 20	21/10/2021 Christine Walters	15/08/2023	1 x 1 = 2	✓	Executive Committee
18	Patient Care	3349	**If** the stock of Olympus scopes is not maintained, **then** there is a risk to business continuity for the endoscopy service	4 x 5 = 20	4 x 5 = 20	29/04/2022 Rob Cooper	15/08/2023	4 x 2 = 8	✓	Executive Committee
19	Patient Care	3371	**If** medical wards are to accommodate an additional patient due to insufficient medical beds, **then** there is a risk to patient safety, dignity and patient experience.	4 x 4 =16	4 x 4= 16	29/04/2022 Sue Redfern	13/09/2023	2 x 2 = 4	✓	Executive Committee
20	Money	3392	**If** capital funding is not approved to purchase specialist replacement endoscope equipment, **then** Patients may need to undergo 2 separate procedures	3 x 3 = 9	3 x 5 = 15	03/02/2023 Rob Cooper	25/09/2023	3 x 2 = 6	✓	Executive Committee
21	Activity	3407	**If** phototherapy machines in the dermatology department are not replaced or maintained, **then** there is a risk that patient treatments will be delayed	4 x 5 = 20	3 x 5 = 15	26/09/2023 Rob Cooper	10/10/2023	1 x 5 = 5	✓	Executive Committee
22	Patient Care	3475	**If** there is a delay in NWAS transferring patients who have had a stroke for neuro radiology intervention(thrombectomy), **then** this can make a significant difference to patient outcomes.	4 x 5 = 20	4 x 4 = 16	09/08/2022 Rob Cooper	11/09/2023	4 x 1 = 4	✓	Executive Committee
23	Patient Care	3496	**If** there are insufficient staff to provide effective Operational Site Management overnight, **then** there could be an impact on patient safety	3 x 3 = 9	3 x 5 = 15	27/10/2022 Sue Redfern	01/09/2023	3 x 1 = 3	✓	Executive Committee
24	Patient Care	3513	**If** there is reduced capacity in patient booking, **then** there could be delays in adding referrals or appointment and patient care could be delayed	3 x 5 = 15	3 x 5 = 5	05/09/2023 Lesley Neary	09/10/2023	3 x 3 = 9	✓	Executive Committee

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
25	Patient Care	3525	**If** there is not sufficient capacity to meet the demand for 72 hour obstetric ultrasound scans, **then** there would be a delay to patient care	5 x 3 = 15	5 x 3 = 15	31/07/2023 Sue Redfern	18/09/2023	5 x 2 = 10	✓	Executive Committee
26	Patient Care	3527	**If** there is not sufficient plastic surgery capacity commissioned **then** non urgent patients in North Wales may face extended waits to be seen, and there will be a reduction in follow up appointments for cancer patients	4 x 5 = 20	4 x 5 = 20	21/09/2022 Rob Cooper	26/09/2023	4 x 1 = 4	✓	Executive Committee
27	Patient Care	3532	**If** the ENT service does not have the appropriate equipment, **then** it will not be compliant with BAHNO recommendations for nasoendoscopy	3 x 5 = 15	3 x 5 = 15	30/11/2022 Rob Cooper	30/06/2023	3 x 2 = 6	✓	Executive Committee
28	Patient Care	3535	**If** operational pressures mean that a 5th surgical patient needs to be accommodated in the bays on surgical wards, **then** there is a requirement for additional staffing to provide the required level of care	5 x 4 = 20	5 x 4 = 20	15/11/2022 Sue Redfern	07/08/2023	5 x 2 = 10	✓	Executive Committee
29	Patient Care	3574	**If** Careflow does not allocate patients correctly **then** there is a risk that outpatient appointments will not be scheduled	3 x 5 = 15	3 x 5 = 15	09/11/2022 Rob Cooper	24/08/2023	3 x 3 = 9	✓	Executive Committee
30	Patient Care	3586	**If** the trust cannot secure a regular supply of the goods it needs to deliver services, **then** patient care could be impacted	4 x 4 = 16	4 x 4 = 16	01/08/2023 Rob Cooper	17/08/2023	4 x 2 = 8	✓	Executive Committee
31	Money	3598	**If** specialist orthopaedic drills are not replaced before the current equipment becomes obsolete, **then** theatre productivity will decrease	3 x 5 = 15	3 x 5 = 15	23/02/2023 Rob Cooper	05/09/2023	3 x 2 = 6	✓	Executive Committee
32	Patient Care	3600	If there are not the required number of surgical diathermy machines, **then** patient procedures could be cancelled	3 x 5 = 15	3 x 5 = 15	09/02/2023 Rob Cooper	26/09/2023	3 x 1 = 3	✓	Executive Committee
33	Patient Care	3606	**If** the current end of life neonatal resuscitaires are not replaced, **then** this would pose a safety risk to the effective and efficient resuscitation of the new born babies.	3 x 4 = 12	3 x 5 = 15	09/03/2023 Sue Redfern	04/09/2023	3 x 2 = 6	✓	Executive Committee
34	Staff	3624	**If** there are not suitable trained staff available out of hours to support clinicians**, then** endoscopy therapeutic interventions could be delayed.	3 x 5 = 15	3 x 5 = 15	19/01/2023 Sue Redfern	24/08/2023	3 x 1 = 3	✓	Executive Committee
35	Patient Care	3647	**If** the design of the endoscopy suite at St Helens is not adapted to meet national guidance for single sex recovery facilities**, then** there is a risk of not maintaining JAG accreditation**.**	3 x 5 = 15	3 x 5 = 15	09/03/2023 Rob Cooper	13/09/2023	3 x 2 = 6	✓	Executive Committee
36	Patient Care	3748	**If** referrals to dermatology continue to increase, **then** there will be insufficient capacity to meet demand and waiting times will increase	3 x 5 = 15	3 x 5 = 15	Not approved by a director	13/09/2023	3 x 2 = 6	✓	Executive Committee
37	Activity	3754	**If** Society of Radiographer Industrial Action continues**, then** there could be an impact on waiting times for diagnostics	4 x 5 = 20	4 x 5 = 20	Not approved by a director	13/09/2023	4 x 2 = 8	✓	Executive Committee

No	New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Date of last review	Target Risk Score I x L	Action plan in place	Governance and Assurance
38	Patient Care	3770	**If** there is not sufficient capacity, **then** a backlog of clinic letters could mean a risk to patient treatments	3 x 3 = 9	3 x 5 = 15	Not approved by a director	12/10/2023	3 x 2 = 6	✓	Executive Committee
39	Activity	3783	**If** there are vacancies in the radiology nurse workforce, **then** there could be an impact on waiting times for interventional radiography procedures	4 x 3 = 12	4 x 5 = 20	Not approved by a director	22/09/2023	4 x 2 = 8	✓	Executive Committee

blue text denotes new risks

Risks escalated to the CRR without completing the correct escalation and approval process.

Risks closed or downgraded since the July report.

Patient Care	2545	**If** the maternity service cannot consistently allocate 2 midwives to complete the BSOTS triage system, **then** there is a risk that compliance with this standard may not be maintained	4 x 4 = 16	4 x 4 = 16	21/07/2021 Sue Redfern	4 x 2 = 8
Patient Care	3722	**If** there is a lack of specialist physiotherapy support for the breast cancer services, **then** patient waiting times and recovery could be impacted	4 x 4 = 16	4 x 4 = 16		4 x 3 = 12

STHK Sites Risk Profile – July 2023

Comparison of the risk profile in the previous quarterly board report

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
25	**36**	**16**	**82**	**9**	**162**	**66**	**160**	**29**	**166**	**13**	**8**	**9**	**0**
77 = 9.67%			**253 = 31.78%**			**421 – 52.89%**				**30 = 3.80%**			

STHK Sites Risk Profile – October 2022

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

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
33	**34**	**15**	**92**	**10**	**174**	**67**	**174**	**30**	**163**	**10**	**11**	**11**	**0**
82 = 9.95%			**276 = 33.50%**			**434 = 52.67%**				**32 = 3.88%**			

Appendix 3

S&O Sites Risk Profiles and Corporate Risk Register Report – October 2023

1. Business unit risk profiles

Business Unit	Very Low Risk			Low Risk			Moderate Risk				High/Extreme Risk			
	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Clinical Support Services	0	0	0	0	0	5	4	2	1	2	0	1	0	0
	0 = 0.00%			5 = 33.33%			9 = 60.00%				1 = 6.67%			
Corporate Governance	0	0	0	0	0	0	1	0	0	2	0	0	0	0
	0 = 0.00%			0 = 0.00%			3 = 100.00%				0 = 0.00%			
Estates & Facilities	0	0	0	0	0	0	1	2	2	0	0	0	1	0
	0 = 0.00%			0 = 0.00%			5 = 83.33%				1 = 16.67%			
Executive Management	0	0	0	0	0	2	0	0	0	0	0	1	0	0
	0 = 0.00%			2 = 66.67%			0 = 0.00%				1 = 33.33%			
Finance	0	0	0	0	0	3	1	1	2	0	2	0	0	0
	0 = 0.00%			3 = 33.33%			4 = 44.44%				2 = 22.22%			
Human Resources	0	0	0	2	0	0	2	0	0	0	0	0	0	0
	0 = 0.00%			2 = 50.00%			2 = 50.00%				0 = 0.00%			
Integrated Governance & Quality	0	0	1	0	0	1	1	0	0	2	0	0	0	0
	1 = 20.00%			1 = 20.00%			3 = 60.00%				0 = 0.00%			
Medical Director	0	0	0	1	0	6	1	1	1	0	0	2	0	0
	0 = 0.00%			7 = 58.33%			3 = 25.00%				2 = 16.67%			
Planned Care	0	0	2	4	0	5	2	7	4	11	1	0	3	0
	2 = 5.13%			9 = 23.08%			24 = 61.54%				4 = 10.26%			
Trust	0	0	5	10	0	41	24	34	13	33	3	6	5	0
	5 = 2.87%			51 = 29.31%			104 = 59.77%				14 = 8.05%			
Trust wide - Multiple CBU's (RISK REGISTER USE ONLY)	0	0	0	1	0	1	1	1	0	1	0	1	1	0
	0 = 0.00%			2 = 28.57%			3 = 42.86%				2 = 28.57%			
Urgent Care	0	0	1	0	0	12	4	12	2	6	0	1	0	0
	1 = 2.63%			12 = 31.58%			24 = 63.16%				1 = 2.63%			
Women & Children's	0	0	1	1	0	6	5	8	1	9	0	0	0	0
	1 = 3.23%			7 = 22.58%			23 = 74.19%				0 = 0.00%			

2. The S&O Corporate Risk Register

ID	ADO/Exec Lead	Business Unit	Title	Rating (current)	Last updated
2432	Nicola Bunce	Estates & Facilities	Critical Infrastructure risk	20	Chris Davies 03/10/2023 13:14:54

2545	Neil Schroeder	Trust wide - Multiple CBU's	Temperature Monitoring and Control - Ward/Department drug storage areas	20	Brendan Prescott 03/10/2023 16:46:11
2287	Taggart, Nicky	Medical Director	Aseptic service does not have an automated worksheet & labelling system there is a risk of labelling errors	16	Helen Vangikar 03/10/2023 09:39:21
2230	Peter Williams	Executive	Fragile Services	16	Helen Vangikar 03/10/2023 11:22:57
2572	Taggart, Nicky	Clinical Support Services	Malfunction and failure of the ADS (Automatic Dispensing System) Pharmacy Robot	16	Cathy Knight 03/10/2023 23:19:25
1528	Peter Williams	Medical Director	Medication error and patient harm due to absence of an Electronic Prescribing and administration of Medicines (EPMA) system	16	Helen Vangikar 03/10/2023 11:08:41
2549	Neary, Lesley	Trust wide - Multiple CBU's	Potential impact of regional industrial action to Southport & Ormskirk Hospitals Mental Health (in reach) and Walk in Centres	16	Jessica Hassan 03/10/2023 09:55:28
2031	AMBROSE-MINEY, Nicky	Urgent Care	Risk to Patient Flow and Capacity on southport site	16	Helen Vangikar 03/10/2023 11:13:28
2168	Walters, Christine	Finance	Cyber Security - Unsupported systems	15	Helen Vangikar 03/10/2023 11:32:09
2411	Walters, Christine	Finance	Major and sustained failure of essential IT systems	15	Helen Vangikar 03/10/2023 12:22:30

3. Risks removed or deescalated from the CRR since July 2023

Risk ID	Exec lead	CBU	Risk	Operational Lead
2059	Medical Director	Specialist Services	Difficulty Recruiting to Authorised Establishment of Radiologists	Nicky Taggart

END

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	**25 October 2023**
Agenda Item	**MWL TB 23/047**			
Report Title	MWL Board Assurance Framework (October 2023)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required	X	**To Approve**		**To Note**

Purpose

For the Board to review and agree updates to the MWL Board Assurance Framework (BAF).

Executive Summary

This is the first MWL BAF (appendix 1), that has been developed using the revised format agreed by the Board in June and populated with the information from the legacy STHK and S&O BAFs which were updated for the final time and reported to Board in July and then reviewed by the Executive Committee.

The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans, and long term objectives.

In line with governance best practice the BAF will be reviewed by the Board four times a year. The last review of the legacy STHK and S&O BAFs was in July 2023.

At each quarterly review the Executive Committee will review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite.

Key to proposed changes:
~~Score through~~ = proposed deletions/completed
Blue Text = proposed additions
Red = overdue actions

Proposed changes/updates of risk scores for MWL.
Risk 1 – proposed to revise the risk score to 15, having reviewed the mitigations and assurances in place.

Risk 2 – proposed to increase the risk score to 12 due to the increased financial uncertainty arising from the continued impact of industrial action on the elective activity targets.

Risk 3 – proposed increase to 20 due to the impact of industrial action and system pressures impacting both elective and non-elective activity plans and performance.

Financial Implications

None directly because of this report.	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board is asked to approve the changes to the Board Assurance Framework	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Appendix 1

BOARD ASSURANCE FRAMEWORK 2023-2024

BAF Dashboard 2023-2024

BAF	Risk Description	Exec Lead	Risk Score					
			Inherent	STHK Apr	STHK Jul	MWL Oct	Jan	Target
1	Systemic failures in the quality of care	Medical Director/ Director of Nursing	20	20 ↔	20 ↔	15 ↓	n/a	5
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Director of Finance and Information	20	16 ↔	8 ↓	15 ↑	n/a	10
3	Sustained failure to maintain operational performance/deliver contracts	Chief Operating Officer	16	20 ↔	16 ↓	20 ↑	n/a	12
4	Failure to protect the reputation of the Trust	Director of Human Resources	16	12 ↔	12 ↔	12 ↔	n/a	8
5	Failure to work in partnership with stakeholders	Director of Human Resources/ Managing Director	16	12 ↓	12 ↔	12 ↔	n/a	8
6	Failure to attract and retain staff with the skills required to deliver high quality services	Director of Human Resources	20	20 ↔	15 ↓	15 ↔	n/a	10
7	Major and sustained failure of essential assets and infrastructure	Director of Corporate Services	16	12 ↔	12 ↔	12 ↔	n/a	8
8	Major and sustained failure of essential IT systems	Director of Corporate Services	20	16 ↔	16 ↔	16 ↔	n/a	16

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

~~**Score through**~~ **= proposed deletions/completed**

Blue Text = proposed additions

Red = overdue actions

BAF 1 Systemic failures in the quality of care

Exec Lead: Medical Director/Director of Nursing

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	3	5	15	1	5	5

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services **Effect:** • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage **Impact:** • Harm to patients • Loss of reputation • Loss of contracts/market share	• Clinical Strategy • Nursing and Quality Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings • NHSE Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • CNST premium • Patient Safety Incident Response Framework (PSIRF) • Safer staffing/ establishment and Birth Rate + staffing reviews	**LEVEL 1** Operational Assurance • Staff Survey • Friends and Family scores • Quality Ward Rounds **LEVEL 2** Board Assurance • IPR • Patient stories • Quality Committee • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • IPC Board Assurance Framework **LEVEL 3** Independent Assurance • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital	Development of a revised Clinical Strategy Standardised approach to Quality Improvement for MWL Single approach to ward accreditation for MWL	Routinely achieve 30% of discharges by midday 7 days a week to improve patient flow. Single set of key clinical and quality policies for MWL Incident reporting framework to still include reports all incidents and learning points, in parallel to PSIRF.	Deteriorating patient improvement project (Project scope reviewed and refreshed interim report provided to the Executive Committee in August. Project completion for STHK sites revised to March 2024) ~~Birth Rate Plus review of maternity staffing monitored via quarterly staffing reviews and reported to Quality Committee.~~ IPC Summit and action plan to achieve the 2023/24 IPC tolerance trajectories (Now scheduled for November 2023) ~~Implementation of PSIRF~~ ~~Post-transaction Clinical Strategy under development (October 2023)~~ Alignment of key clinical and quality policies across the new organisation (April 2024)

BAF 2 Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners

Exec Lead: Director of Finance

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	3	5	15	2	5	10

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to secure sufficient capital to support additional equipment/bed capacity **Effect:** • Failure to meet statutory duties • NHSE/I Single Oversight Framework rating **Impact:** • Unable to deliver viable services • Loss of market share • External intervention	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 3-year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all ICBs and Spec Comm • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Conflict of interest declarations • Benchmarking and reference cost group	**LEVEL 1** Operational Assurance • Monthly CBU Finance and Performance Meetings • CIP Council Meetings • Agency and locum spend approvals and reporting process • Operational planning **LEVEL 2** Board Assurance • Finance and Performance Committee • Annual Financial Plan • Audit Committee • Integrated Performance Report • Benchmarking and market share reports (inc. GIRFT) • Internal Audit Programme • CQUIN Monitoring **LEVEL 3** Independent Assurance • ICB &NHSE monthly reporting and review meetings • Use of Resources reviews • Contract Review meetings • Place Based Partnership Boards • Financial sustainability self-assessment • External Audit reports including VfM Assessment • Head of Internal Audit Opinion	Continue collaboration across C&M to deliver transformational CIP contribution. Medium and long-term financial plan, taking into account current position and savings from any reconfiguration, that addresses drivers of the underlying financial position of services at legacy S&O sites.	Develop capacity and demand modelling and a consistent approach to service development business case approval. Foster positive working relationships with health economy partners to help create a joint vision of the future of health services. Continue to achieve cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances	Seek all possible sources of capital funding including national bids to support capacity planning and delivering the MWL Estate development plans (March 2024) Delivery of final agreed 2023/24 financial plan (March 2024) Delivery of the 3.7% reduction in bank and agency spend compared to 2022/23 levels (March 2024) Continue to track the activity and financial impact of continued Industrial Action and national guidance/direction on how the impact will be funded (December 2023) Continued monitoring of the impact of above plan inflation in 2023/24 (February 2024) Tracking of the costs of services over the winter period if outside planning assumptions included in the financial plan (e.g., 92% bed occupancy) (February 2024)

BAF 3 Sustained failure to maintain operational performance/deliver contracts

Exec Lead: Chief Operating Officer

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	5	4	20	3	4	12

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand **Effect:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand **Impact:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	**LEVEL 1** Operational Assurance • Winter resilience plans • Care Group Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • IA EPRR response and recovery plans **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE/I & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance oversight of pathways	Implementation of routine capacity and demand modelling A defined preferred option and capital secured for Shaping Care Together programme. Implementation of CDC at Southport and Ormskirk sites.	Assurance that there is sufficient system response to operational pressures and delayed discharges Progress against waiting list reduction and recovery targets	Deliver 2023/24 combined STHK & S&O waiting list reduction and elective recovery targets (April 2024) Work with Place partners to achieve 92% bed occupancy and reduce delayed discharges (April 2024) Improve effectiveness of discharge processes to support 30% of discharges by noon (Now part of the 2023/24 winter plan to be implemented by December 2023) Implementation of Theatre Improvement Programme at Ormskirk Hospital (April 2024) Implementation of Diagnostics Improvement Plans across MWL (April 2024) Deliver the 2023/24 winter plan to maintain access to urgent and emergency care across the Trust (March 2024)

BAF 4 Failure to protect the reputation of the Trust

Exec Lead: Director of HR

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information • Failure of FPPT procedure **Effect:** • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review **Impact:** • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	• Communication and Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	**LEVEL 1** Operational Assurance • Winter resilience plans • Care Group Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE/I & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance oversight of pathways	Regular media activity reports, including social media, to the Executive Committee Implementation of the revised Fit and Proper Persons Test Framework (March 2024)	Media and Public Engagement Strategy for the new organisation Creation of good working relationships with new Healthwatch/PBP areas post transaction	~~Deliver Phase 1 of the Communication and engagement plans for MWL (September 2023)~~ Deliver the next phase of the communication and engagement plan for MWL – focusing on Trust values (December 2023) Create effective working relationships and enhance the Trust's reputation with the new Places and stakeholders for MWL, including MPs

BAF 5 Failure to work effectively with stakeholders

Exec Lead: Director of HR/ Managing Director

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information **Effect:** • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff **Impact:** • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • Place Director Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • St Helens Cares Peoples Board • Involvement in Halton and Knowsley PBP development • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care Board governance structure • Exec to Exec working • MWL Hospitals Charity annual objectives • Regular meetings with local MPs, OSCs etc. • Equality impact assessments	**LEVEL 1** Operational Assurance • LUHFT Partnership Board • North Mersey Ophthalmology Steering Group • Shaping Care Together Programme • Capital Assurance Group • ED&I Steering Group • Monitoring of NHS Choices comments and ratings • Review of digital media trends • Healthwatch feedback **LEVEL 2** Board Assurance • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • Quality Account • Annual staff engagement events programme **LEVEL 3** Independent Assurance • NHSE/I review meetings • Participation in C&M ICB leadership and programme Boards • Collaborative working with Place Directors to develop plans for PBPs • Membership of St Helens People Board • OSC attendance/presentations	~~Effective working with the Shaping Care Together Programme in Southport and Formby, and West Lancashire~~ ~~Establishment of Patient and Public Reference Group for Southport and Formby, and West Lancashire~~	**C**&M Integrated Care System performance and accountability framework ratings and reports Development of good working relationships with Primary Care Networks Maintain or improve NHS Operating framework segment 2 (April 2024)	Work with each Place Based Partnership in the MWL catchment to improve the health of the population and reduce health inequalities (March 2024) Deliver 92% bed occupancy target for each PBP (March 2024) Re start the Shaping Care Together Programme to develop a new PCBC for the configuration of services between the Southport and Ormskirk Hospital sites (March 2024) Work with NHSE/ICB post transaction to continue to support fragile services for MWL as required (September 2024) Cultural engagement and communication programme “the big conversation” to create the MWL values and culture (December 2023)

BAF 6 Failure to attract and retain staff with the skills required to deliver high quality services — Exec Lead: Director of HR

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	3	5	15	2	5	10

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff **Effect:** • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff **Impact:** • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	• Team Brief • Staff Newsletter • Staff App • Mandatory training • Appraisals • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/LNC • Education and Workforce Development Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Strategy action plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • ACE Behavioural standards • Medical Workforce OD plan • Talent Management action plan • Equality, Diversity, and Inclusion action plan	**LEVEL 1** Operational Assurance • Premium Payments Scrutiny Council • Monitoring of bank, agency and locum spend • Workforce operational plans **LEVEL 2** Board Assurance • Strategic People Committee • People Performance Council, Valuing Our People Council and HR Commercial Services Council • Finance and Performance Committee • Integrated Performance Report • Staff Survey • Monthly monitoring of vacancy rates Labour stability and staff turnover • WRES, WDES, EDS3 and Gender Pay Gap, reports and action plans • Quality Ward rounds • Employee Relations Oversight Group **LEVEL 3** Independent Assurance • HR Benchmarking • Nurse & Midwifery Benchmarking • Freedom to Speak Up Guardian reports • Guardian of Safe Working Hours report	Increase frequency of the Strategic People Committee meetings in 2023/24 Evaluation of the impact of introducing 12 hour long day nursing shifts (StHK) Improve ease with which staff can move roles internally Integration of education structure (S&O)	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g., international recruitment and working closely with NHSE. CDC recruitment campaign continues with recruitment events and new training opportunities for Physician Associates, Phlebotomy, international recruitment, and use of apprenticeships (March 2024) C&M Endoscopy bank pilot extended to January 2024. Achieve 2023/24 targets for international recruitment and Nurse Associate expansion with new cohort commencing Q3 2023/24 (March 2024) ~~Achieve compliance rates for PDR completion at S&O~~	~~Provide consistent messaging and communications channels for staff and stakeholders about the Transaction (April 2024)~~ ~~(S&O)~~ Delivery of the 2022 staff survey action plan for legacy organisations in 2023/24 and combine surveys and action plans for future (March 2024) Revise reporting (Datix) system to allow more robust recording of incidents relating to ED&I and staff safety, with interim paper based recording for MWL (revised to November 2023 to align process across the legacy STHK and S&O Datix systems, with single reporting system for MWL planned for 2024). Achieve the Mandatory Training and Appraisal compliance targets of 85% (March 2024) Provide the necessary support for organisational change to impellent the MWL operating model and integrated management structure (March 2024)

BAF 7 Major and sustained failure of essential assets or infrastructure

Exec Lead: Director of Corporate Services

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services **Effect:** • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints **Impact:** • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5-year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning, food standards • Compliance with NHS Estates HTMs • Green Plan	**LEVEL 1** Operational Assurance • Major Incident Plan • Business Continuity Plans • Planned Preventative Maintenance Programme • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee to capture ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance • S&O safety groups and E&F Governance Group **LEVEL 2** Board Assurance • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • Integrated Performance Report • ERIC returns/data **LEVEL 3** Independent Assurance • Authorising Engineer Appointments • Authorising Engineer Audits • Condition surveys • Premises Assurance Model benchmarking • Model Hospital • PLACE Audit Results and benchmarking	Maintain up to date 10-year strategic estates development plans for MWL n to support the Trusts service development and integration strategies. Create strategic site development plans for the S&O hospital sites when transaction completed (February 2024) ~~Completion of asset surveys at S&O hospital sites~~ Development of an Estates Strategy in response to Shaping Care Together preferred service configuration option (aligned to SCT timetable)	Implementation of new National Standards of Cleaning for MWL - continued engagement with NHSE and proposals agreed with IPC (December 2023) Implementation of the national Hospital Food Review recommendations and mandatory standards (Gap analysis being undertaken) Compliance with the new Protect legislation for premises security – Consultation closed in July 2022 and draft legislation not yet published. Compliance with Fire Enforcement Notice from Mersey Fire and Rescue at S&O hospital sites ~~Completion of RAAC surveys to identify the level of risk~~	3-year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2024/5) Delivery of the Whiston Additional Theatres Scheme (June 2024) ~~Implementation of new CAFM system at S&O sites (April 2023)~~ Fire alarm and compartmentation upgrades at SDGH and fire alarm upgrades at ODGH (November 2023) Complete review of Estates and FM systems, processes, and policies across all MWL sites (March 2024) Deliver the high risk backlog maintenance remediation programme for the S&O sites agreed for 2023/24 (March 2024) Deliver the MWL capital programme (capital works) for 2023/24

BAF 8 Major and sustained failure of essential IT systems

Exec Lead: Director of Informatics

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	4	4	16	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure **Effect:** • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity • Loss of data or patient related information **Impact:** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share contracts	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register • Service improvement plans	**LEVEL 1** Operational Assurance • Information security dashboard • Information asset owner register • Information security dashboard • IT On Call (including network specific cover provided by MMDA) • Benefit realisation framework monitoring **LEVEL 2** Board Assurance • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • MMDA Service Operations Board • MMDA Strategy Board • Programme/Project Boards • Information Governance Steering Group **LEVEL 3** Independent Assurance • Internal/External Audit Programme • CareCert, Cyber Essentials, External Penetration Test • Support contracts for core systems • Quarterly NHS Digital simulated phishing attack reports • Digital Maturity Assessments	Annual Corporate Governance Structure review Technical Development of staff	Compliance with ISO27001 IT communications strategy Digital Maturity assessment Cyber Essential Certification/Accreditation – achieve by January 2026 Migration from end-of-life operating system at S&O sites	Review benefits of ISO27001 – if not superseded plan for implementation (revised to March 2024) Achieve HIMMS Level 5 2018 standards and ~~minimum digital foundation~~ core digital capabilities and WGLL standards (March 2025) ~~Migration from end-of-life operating systems to include decommissioning of Microsoft 2012 (October 2023)~~ Windows Server 2012 servers have had extended support taken out while work continues on the decommissioning (October 2024). Windows Server 2008 Servers are gradually being retired and will be fully replaced by March 2025. Delivery of the EPR Digital Maturity Programme (March 2025) Delivery of Community EPR (Completion revised to March 2024) Respond to cyber threat alerts and update systems as required (on going) Test major incident and data recovery plans for MWL (Revised to February 2024) ~~Network remediation rollout at legacy S&O sites (July 2023)~~

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 October 2023
Agenda Item	**MWL TB23/048 (11.1)**			
Report Title	Incidents, Complaints, Concerns and Claims (Quarter 1) (STHK)			
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Sue Redfern, Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

The aim of this paper is to provide the Board with a closure report on the management of incidents, complaints, concerns and claims during the first quarter of 2023/24, as the final quarter of legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK).

Executive Summary

Incidents

- 5023 incidents reported in Q1 (4.15% increase on Q4 2022-23)
- 3825 patient incidents (2.99% decrease on Q4 2022-23)
- 21 patient incidents graded as moderate or above
- The highest number of incidents reported relate to:
    - Pressure ulcers = 677 (which include pressure ulcers acquired prior to admission to Trust services)
    - Patient slips, trips or falls = 532

Complaints

- 54 first stage complaints were received in Q1, 65 complaints of all stages in total
- Clinical treatment was the main reason for complaints, in line with previous quarters
- ED remained the main department to receive complaints, although numbers have reduced
- The Trust closed 59 1st stage complaints in Q1, 77 in total

Claims

- There were 41 new claims intimated in Q1 (43 in Q4 2022-23), or which 11 were NHSR instructed claims
- In addition, 11 pre-action claims converted to NHSR instructed claims
- Failure/delay in diagnosis remained the main cause of new claims
- 15 new inquests were received in Q1 and 16 inquests were closed

PALS

- 1150 contacts were received in Q1, a 31% increase from Q1 2019-20 and a 1.8% decrease from Q4 2022-23
- 1124 PALS contacts were closed
- 35 first stage complaints opened in Q1 had had previous contact with PALS
- Top 5 subjects for PALS concerns and complaints are consistent with the previous quarter, with communications featuring the most

A combined report for quarter 2 for the Mersey and West Lancashire Teaching Hospitals NHS Trust will be presented to January's Board.

Financial Implications

None as a direct consequence of this paper.
Quality and/or Equality Impact
Not applicable
Recommendations
The Board is asked to note the Incidents, Complaints, Concerns and Claims (Quarter 1) (STHK) report for assurance.

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Introduction

This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during quarter 1 2023-24, highlighting any trends, areas of concern and the learning that has taken place. The Trust uses Datix to record incidents, complaints, PALS enquiries and claims.

2. Incidents

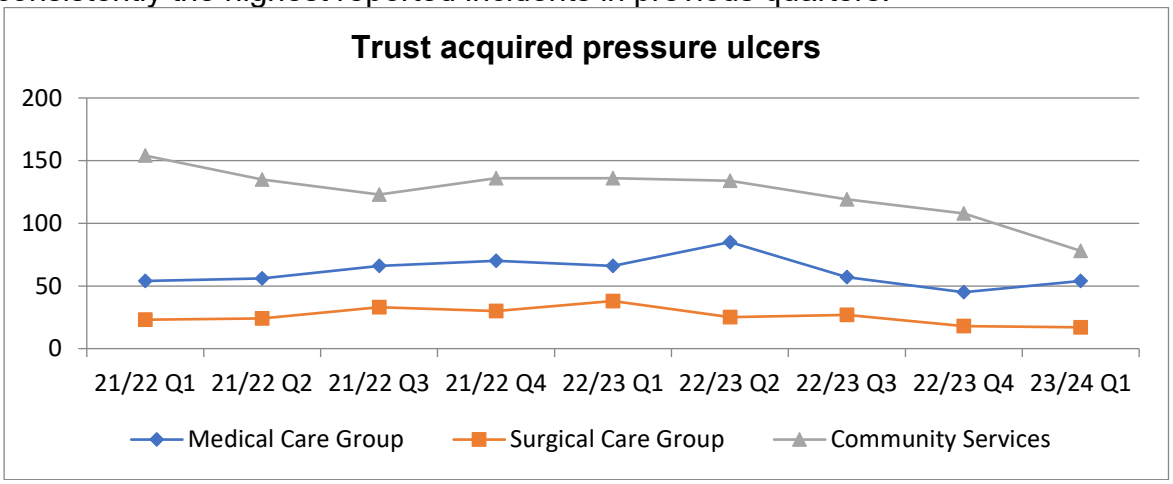
During Q1, 5023 incidents were reported, of which 76.15% (3825) were patient safety incidents. This is an 4.15% increase on Q4 2022-23 (4823) in all incidents and 2.99% decrease in patient incidents (3943).

	2023-24 Q1
Incidents affecting patients	3825
Incidents affecting staff	555
Incidents affecting the Trust or other organisation	609
Incidents affecting visitors, contractors or members of the public	34
Total	5023

In Q1 2023-24 there were 21 patient safety incidents categorised as moderate harm, severe harm or death. This is a reduction compared to the previous quarter's 31 incidents to Q1 in 2022-23 which had 29.

	2021-22				2022-23				2023-24
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Moderate	22	24	21	21	19	16	17	16	15
Severe	7	7	9	14	8	10	11	10	3
Death	3	3	4	2	2	3	8	5	3
Total	32	34	34	37	29	29	36	31	21

All patient safety incidents were categorised by the National Reporting and Learning System (NRLS) dataset. The Trust has now adopted the new framework, Learn from Patient Safety Events (LFPSE). The highest reported categories during Q1 were pressure ulcers (677), which included all patients who were admitted with pre-existing pressure ulcers. The second highest reported category was slips, trips and falls (532). These were consistently the highest reported incidents in previous quarters.

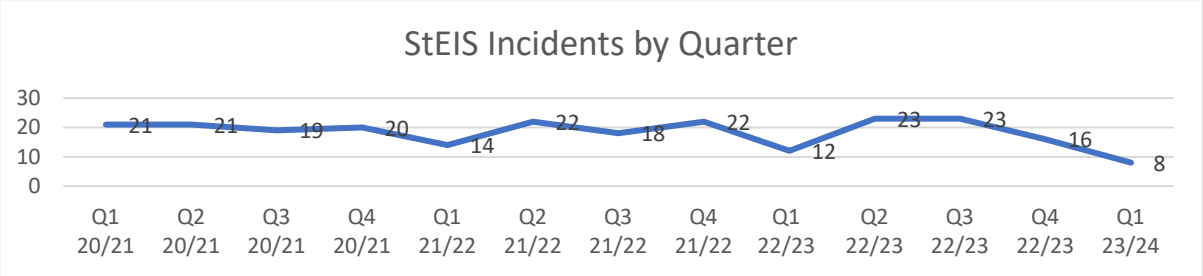


Two severe harm Trust acquired pressure ulcers were identified in Q1 2023-24, with comprehensive actions being taken to reduce further risk.

STHK Acquired PU	2021-22				2022-23				2023-24
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
None	85	74	97	120	141	146	132	109	76
Low	145	141	126	117	100	99	67	60	69
Moderate	0	0	0	0	0	1	0	0	0
Severe	1	0	1	0	0	0	0	0	2
Ungraded to date	0	1	1	1	1	2	5	6	1
Total	231	216	225	238	242	248	204	175	148

2.1. Review of incidents reported to StEIS in Q1 2023-24

During quarter 1 2023-24, the Trust had 8 incidents which were reported to StEIS compared to 16 incidents reported during Q4 and 12 in Q1 2022-23. These incidents met the serious incident reporting criteria.



During Q1 there were 22 StEIS reports submitted to the ICB. All reports were submitted within the agreed timeframes. Actions taken and lessons learned are shared both internally and with the ICB.

2.2. Duty of Candour

Duty of candour was completed for all cases reported via StEIS during Q1. Duty of candour is completed for all patient safety incidents graded as moderate or above harm. Moderate harm incidents and Level 1 incidents are monitored within the Care Groups.

2.3. Benchmarking

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

% of all reported incidents (STHK only)	April 20 to March 21			April 21 to March 22		
	National %	STHK %	S&O %	National %	STHK %	S&O %
No harm	72.7%	81.7%	86.7%	70.6%	79.0%	90.1%
Low	24.6%	17.5%	12.2%	26.0%	20.2%	9.3%
Moderate	2.2%	0.4%	0.9%	2.9%	0.5%	0.5%
Severe	0.3%	0.3%	0.2%	0.3%	0.3%	0.1%
Death	0.2%	0.06%	0.05%	0.2%	0.1%	0.04%

2.4. Dissemination of learning

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

3. Complaints

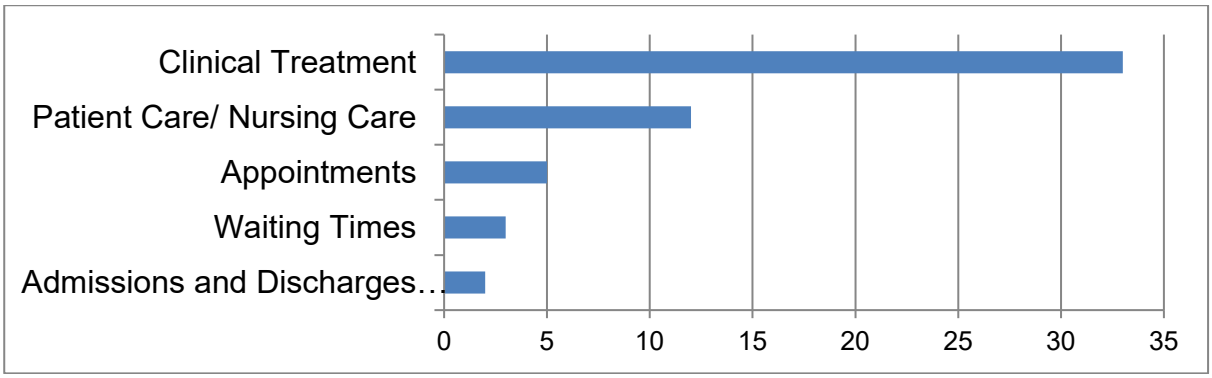
The table below shows the number of received and opened first stage complaints in Quarter 1 (65 in total). The Trust received 10 more complaints than in Q1 2022-23, but 23 less than in Q1 2021-22.

Indicator	2019-20	2020-21	2021-22	2022-23	2023-24
					Q1
Total number of new complaints including community services	325	251	266	213	54
Total number of new complaints received (excluding community services)	320	242	254	207	48
Acknowledged within 3 days	100%	100%	100%	100%	100%
Response to first stage complaints within agreed timescale – target 90%	93.4%	94%	80%	75.67%	72.9%
Number of overdue complaints	1	4	7	11	8
Second stage complaints	36	23	32	38	12

Data correct as at 3 July 2023.

The Trust acknowledged 100% of all complaints received within 3 working days in line with NHS legislation, maintaining the standard achieved consistently since 2019-20. The Trust responded to 72.9% of complaints within the agreed timescale. As at 3 July 2023 there were 78 open first stage complaints (99 open complaints of all types/stages). The Trust moved to a target of 60 working days for all complaints from 1 July 2023.

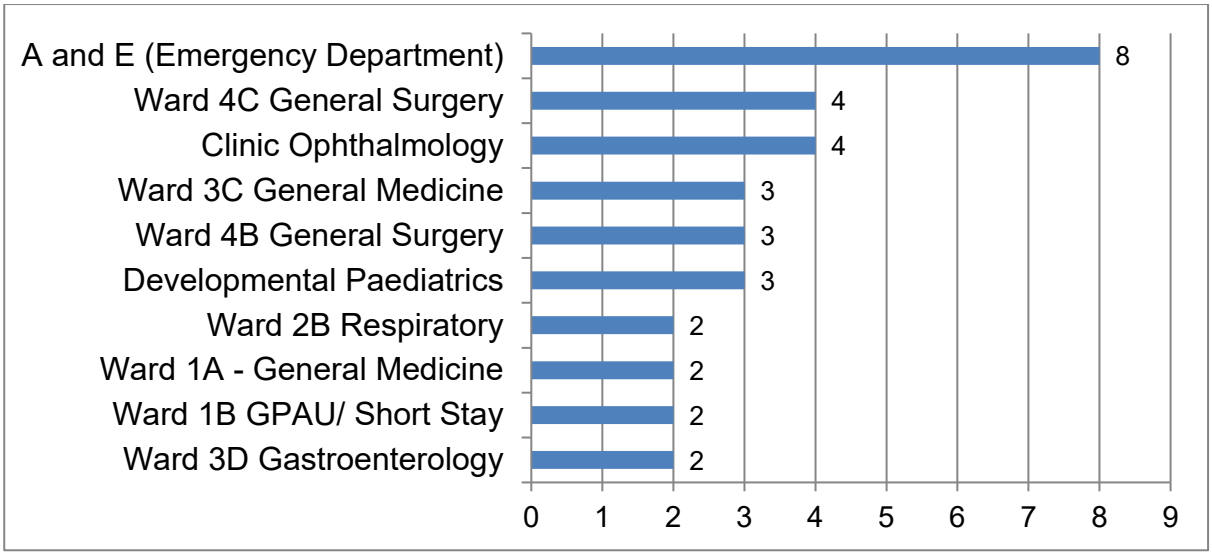
3.1. Top five reasons for complaints Q1 2023-24



Clinical treatment remained the main reason for complaints. Values and behaviours and communications, which were the second and third biggest reasons for complaints in Q4 of 2022-23 do not feature here. Patient and nursing care is the second largest, having not featured in the top 5 in Q1.

3.2. Complaints by top location

The Emergency Department received the highest number of complaints in Q1 with 8 (4 related to clinical treatment, 2 to waiting times and 1 each for values & behaviours and admissions & discharges). This is a reduction of 1 from Q4 and less than half of the number in Q3 (18), which is a positive result considering the pressures within ED remain. Four complaints were received for Ward 4C (all clinical treatment) and ophthalmology clinic (2 relate to clinical treatment, 1 each for waiting times and values & behaviours); neither featured in the top 10 in the previous quarter. Developmental Paediatrics, Ward 3C and Ward 4C received 3 complaints (4C also received 3 complaints in Q4).



3.3. Comparison of written complaints received with neighbouring trusts

NHS Digital have indicated that data for written complaints with the NHS for 2022-23 should be published on 26 October 2023.

3.4. Closed complaints

The Trust resolved 59 complaints with Q1. 72.9% of these were resolved within agreed timescales. The Trust responded to 77 complaints in total during this period. It should be noted that the majority of the complaints are not upheld. Additional information on complaints is contained in Appendix 1.

3.5. Dissemination of learning

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

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

In Q1 the Trust did not receive any new enquiries, and no further contact has been made regarding the existing cases. The Trust have contacted the PHSO for an update.

4. PALS

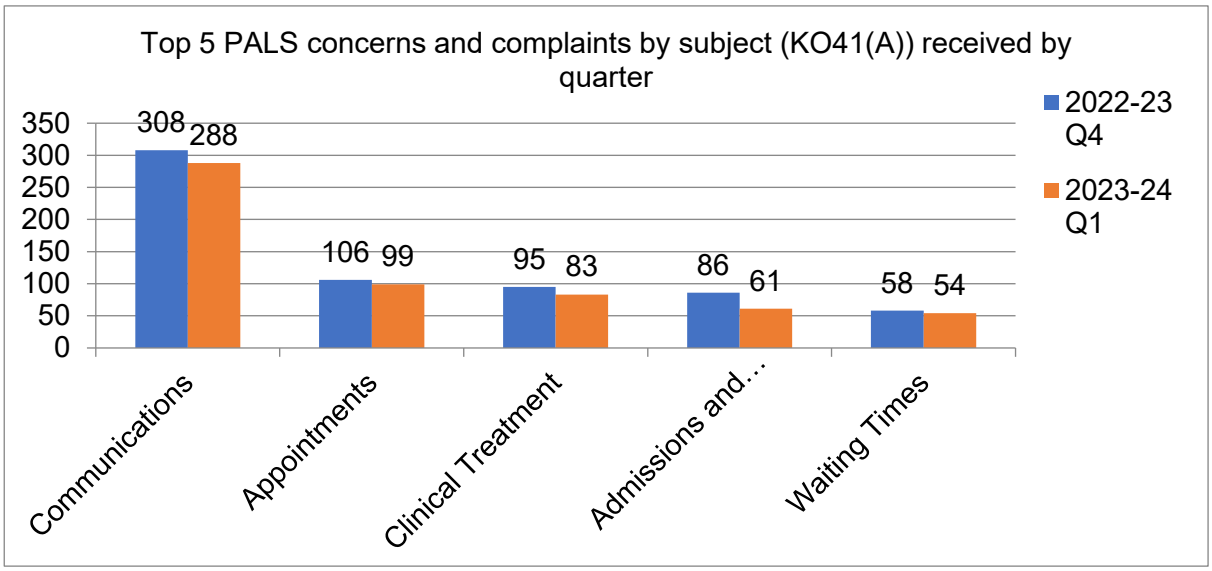
1150 contacts were received in Q1, which is a 31% increase from Q1 2019-20, a 0.5% increase from Q1 2022-23 and a 1.8% decrease from Q4 2022-23. 373 PALS contacts were for signposting and one was a compliment, with 775 (67%) being concerns or complaints.

4.1. PALS contacts resolved by quarter

In Q1 1124 PALS contacts were closed. 35 first stage complaints opened in Q1 had had previous contact with PALS.

4.2. PALS enquiries by subject

The top 5 subjects are the same for Q1 2023-34 as for the previous quarter.

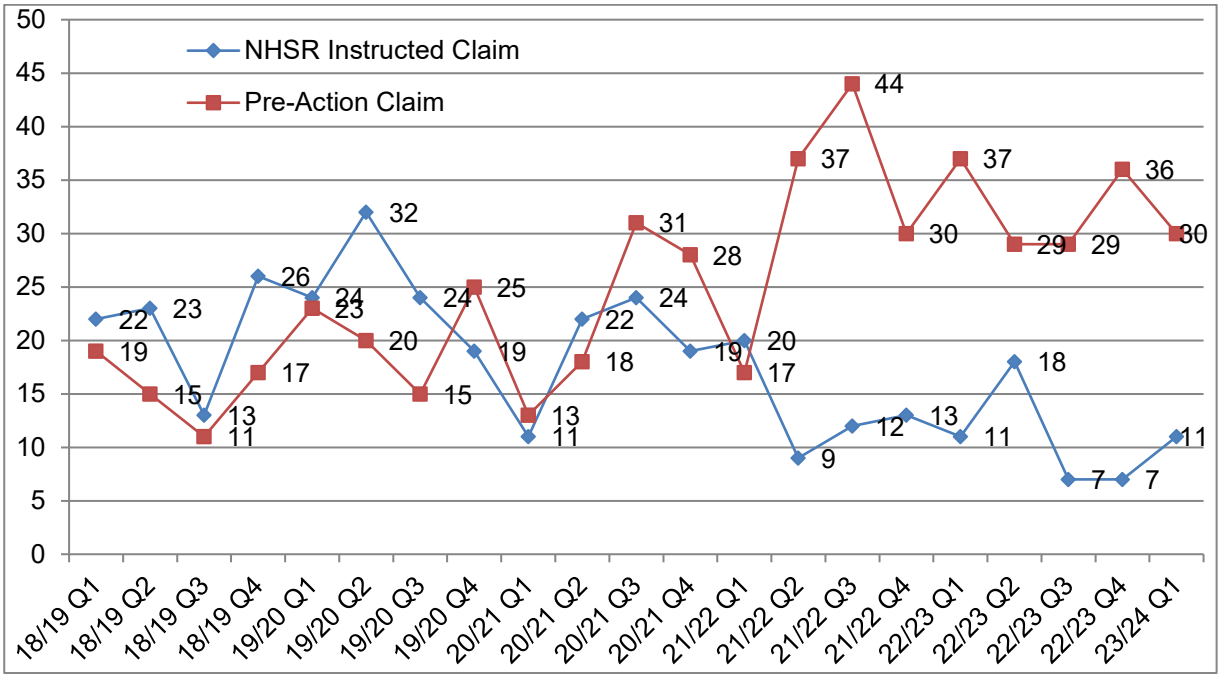


5. Clinical Negligence Claims

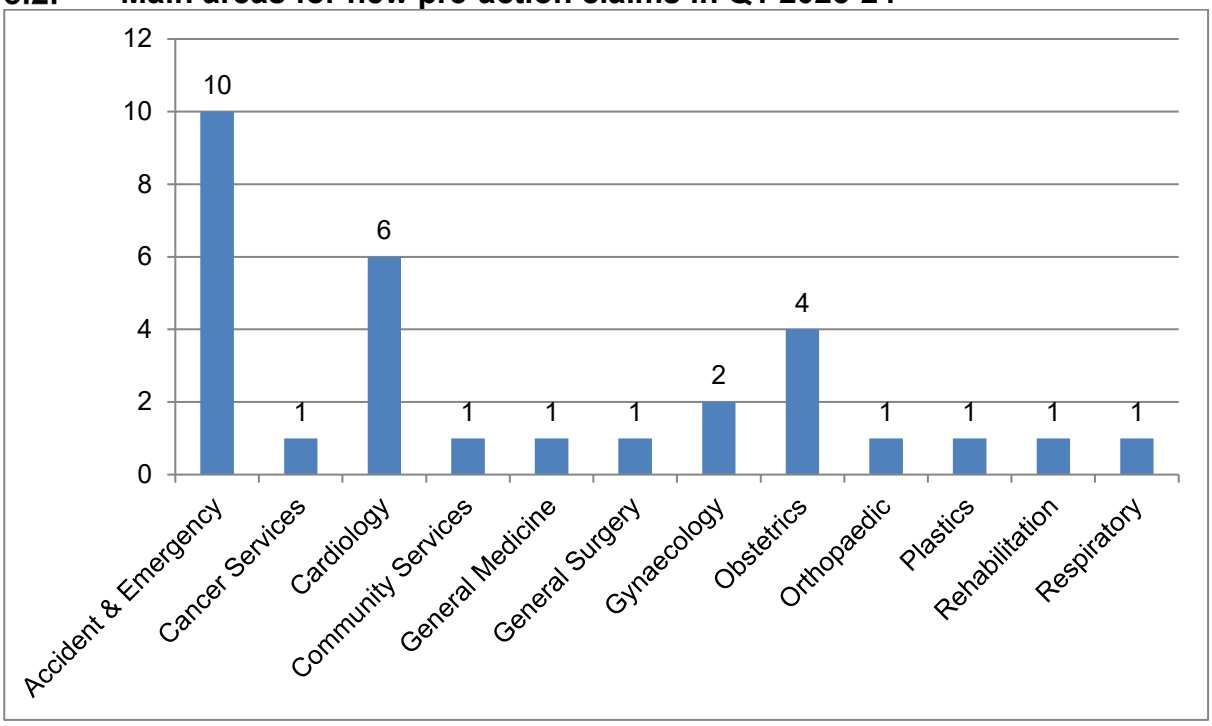
The graph below shows the total number of claims where the Trust has been asked for records (pre-action claims) and the total number of letters of claim or proceedings (NHSR instructed claim) received. There are some limited circumstances where NHSR are instructed before a letter of claim, for example when there is clear evidence of breach of duty and causation already.

The Trust received 11 new NHSR instructed claims and 30 pre-action claims. 11 previous pre-action claims converted to NHSR instructed claims during Q1. Failure/delay in treatment was the main reason for claims. This is in contrast to previous quarters, when failure/delay of diagnosis is generally the largest cause of claims.

5.1. Pre-action and NHSR instructed claims received by quarter



5.2. Main areas for new pre-action claims in Q1 2023-24



This data relates to pre-action claims and reflects the fact that claims can include more than one speciality. ED usually receives the highest number of claims. Cardiology received 6 potential claims; this is not normally an area that attracts a lot of claims. Four of these provided no specific details when records were requested, 1 related to the failure to recall a patient in 2015 following an aneurism and 1 relates to a delay in diagnosing achalasia. Obstetrics attracted 4 potential claims, along with 5 in Q4 of 2022-23. Neither cardiology nor obstetrics received any new NHSR instructed claims in Q1.

6. Inquests

15 inquest notifications were received in Q1, a decrease of 9 from Q4 2022-23 and the lowest quarter since Q1 in 2022-23 (11).

16 inquests were closed in Q4. There were no Prevention of Future Deaths (PFD) Orders this quarter and the Trust was not asked to provide any further evidence by the Coroner on any matter. It is of note that the Trust has not received a PFD for over 2 years.

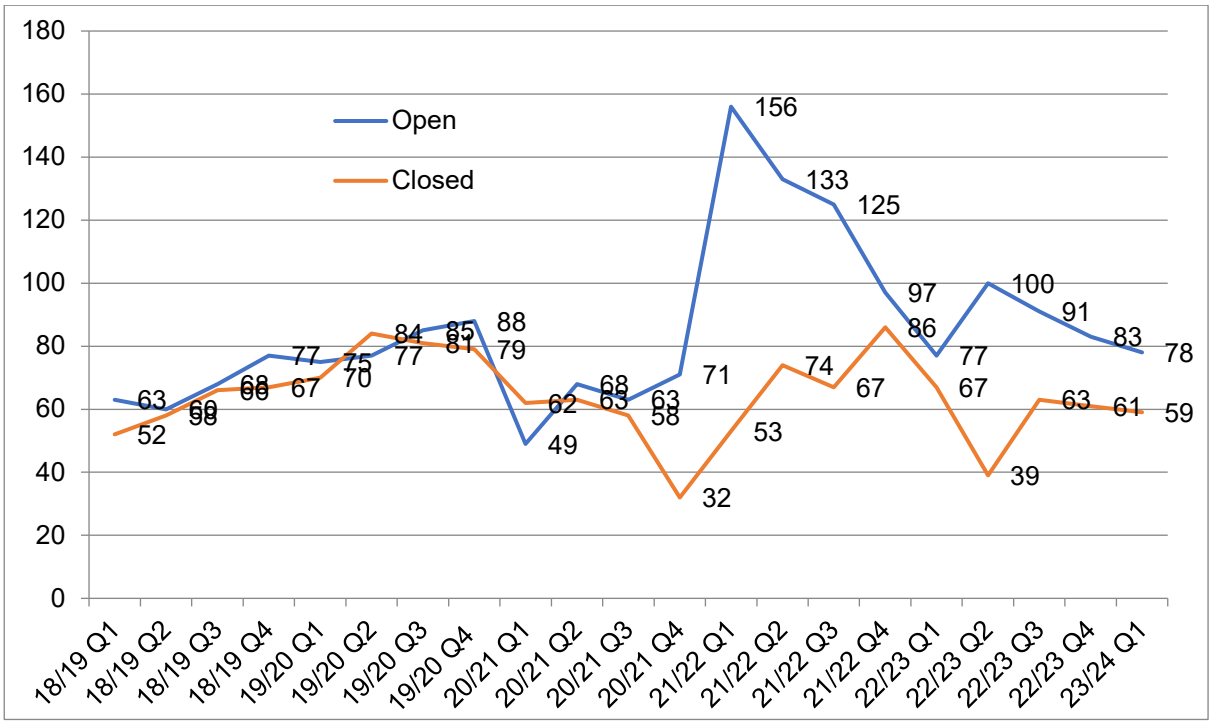
7. Recommendations

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

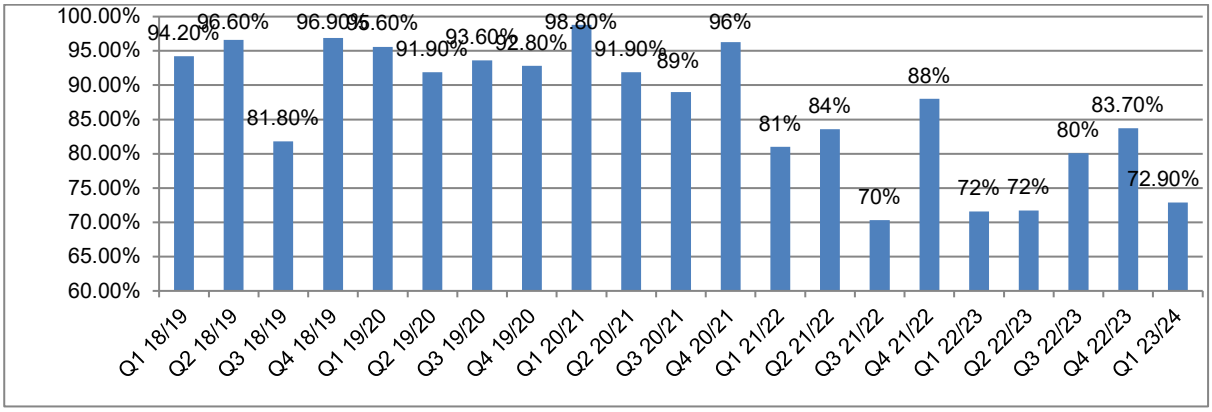
ENDS

Appendix 1 – summary of complaints activity

Open vs Closed Complaints



Responses within agreed timescales



Outcome of closed complaints in 2023-24

	Apr 2023	May 2023	Jun 2023	Total
Not Upheld Locally	1	9	5	14
Partially Upheld Locally	8	15	9	32
Upheld Locally	4	1	7	12
Total	13	25	21	59

Title of Meeting	**Trust Board**		**Date**	25 October 2023
Agenda Item	**MWL TB23/048 (11.2)**			
Report Title	Incidents, Complaints, Concerns and Claims (Quarter 1) (S&O)			
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Sue Redfern, Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

To provide the Trust Board with an update on the management of Complaints, PALS, Claims and the Friends and Family Test across Southport and Ormskirk Hospitals for Quarter 1, 2023/24.

Executive Summary

Complaints

- 52 formal complaints were received in Q1
- There has been a focus on the Trust's complaint response time and the number of open complaints. The number of open complaints has reduced by 71.4% and the number of overdue complaints has reduced by 87.3%.
- Reopened complaints have reduced from 2.6 to an average of 1.3 per month, demonstrating improvements in the quality of the Trusts formal responses.
- The number of complaints over 100 days peaked at 14 in September 2022. At the end of March 2023, this reduced to one and currently stands at zero.
- The number of new complaints averaged 23 per month in the previous year. This has reduced to an average of 13 per month. This is due to early intervention to prevent patient concerns escalating into formal complaints.

Claims

- There were 16 new claims received in Q1, compared to 41 and 15 in the previous two quarters, respectively.
- All of the 16 claims in Q1 were pre-action claims, received into us via a 'letters before action'. It is not yet known whether these will convert into 'confirmed' claims where we received formal letters of claim.
- Four inquests were notified by the Coroner in Q1 compared to five in Q4 and nine in Q3.

PALS

- 503 contacts were received in Q1 this generated 1,653 forms of communication made by the team.
- In 2022/23 there has been a 20% decrease in PALS contacts on comparison to the previous year.

Friends and Family Test

- Inpatients, outpatients, antenatal community, birth/delivery and postnatal community were all at or above target for Q1.
- ED recommendation rates remain below trust target.
- Overall trust score average for 2022/23 was 88.64%. However, we have sustained a score of over 90% since January 2023.

- The top five positive and negative themes have remained the same this quarter as they were throughout 2022/23.

Work is ongoing to align the Trust processes for the management of complaints and claims. Work is also underway to improve FFT responses with a focus on maternity users.

Financial Implications

No financial implications resulting from this report.

Quality and/or Equality Impact

Not applicable

Recommendations

The Trust Board is asked to note the legacy report for Q1 2023-24 for Southport and Ormskirk Hospital NHS Trust.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Title of paper: Southport and Ormskirk Hospitals : Complaints, PALS, Claims and Friends & Family Test (FFT) Quarter 1
2023-24

Purpose: The aim of this paper is to provide the Quality Committee with an update on the management of Complaints, PALS, Claims and the Friends and Family Test across Southport and Ormskirk Hospitals

Summary

Complaints

- 52 formal complaints were received in Q1
- Between April 2022 and March 2023, the Trust received 243 formal complaints which is a 10.6 % decrease compared to the previous year.
- There has been a focus on the Trust's complaint response time and the number of open complaints. The number of open complaints has reduced by 71.4% and the number of overdue complaints has reduced by 87.3%.
- Reopened complaints have reduced from 2.6 to an average of 1.3 per month, demonstrating improvements in the quality of the Trusts formal responses.
- The number of complaints over 100 days peaked at 14 in September 2022. At the end of March 2023, this reduced to 1 and now 0.
- The number of new complaints averaged 23 per month in the previous year. This has reduced to an average of 13 per month. This is due to early intervention to prevent patient concerns escalating into formal complaints.

Claims

- There were 16 new claims received in Q1, compared to 41 and 15 in the previous two quarters, respectively.
- All of the 16 claims in Q1 were pre-action claims, received into us via a 'letters before action'. It is not yet known whether these will convert into 'confirmed' claims where we received formal letters of claim.
- 4 inquests were notified by the Coroner in Q1 compared to 5 in Q4 and 9 in Q3.

PALS

- 503 contacts were received in Q1 this generated 1653 forms of communication made by the team.
- In 2022/23 there has been a 20% decrease in PALS contacts on comparison to the previous year.

Friends and Family Test

- Inpatients, outpatients, antenatal community, birth/delivery and postnatal community were all at or above target for Q1.
- ED recommendation rates remain below trust target.
- Overall trust score average for 22-23 was 88.64%. However we have sustained a score of over 90% since January 2023.
- There were 12,427 ratings and 8,383 comments received during Q1.

• The top 5 positive and negative themes have remained the same this quarter as they were throughout 2022-23.
Corporate objectives met or risks addressed: Care and safety
Financial implications: None as a direct consequence of this paper
Stakeholders: Patients, carers, commissioners, Healthwatch, regulators and staff
Recommendation(s): Members are asked to note the report
Presenting officer: Brendan Prescott / Carol Fowler
Date of meeting: Presented to Quality Committee, 18th July 2023

Introduction

This paper covers complaints, PALS enquiries, claims and inquests during Q1 2023-24, highlighting any trends, areas of concern and the learning that has taken place. It provides a summary of FFT responses for Q1.

The Trust uses Datix to record complaints, PALS enquiries and claims and Envoy to record FFT. The figures were correct at the point of producing this report.

1. Complaints – data correct as of 5th July 2023

Indicator	2021-22	2022/23	2023/24			
	Total	Total	Q1	Q2	Q3	Q4
Total number of new complaints	274	247	39			
Acknowledged within 3 days	100%	100%	100%			
Response to complaints within agreed timescale – target 80%	59%	51%	55%			

Southport and Ormskirk sites moved to 60 working day target for all new formal complaints from 1st July 2023, previously this was 40 working days.

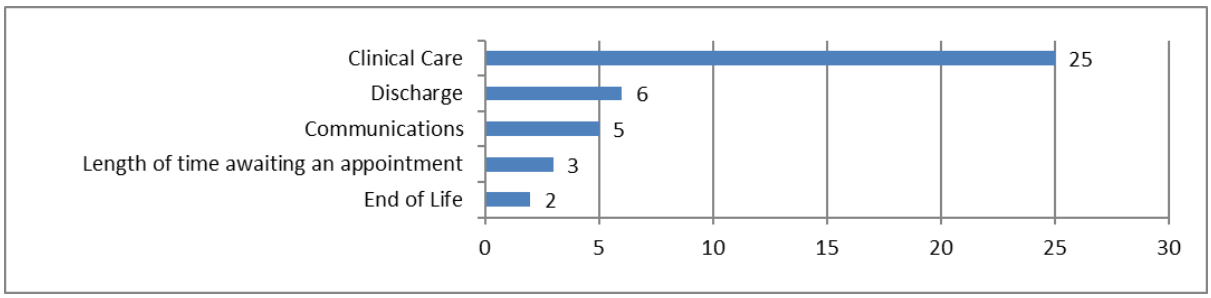
100% of complaints received in Q1 of 2023-24 were acknowledged within 3 working days as per the regulations.

2. Complaint activity – Formal Complaints

In Q1 the Trust received and opened 39 formal complaints. There are currently 14 open complaints (all stages).

The number of re-opened complaints was 3 in Q1. The main reasons that complainants lodge second complaints are because they want further information or do not agree with the findings.

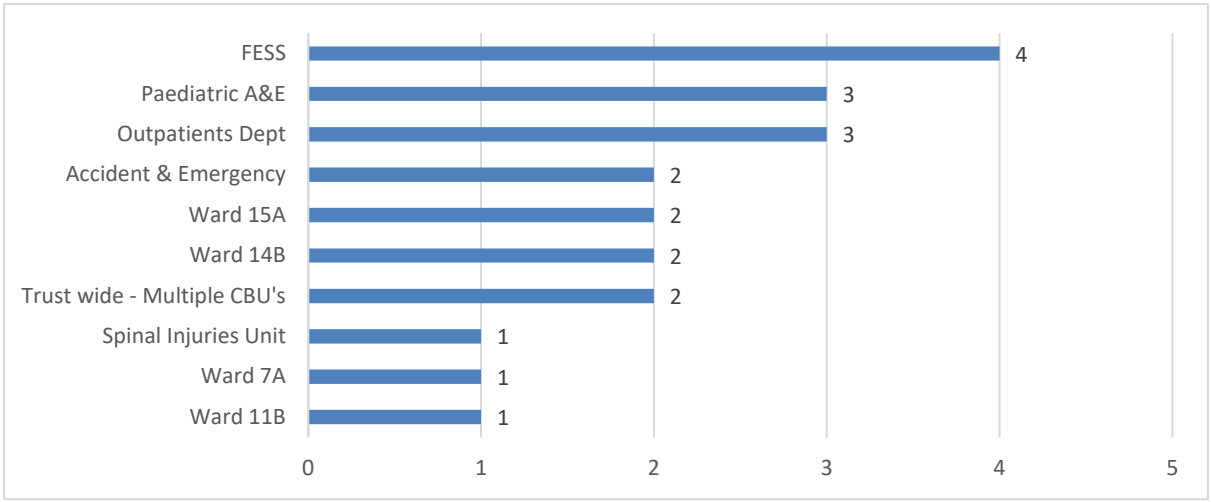
3. Top five themes for complaints Q1 2023-24



Clinical treatment remained the main reason for complaints, the theme remains unchanged.

3.1. Complaints - top ten locations

Frail elderly short stay (FESS) received the highest number of complaints in Q1 with 4. 3 complaints were received for paediatric A&E and outpatient clinics relating to different specialities, which relate to clinical treatment and timeliness.

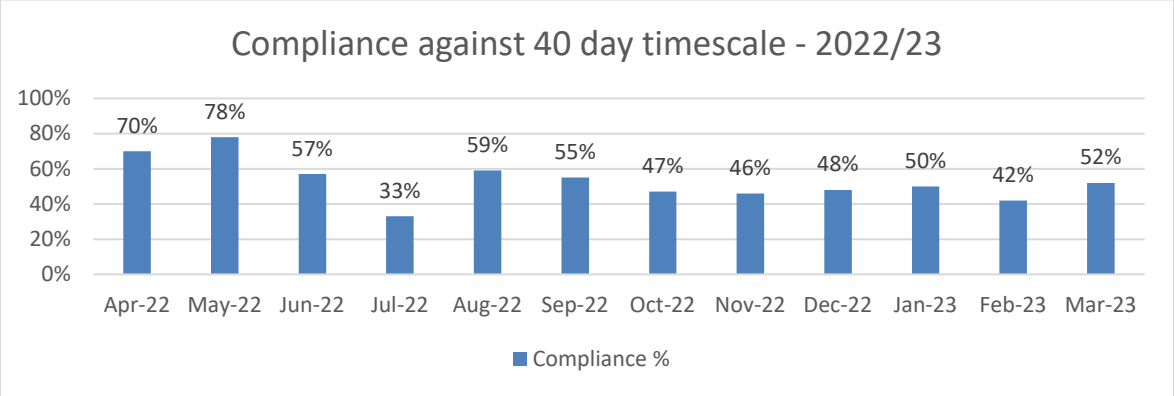


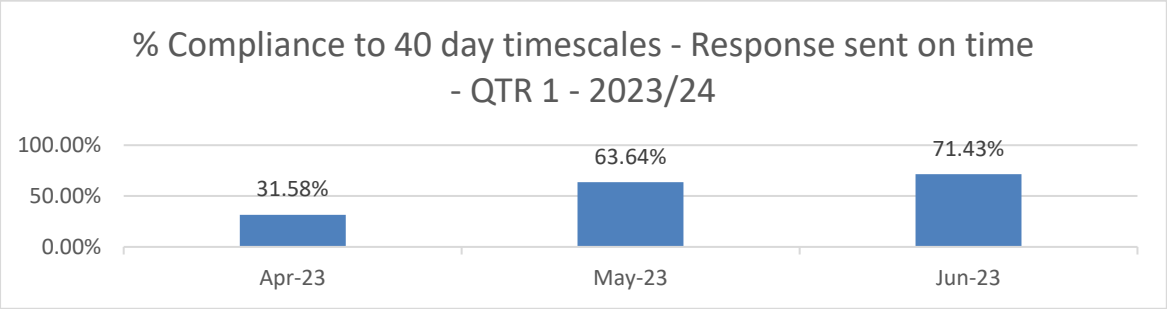
3.2. Closed complaints

During Q1, 52 formal complaints were closed. It should be noted that the majority of the complaints are not fully upheld as noted in the table below:

	Apr 2023	May 2023	Jun 2023	Total
Upheld	3	7	2	12
Partly Upheld	6	5	5	16
Not Upheld	8	10	6	24
Total	17	22	13	52

The table below sets out the performance 2022/23 against 40 working day targets. The average number of working days to close a complaint in Q1 is 42 working days.





4. Decisions, actions and learning

It is paramount that the Trust continues to learn from complaints and that this is reflected in service improvements. The examples below outline the actions taken for learning from complaints.

- Discharge process has been improved, the discharge planning team have supplied all areas with a flow chart that clearly explains the discharge process for all patients and discharge locations.

- To improve communication in response to restricted visiting, a communication care plan has been successfully piloted across a number of medical wards. This has now been implemented throughout the Trust.

- The Integrated Governance Team have introduced governance learning bulletins which includes learning from complaints, and these are shared amongst all staff.

- Palliative care training has been carried out by Queenscourt hospice to improve end of life care and early recognition of patients approaching end of life.

- Family liaison has been implemented and included within the revised Concerns, Complaints and Compliments policy. A field to acknowledge this has also been added to the Datix system for recording. An appointed family liaison person will be required for level 4 and above complaints, or any complaints linked to a serious incident (SI).

- End-of-Life Care (EOL) and Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) training. Following family feedback from a complaint that was investigated within this year. This was carried out on trust brief, EOL steering group and junior doctor induction training. This was also incorporated in the 2022-2023 Trust objectives.

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

Complainants dissatisfied with the Trust's complaint response have the right to ask the PHSO to consider their case. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

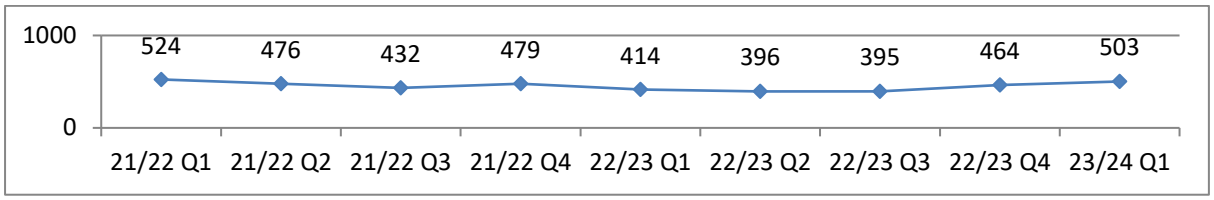
The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate, and no further action will be required from the Trust or, alternatively, make recommendations for the Trust to consider. The PHSO may decide to conduct a full investigation, which might result in the Trust being required to make an apology, pay compensation and/or produce an action plan outlining changes to be made to rectify the situation and prevent further occurrences.

There were no enquires made by the PHSO in Q1.

5. PALS

503 contacts were received in Q1, this generated 1653 forms of communication made by the PALS team. Overall, there were 1669 contacts received in 2022-23 this is a 20% reduction in comparison to the previous year.

5.1. Total contacts by quarter



5.2. Percentage of PALS contacts resolved by quarter

This is not something that the S&O site currently record. However, this will be developed in terms of MWL development and changes can be made to datix (recording system) to capture this data going forward. All forms of contact made to both the PALS and complaints team are triaged on receipt. A decision is then made on how to best resolve the query or concern in the timeliest manner.

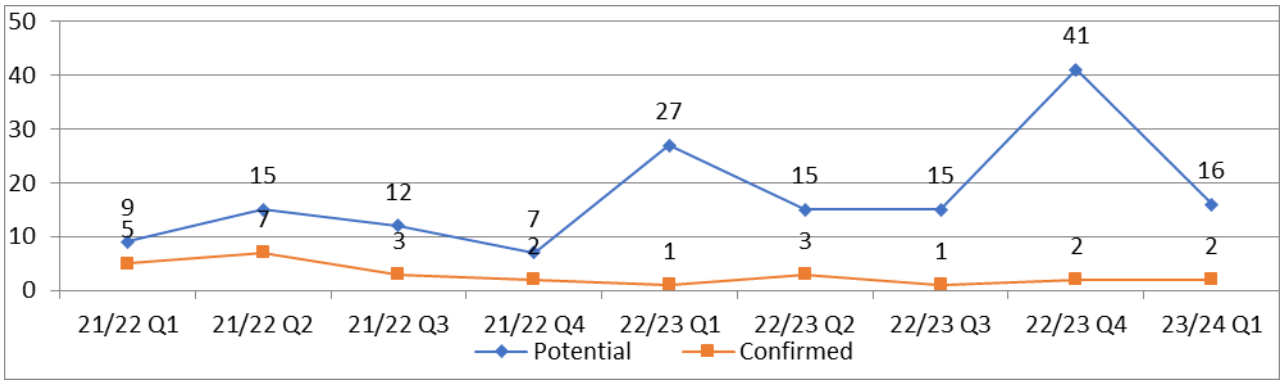
The PALS team for S&O and complaints team also ask the patient / relative on how they would like to receive their response i.e. email, verbal, face to face or written.

5.3. PALS enquiries by subject

The five main themes for PALS concerns (L2) in Q1. Listed in quantity order:

- Communication
- Clinical Care
- Values / Behaviours and Attitude
- Length of waiting time for appointments
- Discharge

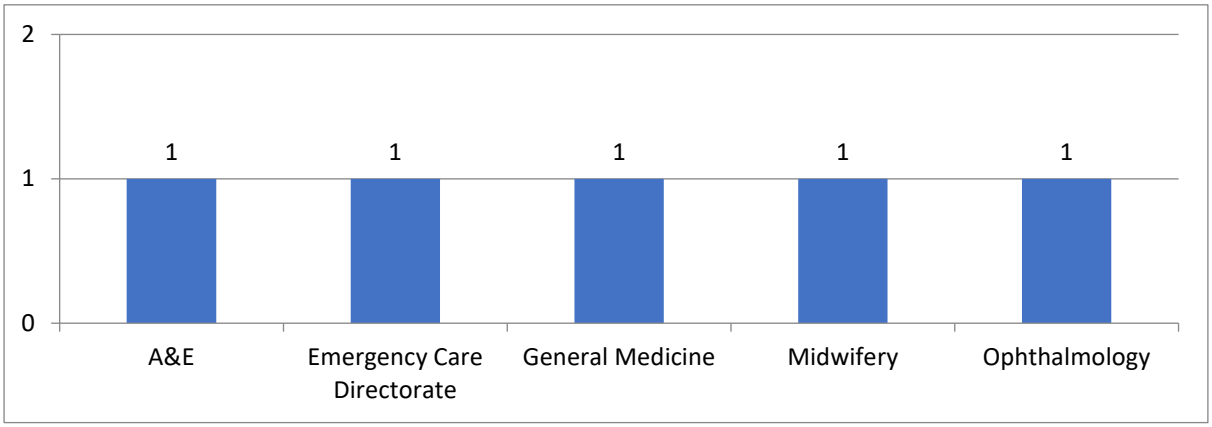
6. Clinical Negligence Claims



The graph above shows the total number of claims where the Trust has been asked for records (pre-action claims) and the total number of letters of claim or proceedings (NHSR instructed claim) received. There are some limited circumstances where NHSR are instructed before a letter of claim, for example when there is clear evidence of breach of duty and causation already.

In Q1 23/24 the Trust received 5 new NHSR instructed claims and 16 potential claims where 'letters before action' and/or requests for medical records citing alleged negligence were received.

6.1. Pre-action clinical negligence claims opened in Q1 2022-23 by speciality



This data shows that of the 5 letters of claim received, there were 5 different claim specialities alleged.

The data in regard of the 16 potential claims is not useful as there is significant inconsistency in the letters before action as to the description of the alleged negligence. A common example of alleged negligence as reported in the letters before action/medical records requests is “negligent care and treatment”.

6.2. Actions taken as a result of clinical negligence claims closed in Q1

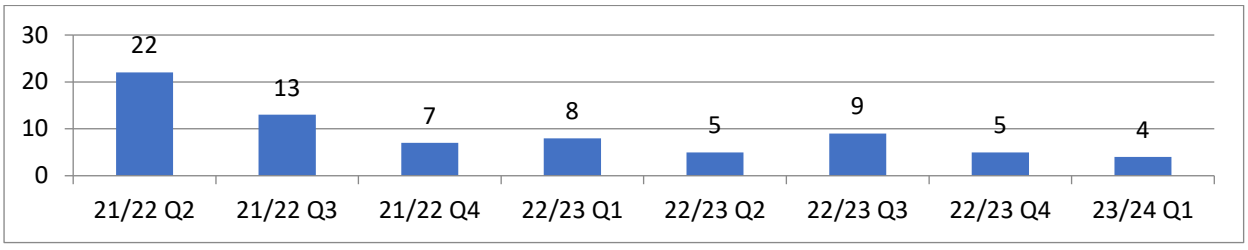
The Claims Team closed 10 files this quarter. 6 of those were settled claims, 1 was withdrawn and 3 were claims where, following repudiation in the Trust’s letter of response, no response was received from the Claimant or their Solicitor.

Below are examples of lessons learned/actions taken from closed claims.

Failure to diagnose lung cancer
Case was discussed at the Serious Incident Review Meeting (SIRG) and a number of actions were identified and completed via the Radiology Department action plan and the accuracy of Locum Consultant Radiologist reporting discrepancies were within tolerance.

Issues in diagnosis and treating a scaphoid fracture
The findings highlighted that there was a need to ensure that junior doctors were made aware of the complexities of scaphoid fractures which was highlighted and incorporated into the induction schedule for all new starters and mooted the idea of a future QIP for ST trainees regarding a ‘Scaphoid’ pathway.

7. Inquests



4 inquest notifications were received in Q4, a decrease of 1 from Q4 of 22/23 and the lowest quarter since the 22 received in Q2 2021-22. Across the last 4 quarters the Trust has received an average of 5.75 inquests per quarter.

The Coroner for Sefton, St Helens & Knowsley has made it clear that, to assist in the backlog of inquests listed, they are trying to hold as many ‘on paper’ inquests as possible. Trust colleagues experienced a number of inquests where, following minor involvement in the initial investigation, the Coroner decided not to progress their initial investigation into an inquest.

4 inquests were closed in Q4. There were no Prevention of Future Deaths (PFD) Orders this quarter and the Trust was not asked to provide any further evidence by the

Coroner on any matter. It is of note that the Trust has not received a PFD for over 2 years.

8. Friends and Family Test

All areas with the exception of antenatal and postnatal community are automated with patients receiving SMS text to phones to encourage them to rate Trust services. QR codes are used for antenatal and postnatal community with service users encouraged by their midwives to scan the code with their phones. Work is ongoing to automate postnatal community as response rates remain below the internal target of 15% despite various initiatives to try to improve it.

8.1. Response rates – internal monitoring

Area		APRIL 23	MAY 23	JUNE 23	Q1 average 2023-24	Internal target
Emergency Department		21.66%	22.54%	21%	21.7%	15%
Inpatients		38.65%	39.10%	36.93%	38.2%	15%
Outpatients		n1724	n2096	n2135	n1985	-
Maternity	Antenatal Community	n2	n2	n1	n1.66	-
	Birth/Delivery	32.41%	37.50%	29.32%	33.07%	15%
	Postnatal Ward	10.58%	22.11%	24.75%	19.14	15%
	Postnatal Community	0%	1.26%	0%	0.42	15%
Overall Inpatients and ED		30.15%	30.82%	28.96	29.95%	

8.2. Overall Satisfaction Ratings of Very Good/Good – national submission

Inpatients, outpatients, antenatal community, birth/delivery and postnatal community were all at or above target for Q1. ED recommendation rates remain below Trust target of 90% but above regional and national scores.
Overall trust score average for 22-23 was 88.64%. However, the Trust has sustained a score of over 90% since January 2023.

Area		APRIL 23	MAY 23	JUNE 23	Q1 average 2023-24	Internal target
Emergency Department		♦89.5%	♦88.89%	♦88.27%	♦88.88%	94%
Inpatients		♦94.12%	♦95.16%	♦95.14%	♦94.82%	94%
Outpatients		♦94.3%	♦93.98%	♦94.28%	♦94.18%	94%
Maternity	Antenatal Community	♦100%	♦100%	♦100%	♦100%	94%
	Birth/Delivery	♦100%	♦91.67%	♦94.87%	♦95.51%	94%
	Postnatal Ward	♦81.82%	♦95.24%	♦88.0%	♦88.35%	94%

	Postnatal Community	No score	♦100%	No Score	♦100%	94%
	Overall Inpatients and ED	91.81%	92.02%	91.75%	91.85%	

8.3. Trust overview Q1

12,427 ratings and 8,383 comments were received during Q1.

The top 5 positive and negative themes have remained the same this quarter as they were throughout 2022-23. Most comments received were positive. The highest negative theme (staff attitude) was 4.52% of the total number of comments in Q1.

Q1 top 5 themes		Positive	Negative
1	Staff attitude	63.47%	4.52%
2	Implementation of Care	36%	3%
3	Environment	83.9%	3.4%
4	Waiting time	18%	3.5%
5	Patient Mood/Feeling	16.1%	2.5%

8.4. You Said, We Did (YSWD)

The You Said We Did (YSWD) posters demonstrate to patients that their feedback is very important and is vital in helping to make improvements to the care and service offered to all patients.
Examples of feedback are provided below.

You Said	We Did
"Better food options at lunchtime, no hot meals" Acute medical Unit	Patient experience team has worked collaboratively with ward staff to ensure improved options and hot meals are always available. This has been monitored as part of continual audit on protected mealtimes.
"Better communication about what is happening with the patient who has dementia and relies on family".	Introduction of communication tool inclusive of 'what matters to me' available within bedside documentation.

Ward 7b	
"Not always enough information on induction of labour to enable informed decision making, we had to seek it out ourselves". Maternity ward	An induction of labour leaflet has been co-produced with the Maternity Voices Partnership (MVP) and is now in circulation.

8.5. Actions to improve feedback

The actions being taken to improve recommendation and response rates include; -

- QR codes implemented for maternity, community children's nurse outreach team (CCNOT) and specialist paediatric respiratory nurse.
- Collaborative work with the business intelligence team and survey provider to automate FFT in the postnatal community setting.
- Local survey implemented on discharge from maternity unit with questions based on feedback from results of 2022 national maternity survey, FFT themes and any complaint themes.
- World café event jointing hosted by maternity and the local MVP planned for beginning of Q2.
- Since further lifting of visiting restrictions a focus has been placed on supporting the presence of carers in the ward environment. This has been supported by the carer's passport, 'I am a carer' lanyard and the purchase of 4 beds via the Trust charitable funds.
- Uplifted the environment of ward corridors in line with the 15-step challenge.

ENDS

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 October 2023
Agenda Item	**MWL TB23/049 (12.1)**			
Report Title	**Learning from Deaths Report Quarter 1 (STHK sites)**			
Executive Lead	Peter Williams, Medical Director			
Presenting Officer	Peter Williams, Medical Director			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

Summary:
In Quarter 1 2023/24
April and May cases have been fully allocated to reviewers. June and July cases are due to be allocated in the next few days. To date the combined quarter has 37 cases reported, 21 are green, six are green with learning, nine and green with positive feedback and one amber case.

Financial Implications

None

Quality and/or Equality Impact

Not applicable

Recommendations

The Trust Board is asked to note the Learning from Deaths Quarter 1 report.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Number of reviews carried out Q1 2023/24

	No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
April	**33** (10)	**12**	**4**	**6**	**1**	**0**
May	**28** (14)	**9**	**2**	**3**	**0**	**0**

Datix ID	DOD	Ward	Summary	SJR Rating	Comments
175331	25/04/2023	Bevan Court 1	82 year old female, decompensated heart failure, marginal zone lymphoma, angina	AMBER	Concerns re: management of heart failure. For discussion in next MSG meeting.

	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Total
AMBER	1	3	1	0	1	0	1	1	1	0	0	0	9
RED	0	0	0	0	0	1	0	0	0	0	0	0	1
Total	1	3	1	0	1	1	1	1	1	0	0	0	10

	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total
AMBER	1	1	0	1	1	0	2	0	2	1	1	1	11
RED	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	1	1	0	1	1	0	2	0	2	1	1	1	11

	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total
AMBER	1	0	0	0	0								
RED	0	0	0	0	1								
Total	1	0	0	0	1								

Key learning points

Update 20	Adopting a "comfort first" approach There have been some excellent examples of end-of-life care in recent months, particularly in frail older patients who may benefit from a "comfort first" approach. In frail patients with a limited life expectancy, carefully consider the burdens of treatment as well as the benefits. Communication with the patient and their family is vitally important to establish patient wishes.	Management of the delirious patient Delirium can be challenging to manage, particularly in the patient with an underlying dementia diagnosis. The delirium bundle can be found on the trust intranet. Further advice can be sought by contacting Marie Honey, Nurse Consultant for Older People, psychiatry liaison team or referring to the Department of Medicine for Older People for specialist advice.
Update 19	Availability of Hospital Post-Mortems A hospital post-mortem may be requested for any patient not requiring a coroner's post- mortem. Written consent must be obtained from the next of kin and STHK consent form 5 completed from the policy for Consent to examination or treatment (appendix11); also available from the Bereavement Office. A death certificate must be issued before the post-mortem is performed. Hospital doctors involved with the patient's care can attend the post-mortem and if requested, they will then be contacted by the mortuary staff.	Chronic Liver Disease Care Bundle Following a patient review, in line with Learning from Deaths, we would like to remind you of the Chronic Liver Disease Care Bundle and is available here: Chronic Liver Disease Care Bundle Also, please remember to use Careflow for an urgent gastro opinion / review.
Update 18	Abnormal results When checking a patient's results, please be aware once reviewed, it may not appear on someone else's check list and therefore go unmanaged. It is therefore vital that anything abnormal is duly actioned or escalated according to need.	Recognition of new confusion with Sepsis New confusion (or a worsening confusion from a patient's baseline) may be a first sign of sepsis at initial presentation or as in-patient (think HAP, etc) with an early opportunity to treat and reverse. Please be suspicious, think sepsis and arrange appropriate investigations to evaluate further.
Update 17	Alerts The alert status for COVID risk and shielding is to be removed from the electronic records. This reiterates the need to check the alert status in every clinical interaction when highlighted to be aware of any additional needs / risks.	Recognition of the deteriorating patient This starts at the patient's bedside, adhering to the NEWS2 policy and escalating accordingly. Everyone plays a role from the speciality teams – in hours and out of hours, from FY1 through to consultants, further supported by Medical Emergency Team and ICU.
Further updates can be found on the intranet Learning from Action		

Learning into Action

- Following each quarterly submission to Board, two examples of learning are reported and shared throughout the organisation to ensure that all staff are given the opportunity to determine how this could impact on their practice and try and make things better. The leaning is shared at team brief and via all Trust councils. The learning also appears on the intranet. http://nww.sthk.nhs.uk/about/learning-into-action

Title of Meeting	**Trust Board**		**Date**	**25 October 2023**
Agenda Item	**MWL TB23/049 (12.2)**			
Report Title	Learning From Deaths Quarter 1 (S&O Sites)			
Executive Lead	Peter Williams, Medical Director			
Presenting Officer	Peter Williams, Medical Director			
Action Required		**To Approve**	X	**To Note**

Purpose

To Inform the Board of the triangulated themes from all the available mechanisms for learning from deaths.

Executive Summary

- This report contains the distillation of mortality review work completed in Q1, which includes:
  - There were five investigations involving the death of a patient which fully concluded in Quarter 1
  - None of these deaths were considered to represent deaths more likely than not to be due to problems in healthcare.
  - 227 Medical Examiner reviews and 15 Structured Judgement Reviews took place. The reasons for SJR were: Cardiac arrest reviews in 13 cases and death in patients with Learning Disability Reviews in 2 cases. There were no problems identified in the healthcare of any of the cases
  - The overall Care Rating of these cases was: Excellent in 6, Good in 7 and Adequate in 2
  - Analysis of mortality statistics the output from speciality Mortality and Morbidity Meetings were also used to identify themes and lessons for dissemination

- The themes identified relate to:
  - The risks of shared care within and between organisations and the IT systems used to facilitate them
  - Giving complex information to patients in a way that can be understood and recalled as best as possible including the use of written information.
  - Being aware of the risks inherent with a process for clinical records that relies on the digitisation of loose sheets of paper.
  - Understanding the benefits to patients with appropriate use of DNACPR orders.
  - Improving end of life care, primarily by developing processes and tools to put the wishes of patients at centre of this.

Financial Implications

Actions required resulting from this report may have financial implications, either to meet the recommendations or as a result of not meeting them. The full scope of this will require evaluation of the individual recommendation.

Quality and/or Equality Impact

This report does not include a service change and therefore does not require an EIA or QIA, however this may apply to actions taken in response.

Recommendations	
The Trust Board is asked to note the Learning from Deaths Quarter 1 report.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	25 October 2023
Agenda Item	**MWL TB23/050 (13.1)**				
Report Title	STHK Infection, Prevention and Control Annual Report 2022/23				
Executive Lead	Sue, Redfern, Director of Nursing, Midwifery and Governance				
Presenting Officer	Sue, Redfern, Director of Nursing, Midwifery and Governance				
Action Required	X	**To Approve**		**To Note**	

Purpose

To present the 2022/23 Infection Prevention and Control Annual Report, to provide assurance that the Trust is taking the necessary action to monitor and prevent hospital acquired infections.

Executive 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 2022/23 and Part 2 (Appendix 1) is the annual work plan for 2023/24 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

- 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.
- 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.
- 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.
- During 2022/23 the IPC performance improved in comparison to the previous year and the following were reported:
- The Trust Clostridiodes difficile infection (CDI) objective for 2022/23 was no more than 56 cases. The Trust reported 57 positive samples of which 29 were unavoidable after RCA review; this was based on there being no lapses in care.
- One case of Methicillin Resistant Staphylococcus Aureus (MRSA) hospital onset
- 44 Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases. 32 were hospital onset healthcare associated and 12 were community onset healthcare associated.
- There was a total of 91 E. coli bacteraemia cases. 50 were hospital onset healthcare associated and 41 were community onset healthcare associated.

- There were six cases of hospital acquired Carbapenemase Producing Enterobacterales **(**CPE) colonization.
- There were 135 outbreaks of infection: the vast majority of these were due to SARS-CoV19 and Norovirus.
- IPC Board Assurance Framework (IPC BAF) was reviewed and highlighted areas for further improvement including estate limitations, staff face fit testing and capacity in the IPC team .
- 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.
- Surgical site infection (SSI) surveillance in orthopaedics remains below the national rate.
- Covid NCI rate for 2022/23 was hospital onset definitive 11.9 % and 8.5% hospital onset probable. Total NCI = 20.4%

Part 2 - the IPC forward plan 2023/24, is a combined MWL plan.

Financial Implications
None as a direct consequence of this paper.

Quality and/or Equality Impact
Not applicable

Recommendations
The Board is asked to approve the STHK 2022/23 Infection, Prevention and Control Annual Report

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

St Helens and Knowsley Teaching Hospitals NHS Trust

Infection Prevention Annual Report 2022-2023

EXECUTIVE SUMMARY

1 The Infection Prevention Annual Report outlines the developments and performance related to Infection Prevention (IP) activities during 2022/23. 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 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 Trust website to demonstrate good governance and public accountability.

5 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 UK Health Security Agency as 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* species BSI
- *Pseudomonas aeruginosa* BSI
- Vancomycin Resistant Enterococcal (VRE) Bacteraemia

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

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

- Integrated Care Systems (ICSs)
- UKHSA Cheshire and Merseyside
- Community IP teams
- NHSE

Summary of key performance indicators for 2022/23

- 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 2022/23 was no more than 56 cases. The Trust reported 57 positive samples of which 29 were unavoidable after RCA review; this was based on there being no lapses in care.

- Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia is a key performance indicator with a target of zero tolerance set by NHS England. The Trust reported 1 MRSA bacteraemia.
- The case of MRSA bacteraemia was subjected to a multi-disciplinary Post Infection Review (PIR), deemed avoidable. Lessons learnt were disseminated and action plans were developed, these are monitored via the Hospital Infection Prevention Group (HIPG).
- There was a total of 44 Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases. 32 were hospital onset healthcare associated and 12 were community onset healthcare associated.
- There was a total of 91 E. coli bacteraemia cases. 50 were hospital onset healthcare associated and 41 were community onset healthcare associated.
- There were 6 cases of hospital acquired Carbapenemase Producing Enterobacterales **(**CPE) colonization.
- There were 135 outbreaks of infection: the vast majority of these were due to SARS-CoV19 and Norovirus.
- Hand hygiene continues to be strongly promoted throughout the Trust. Monthly audits of hand hygiene were undertaken on all wards throughout the year. Covert hand hygiene surveillance has also been undertaken.
- Training**:** Infection prevention induction and mandatory training sessions were provided for all clinical staff.
- Infection Prevention Link Nurse training occurs every 2 months.
- Communication**:** Infection Prevention messages were reinforced with the use of many different means of communication including global emails, intranet messages, screen savers, Team Brief, meetings, posters, additional training sessions, and personal communication. A comprehensive IP report is disseminated widely every month including all key learning from root cause analysis reviews.
- Successful collaboration with whole health economy with regards to all issues relating to infection prevention.
- Information technology**:** The ICNet NG electronic infection prevention surveillance and case management system went live in December 2014 and in April 2015, ward reporting of data related to infection prevention was implemented. Clinical staff now have real time access to health care associated infection and audit data specific to their own clinical areas as well as for the rest of the Trust.
- Engagement at ward level**.** 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 remains below the national rate:

April 2022 – March 2023	**Infection Rate STHK**	**Infection Rate National**
Hips 234	0.4%	0.8%
Knees 265	0.0%	1.0 %

Developments in 2022/23

- ANTT programme continues to ensure that the Trust staff reaches the target of 85% annual compliance for ANTT competency.

- The use of information technology to facilitate best practice and improve current practice specifically in relation to CPE risk assessment/screening, Bristol Stool Chart monitoring and Visual Infusion Phlebitis score by incorporating these into electronic systems.
- Work alongside the sepsis team on the correct detection, reporting and management of sepsis.
- Supported genitourinary medicine and Trust staff with infection prevention and control of patients with suspected/ confirmed Monkeypox.
- Continued input into refurbishment projects as required, including the new endoscopy decontamination units.
- Continued education on the standards relating to antimicrobial use and re-audit to monitor compliance with national antimicrobial stewardship guidance.
- Provided advice, support and input at a strategic and ward-based patient facing level to manage patients with infections and prevention of cross transmission.

Background

1.Infection Prevention Arrangements

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 group.

1.1. IP Governance

1.1.1. 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.

1.1.2. The Trust Director of Infection Prevention and Control (DIPC) role is incorporated into the role of the Director of Nursing, Midwifery and Governance.

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

1.1.4. 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.

1.1.5. The Executive Committee and Care Group clinical leads receive monthly updates on patients with Clostridiodes difficile infections, MRSA, MSSA and gram-negative bacteraemia.

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

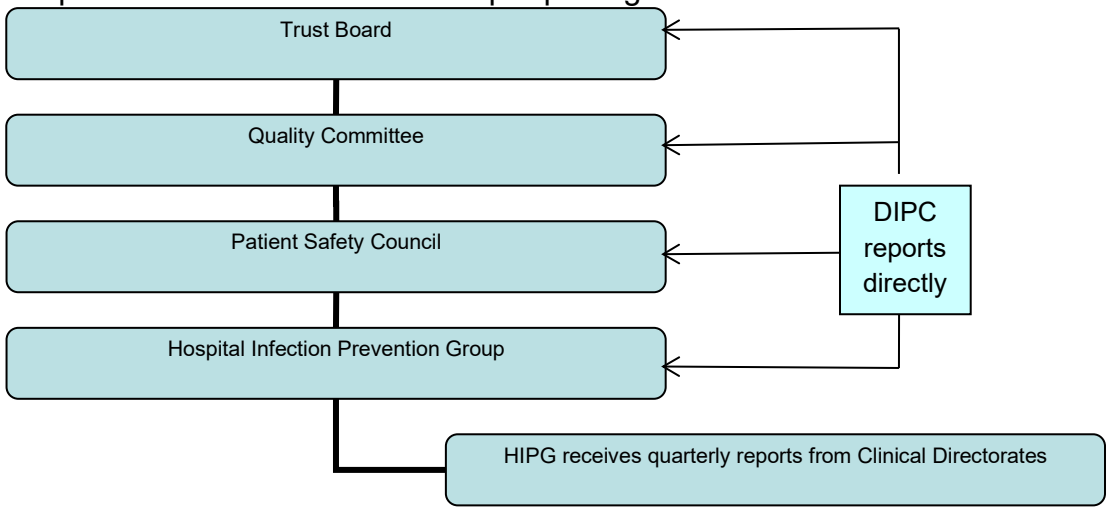
1.1.7. The Trust has 25 Consultant Infection Prevention Leads (‘Consultant Champions’) and 167 link nurses/workers.

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

1.1.9. 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 Hospital Infection Prevention Group (HIPG)

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



1.2.2 The Terms of Reference are reviewed annually and were amended in March 2023.

1.2.3 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 however attend the St Helens hospital, Newton hospital and Marshall Cross sites on a regular basis.

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

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

1.2.6 Isolation facilities

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

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

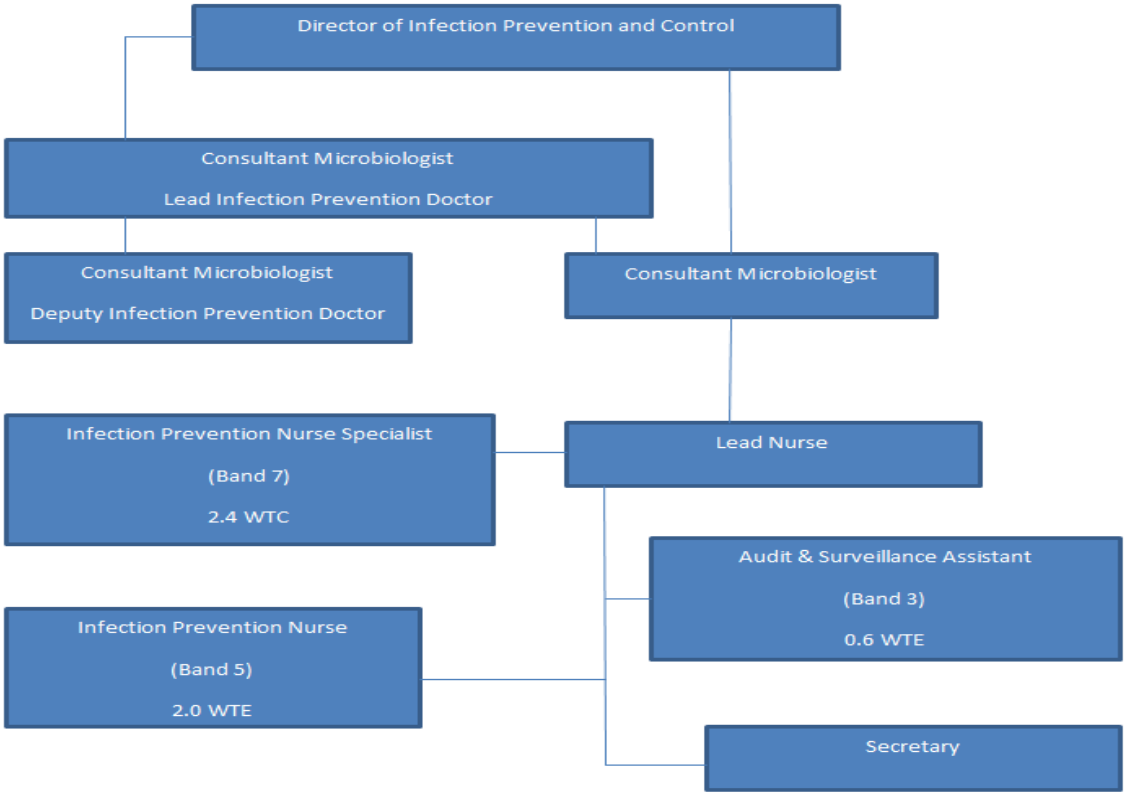
Each ward/clinical department maintains an isolation plan and the IPT send out a Trust wide side room plan daily throughout the year. This identifies who is managed in a side room and the reason for their isolation. This is used by the wards and the site team to enable the correct placement of patients.

1.2.7 The core members of the IPT consist of:

- Director of IPC (DIPC) - Director of Nursing, Midwifery and Governance
- Lead Infection Prevention Doctor
- 8B Lead Nurse IP (1.0 WTE)
- Band 7 Specialist IP Nurses (2.4 WTE)
- Band 5 IP Nurses (2.0 WTE)
- Band 4 IP Secretary (1.0 WTE)
- Band 3 Audit and Surveillance Assistant (0.6 WTE)

1.2.8 IP organisational structure

I



1.2.9 In addition, the IPT has a Link Nurse programme of over 150 personnel with study days/ meetings planned on a bi-monthly basis.

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

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

1.3. Committee representation by members of the IPT:

- Hospital Infection Prevention Group
- Patient Safety Council
- RCA Executive Review Panel Meetings
- Health Economy Healthcare Associated Infection Group (Knowsley)
- Health and Safety Group
- Sharps Safety Group
- Water Safety Group
- Drugs and Therapeutics Group
- Decontamination Group
- 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 IPT undertakes continuous surveillance of target organisms and alert conditions. Pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The IPT advises on the appropriate use of infection control precautions for each case and monitors overall trends.

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

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

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

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

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

2.8 The Trust undertook root cause analysis (RCA) case reviews of mandatorily notifiable infections.

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

HCAI Target/Alert Organisms include:

- MRSA
- Clostridiodes difficile
- Group A Streptococcus
- Salmonella species
- Campylobacter species
- Mycobacterium tuberculosis
- Glycopeptide/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 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	2	0
2021/2022	2	0
2022/2023	1	0

During 2022/2023 the Trust reported one MRSA bacteraemia 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.

This was a patient with a prolonged hospital stay admitted with delirium and psychosis.

Lessons identified – contributory to infection:

MRSA screening - all long stay patients (>1 month) should be screened every month (nose, throat, plus any wound swabs or sputum, if applicable, together with CSU if the patient is catheterised.

Delay in initiation of MRSA decolonisation – nasal ointment and bodywash needs to be prescribed and administered when a patient is found to be MRSA positive.

Environmental issues – equipment and environment in a poor state cannot be adequately cleaned and require repair/ replacement via estates. Full environmental audit was carried out and issues were remedied.

2.11RSA Screening

The Trust continues to use a robust approach to screening the majority of patients, either pre operatively or on admission. Screening compliance is monitored on a monthly basis.
The target for MRSA screening is 100% of eligible patients requiring screening. MRSA screening compliance across the Trust has been at least 98% throughout the year.

2.12 Clostridiodes difficile toxin infection (CDI)

The Trust CDI target for 2022/23 was no more than 56 cases.
In total there have been 57 cases of CDI attributed to the Trust excluding 29 cases which have been deemed unavoidable after RCA review as having no lapses in care and therefore are not included in the year-end performance figure.

Each case has been investigated by the clinical teams using a standardised post-incident review (PIR) process and fed back to all clinical areas. Any lapses in care are discussed and actions agreed and their delivery monitored through Hospital Infection Prevention Group. If there are no lapses in care as determined by the Trust Executive RCA Review process the case is removed for Trust performance purposes.

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	31	In total, there were 54 cases attributed to the Trust (32 HOHA, 22 COHA), 23 of these cases were deemed unavoidable after RCA review.
2022/23	56	57	In total, there were 57 cases attributed to the Trust (45 HOHA, 12 COHA), 29 of these cases were deemed unavoidable after RCA review

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

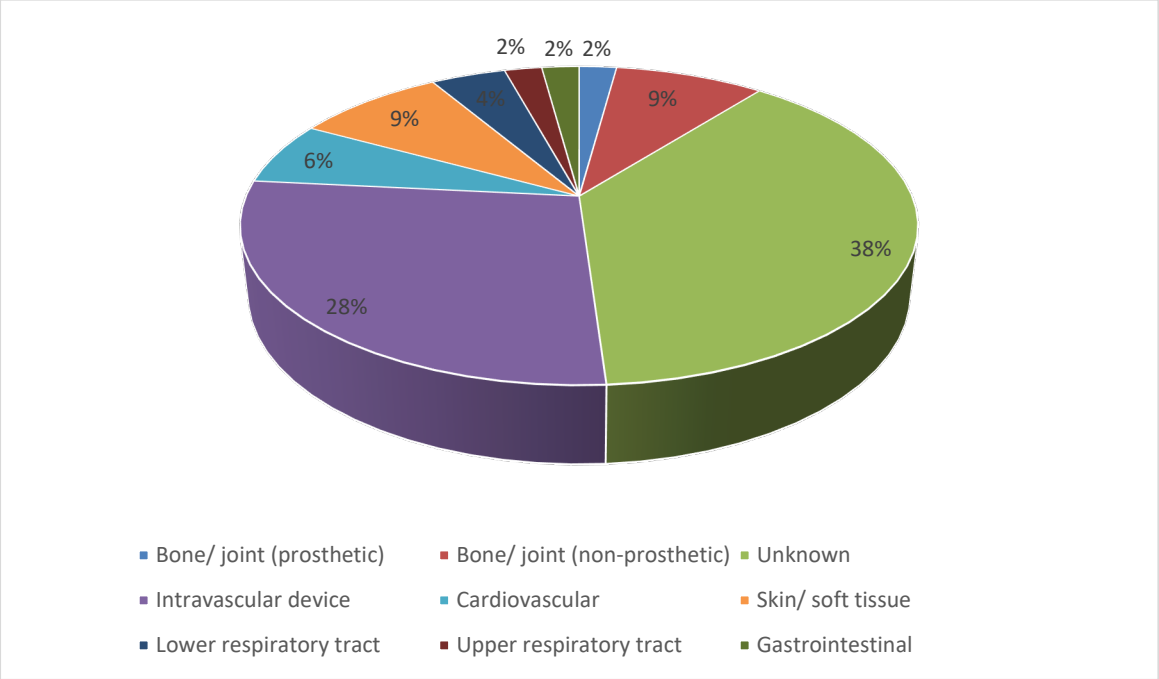
Outbreaks of CDI: There was one outbreak in 2022/23, on ward 5B in February 2023. This involved a total of 3 patients, 2 of whom were infected with the same ribotype of C. difficile suggesting direct transmission between them. The main issues identified and remedied were of environmental cleanliness and wear and tear of equipment making cleaning difficult. Despite delays due to persistent high hospital bed occupancy rates a full deep clean of the ward was performed in May 2023.

2.13 Meticillin-sensitive Staphylococcus aureus (MSSA)

There were 44 cases of Trust acquired MSSA bacteraemia in 2022/23 (32 HOHA and 12 COHA). There are no national or Trust specific reduction targets for MSSA.

The 32 hospital onset cases were subject to an Executive led Root Cause Analysis Review Panel of which 15 were deemed avoidable. The lessons identified were shared for learning.

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



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.

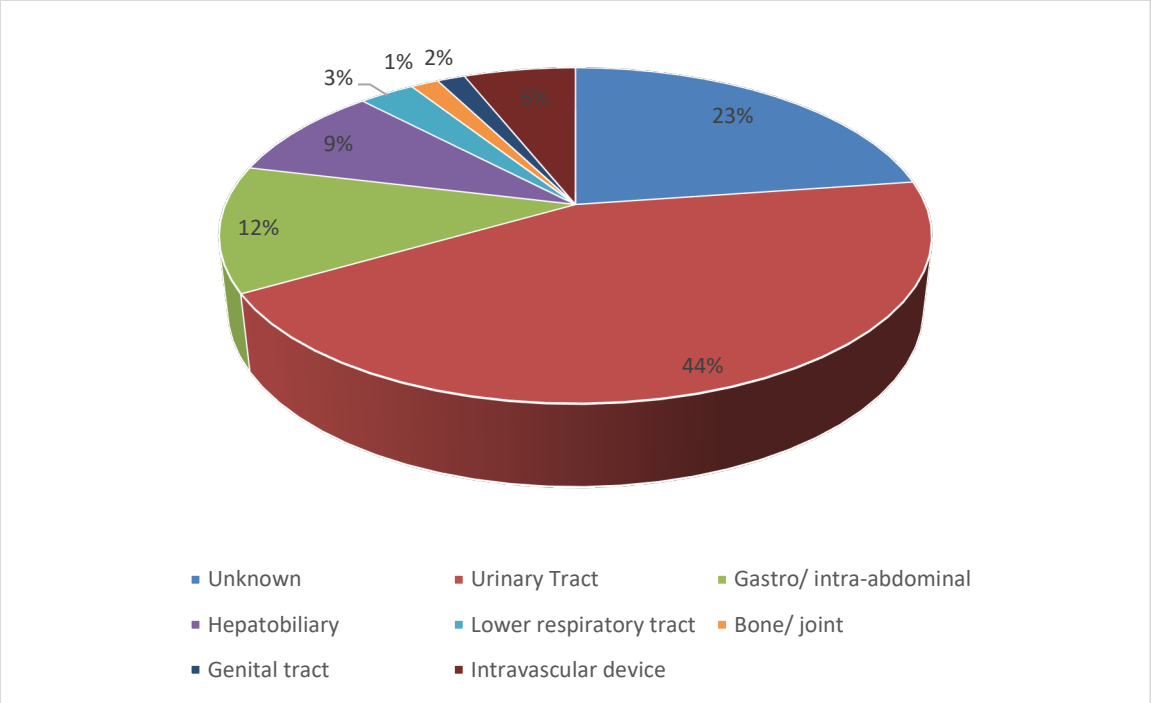
Trust specific reduction targets for E coli/Klebsiella species and Pseudomonas aeruginosa bacteraemias for 2022-2023 published by NHSE/I are as follows:

- E coli bacteraemia – **no more than 85 healthcare associated cases** (significant reduction from 116 cases in 2021-22)
- Klebsiella species bacteraemia – **no more than 20 healthcare associated cases** (from 26)
- Pseudomonas aeruginosa bacteraemia – **no more than 14 healthcare associated cases** (from 11)

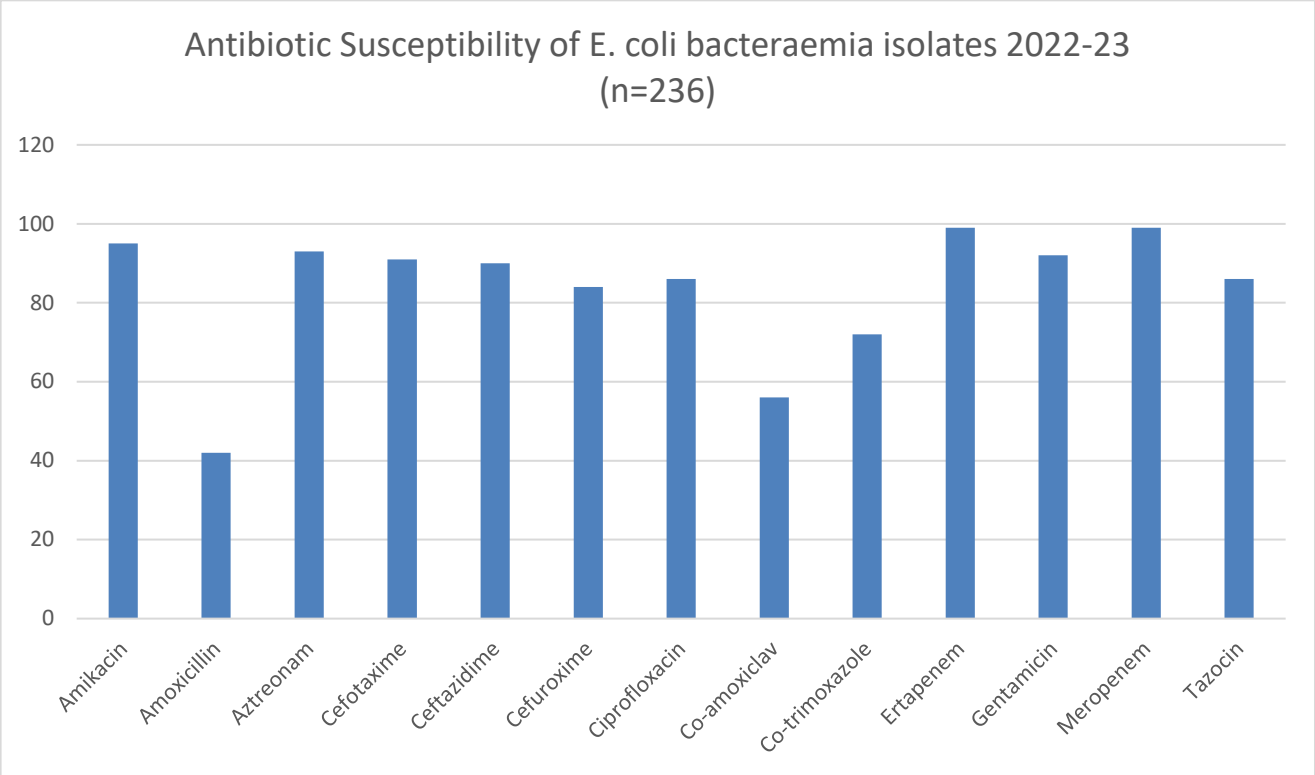
2.15 E. coli

In 2022/23 there were 91 healthcare associated cases (50 HOHA and 41 COHA). Of these 32 were considered unavoidable following RCA review.

The clinical sources of Trust acquired E coli bacteraemia in 2022/2023 are as below:



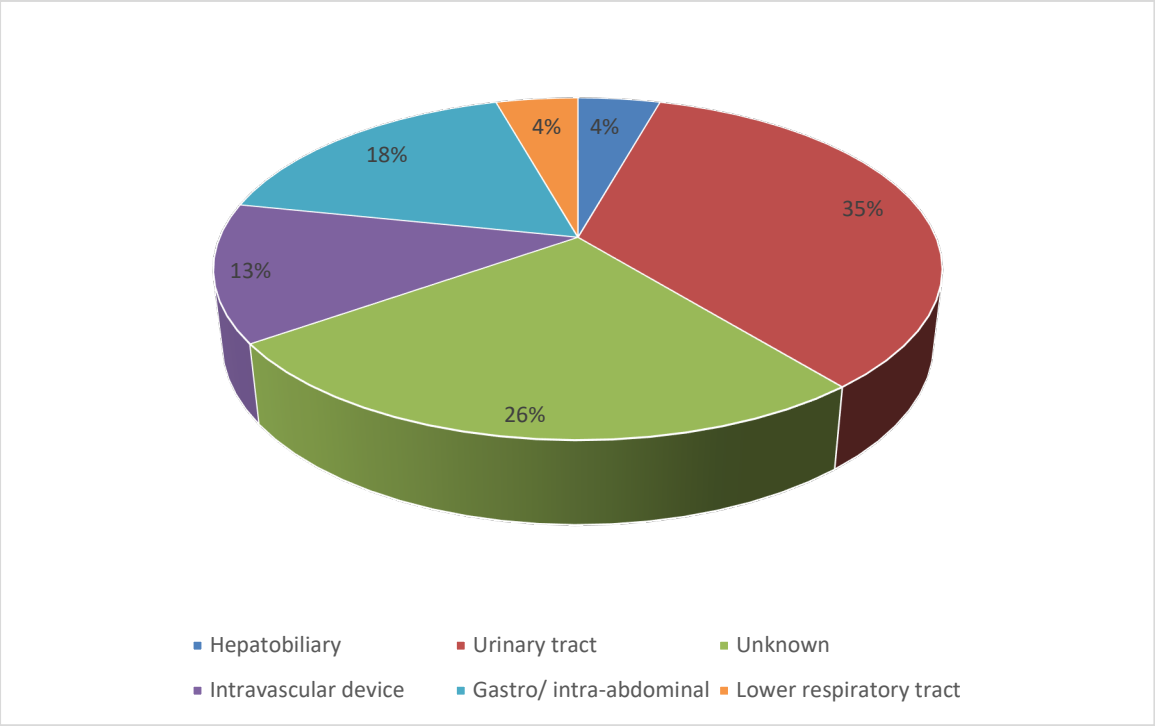
The overall antibiotic susceptibilities for all E coli bacteraemia (i.e. community and Trust acquired) identified at the Whiston Hospital Microbiology Laboratory in 2022/2023 are as below:



2.16 Klebsiella species

There were 24 health care associated cases in 2022/23 (18 HOHA and 6 COHA). Of these 8 were considered unavoidable following RCA review.

The clinical sources of Trust acquired Klebsiella bacteraemia in 2022/2023 are as below:



2.17 Pseudomonas aeruginosa

There were 4 healthcare associated cases in 2022/23. Of these 2 were considered unavoidable following RCA review.

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, intra-abdominal and intravascular device/ line infections.
VRE are low pathogenicity organisms but are resistant to many antibiotics, so infections with these organisms more difficult to treat. Therefore, patients found to be colonised with VRE are isolated to avoid transmission of infection.

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

In 2022/2023, there were 2 Trust acquired VRE bacteraemias (and 3 community acquired).

There were 3 ongoing outbreaks of VRE in 2022-23. Large numbers of VRE screens (rectal swabs) were performed on patients on the outbreak wards and were positive (1500). This was thought to represent high prevalence of VRE in the community and also transmission in the hospital. Patients colonised with VRE were isolated and enhanced cleaning was performed in these areas. However, despite high rates of colonisation, when there were no cases of significant clinical infection with VRE over time in these areas enhanced surveillance was stopped and the outbreaks closed.

2.19 Carbapenemase Producing Enterobacterales (CPE)

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

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

The Trust CPE policy is in line with the DH CPE Toolkit issued in 2013. The updated UKHSA guidance Framework of Actions to Contain Carbapenemase-Producing Enterobacterales was published in 2020 and the Trust CPE policy was updated in line within this guidance in 2021 The guidance concentrates on prevention, isolation of high-risk individuals and screening being of particular importance.

There were 3 CPE bacteraemias in 2022/23. 2 were community acquired. 1 was hospital acquired but already known to be colonized with CPE following screening shortly after admission.

There were 5 cases of hospital acquired CPE colonization detected by screening. Issues identified were late or missed completion of CPE risk assessment which should be performed on admission,

leading to late screening. In all cases, bay contacts were traced, the ward environment and practice reviewed, and relevant patients were screened weekly for 4 weeks as per national guidance.

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):

MRSA screening:

- Patients with wounds or skin breaks must have those sites swabbed as a part of the MRSA screen (regardless of whether there are clinical features of infection) to detect potential MRSA colonisation. Send swabs from wounds which clinically look infected for routine culture.
- MRSA screening - all long stay patients (>1 month) should be screened every month (nose, throat, plus any wound swabs or sputum, if applicable, together with CSU if the patient is catheterised.
- Delay in initiation of MRSA decolonisation – nasal ointment and bodywash needs to be prescribed and administered when a patient is found to be MRSA positive.

Appropriate management of invasive devices:

Intravenous lines

- Document details of 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 to detect in a timely manner any evidence of infection post-removal.
- Remove cannulae as soon as there is no longer a clinical indication to keep a cannula in situ.
- If an infected cannula site is identified by nursing staff, this must be communicated to the medical team for review of the patient so that further appropriate investigations can be done, and antibiotics commenced in a timely manner. Send swab from site for culture.
- Cannula/line sites (current and previous) should be reviewed as a part of medical review in a deteriorating patient. In such patients, infected cannula sites should be considered as a potential site/source of 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.
- Cannula inserted in other departments for investigation purposes, e.g., Radiology.

Wound care:

- Wounds should be reviewed as a part of medical review in a deteriorating patient and swabs from these should be sent for culture if there are clinical features of infection.

Screening for infection/sepsis:

- 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 blood cultures are not able to be taken, document this clearly in the patient's records.

- Document details of staff taking blood culture and where the specimen was taken from (e.g., line, if so which type, or peripheral) on the blood culture request card. For adult patients, this can be done by completing the FREPP sticker included in the blood culture pack.

- Do not perform dipstick testing/urinalysis on urine from indwelling catheters or on patients aged over 65 years to check for evidence of urinary tract infection. The only exception to this is testing urine from a newly inserted catheter at the time of insertion.

Competency in aseptic non touch technique (ANTT) and IPC mandatory training:

- All staff within the Trust who are patient facing must be ANTT competent: theory assessment via e-learning on Moodle every 3 years and in addition for those staff who undertake ANTT procedure, annual practical competency assessment to be done by the Key Trainer in their clinical area. New starters must complete the practical competency assessment within 2 weeks of starting. Note that currently it is not possible to get accurate data from ESR for ANTT competency of Lead Employer Doctors hence leads of individual clinical areas must check whether such doctors have a valid ANTT competency when they commence work.

- All staff must complete Infection Prevention mandatory training: Infection Prevention – Level 1 mandatory training is for non-clinical staff (to be completed every 3 years); Infection Prevention – Level 2 is for clinical staff (to be completed annually; note clinical staff do not need to complete the Infection Prevention Level 1 module in addition to Level 2).

C. difficile:

- 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.
- Clinical assessment of the patient is required to determine whether there is an alternative explanation for diarrhoea before sending stool sample for C difficile testing.
- 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 the first specimen is negative, but there is a strong clinical suspicion of CDI, send a repeat sample 24 hours later.
- 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 prescribed laxatives and antibiotics if the patient is having diarrhoea and/or with confirmed CDI.

Patient isolation:

- Isolate any patient with diarrhea (type 5 to 7 on the BSC) in a single room promptly without waiting for laboratory testing results and if patient has no other reason for diarrhoea, send stool specimen for C difficile testing without delay.
- Escalation rooms (i.e., non-en suite side rooms) should not be used for patients with confirmed or suspected cross infection hazards including CDI.
- Patients with CDI must not be managed on an open ward unless as part of cohort nursing which will only be carried out under the advice of the IPT. If a patient with C. difficile infection is left on the main ward for more than 4 hours, a Datix form must be completed.

Appropriate antimicrobial use and prescribing issues:

- Adhere to Trust Antibiotic Policy and review previous positive microbiology results when

prescribing any antibiotic. Document the indication for the antibiotic in the patient's medical records.
- Stop antibiotics when no longer clinically indicated.
- Ensure that a review date (within 24 – 72h of starting) or a stop date is documented for every prescription of an antimicrobial (this can be done via an order note on EPMA).
- 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.
- In patients prescribed proton pump inhibitors (PPIs) review the need to continue this; there is a correlation between level of acid suppression and CDI infection rates.

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

3.1 There were 96 new confirmed hospital outbreaks/ Increased incidence in 2022/23 – the vast majority were nosocomial COVID-19 outbreaks:

Outbreak type	Number of outbreaks
COVID-19	83
Influenza A	7
Norovirus	3
MRSA	2
C difficile	1

A total of only 20 bed days were lost to outbreaks (12 due to the norovirus outbreak on 1A).

4. Training

4.1 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 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 2022/23. Extensive advice on SARS-CoV19 and monkey pox 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

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.

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.

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

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 Northwest Infection Control Group (NORWIC).

7. Hand hygiene

The Trust continues to strongly promote optimal hand hygiene practices. Wards, Matrons and Link personnel were encouraged to audit each other.

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.

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 96%.

8. Information Technology

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. The Trust procured the ICNet Outbreak Manager Module in 2022.

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. Information regarding Monkeypox was hosted on the front page of the Trust intranet page and moved to the IPT intranet site once the outbreak had resolved.

Electronic Bristol Stool Chart (BSC) and CPE assessments previously on Patientrack were transferred to the System C e-Vitals system in April 2021. Trials to manage Visual Infusion Phlebitis scoring of cannulas electronically are ongoing.

As a routine part of clinical case management, the IPT continue to add infection prevention related alerts to inpatient records on EPMA (the Trust's electronic prescribing system) to support selection of appropriate antibiotic therapy.

9. Audits and Surveillance

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.

Audits undertaken by the Infection Prevention Team:

- Sharps audit – undertaken by Sharp smart, results produced monthly.
- Peripheral cannula (PIVC) trusts wide audit.
- Compliance with IP precautions audits
- 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:

- Commodes 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 teamwork with the external supplier to ensure compliance with standards.
- MRSA screening compliance
- Dirty utilities
- Water coolers
- Hand Hygiene Audits and Compliance - Compliance rate varies from 80-100%.
- Environmental audits are undertaken throughout the year and reported on the monthly Trust wide report.

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).

2022/23 data indicated that:

- There were 234 hip operations performed of which 1 infection was reported, deemed unavoidable at RCA (0.4% compared to 0.8% national average).
- There were 265 knee replacements completed, with no infections reported (0% compared to 1.0% national average).

Actions completed:

- RCA documentation has been revised to include the number of points taken from NICE guidance and One-Togetherness Toolkit

- To ensure a proper senior attendance, regular root cause analysis meetings are conducted quarterly and attended by the Consultant Orthopaedic Surgeons, Microbiologist, Ward Team and Infection Prevention Team

- An audit of pre-operative MRSA and MSSA screening and decolonisation has been performed and processes improved.

10. Antimicrobial Management Team (AMT)

Key Achievements:

- Provided antimicrobial stewardship ward rounds across multiple specialties at Whiston Hospital
- Published version 4 of the Adult Antimicrobial Policy. Maintained up to date Antimicrobial Policies for 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 total consumption of ‘’watch’’ and ‘’reserve’’ antibiotics categories nationally at 39%. National average was 50% for 2022-23.
- Maintained one of the highest levels of consumption of narrow spectrum “access” agents (e.g. amoxicillin, flucloxacillin, etc.) nationally at 61%. National average was 49% for 2022-23.
- Continued to facilitate outpatient parenteral antibiotic therapy (OPAT) with the service formally trialled in March to June 2023. Pharmacist and pharmacy technician, microbiologist seconded, and OPAT nurses recruited to launch the service in late 2023.
- 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 and has been take forward through a regional project in 2023. 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 2023 as per National initiatives and guidance.
- Developed patient information leaflets for high-risk antibiotics such as fluoroquinolones, linezolid, co-trimoxazole and gentamicin.
- Published and maintained up to date patient group directions relating to the use of antimicrobials.
- Junior and senior doctor teaching continued. Delivered teaching on AMS as part of junior doctor induction.
- 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. In 2023 the findings were presented to the regional network group and innovative dosing calculator and therapeutic drug monitoring interpreter calculator presented. Currently awaiting discussions with national AMS groups to determine how to take this forward.

- Completed and achieved the CCG2 UTI CQUIN which applies to all patients ≥16 years old with the following exceptions: Patients prescribed antibiotic prophylaxis for the treatment of recurrent UTI, pregnant women and those with chronic tubulo-interstitial nephritis. StHK achieved 65% average vs the national average of 58%. Based on the audit results several improvement projects were implemented including updating the UTI e-learning package, disseminating CQUIN results to clinicians and providing teaching sessions on the subject

Parameter	Quarter 1 compliance	Quarter 2 compliance	Quarter 3 compliance	Quarter 4 compliance
Diagnosis based on documented clinical signs and symptoms	85%	79%	86%	81%
Appropriate use of urine dipsticks	88%	90%	91%	89%
Antibiotic compliant with Trust guidance and/or microbiology results	92%	94%	94%	97%
Urine sample taken at the time of diagnosis	75%	91%	97%	97%
Documented review of urinary catheter	70%	86%	80%	73%
Percentage of cases achieving CQUIN compliance	65%	63%	64%	65%

Key challenges/issues:

- OPAT continues to be challenging with the OPAT service relaunching in late 2023.
- Increasing use of broad-spectrum antimicrobials for multi drug resistant infections coupled with increasing winter pressures and the Coronavirus crisis coupled with the demand for more community-based services.
- To continue to reduce errors in 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 if capacity allows.
- OPAT service SOPs development (multiple different community IV services offering different capacities and services). Patient management and tracking (virtual wards currently in development).
- Tackling CQUIN03: Prompt switching of intravenous (IV) to oral antibiotics. The target set for the trust as per NHS England is to achieve 60% (or more) patients no longer receiving IV antibiotics past the point at which they meet switching criteria to switch to oral therapy.
- To participate in the NHS standard contract for 2023-24 which requires acute providers to make year-on-year reductions in their per-patient usage of antibiotics from the “Watch and Reserve” categories, in line with the ambition for a 10% cumulative reduction set out in the UK 5year action plan for antimicrobial resistance 2019 to 2024. To date, the Contract requirement for annual reductions has been expressed against the 2018 baseline of actual usage. For consistency with

the UK 5-year AMR National Action Plan target, amendment to the Contract wording so that the requirement is for a 10% cumulative reduction by 31 March 2024 against the 2017 baseline (instead of a 6.5% reduction against a 2018 baseline). The threat to public health posed by antimicrobial resistance is significant, and there is strong evidence that providers can substantially reduce use of antibiotics from the "Watch and Reserve" categories by switching the treatment choice to antibiotics from the "Access" category wherever possible and safely using shorter courses where "Watch" and "Reserve" drugs are unavoidable.

Actions taken.

- AMT continued to do targeted weekly antimicrobial stewardship ward rounds to tackle inappropriate antibiotic prescribing at ward level.
- Antimicrobial point prevalence audits to continue at least annually to look at areas of good practice and areas that require improvement regarding AMS. This has been expanded to incorporate antimicrobial prescribing within A&E to improve antimicrobial prescribing at the very start of the patient's journey.
- Development of EPMA data extraction reports to facilitate AMS initiatives.
- To advertise and recruit a band 7 antimicrobial pharmacist.
- Audit investigating the prescribing and monitoring of gentamicin in infective endocarditis to support the potential switch to 3mg/kg once daily dosing in line with updated ESC guidelines.

Health Work and Well Being

Key Achievements

- **Flu:**

✓ CQUIN was achieved.
✓ Key staff targeted by roving flu clinics, available on all shift patterns including weekends, evening, and early mornings.

Key challenges/issues:

✓ Nationally it was recognised that it was extremely difficult campaign due to vaccine Fatigue.
✓ Co administrative model, staff did not want co administrated vaccines.
✓ Sickness absence of clinical staff made it hard to reach target groups.

Actions taken.

✓ Flu 22/23- engaged with Front line HCW, managers and ADO on best way to support the vaccine delivery model to ensure that front line HCW in have every opportunity to receive the vaccine.
✓ Weekly data and targeted action plan were communicated to exec board for assurance. This will continue in 2023/24 campaign.

Needlestick:

Key Achievements:

✓ Needlestick (NSI) awareness campaign/ re-forming of NSI group.
✓ Sept 2022 saw the commencement of the NSI group which included representation from HWWB, Health and Safety, ICP, L&D, procurement, and key link educator on clinical areas.
✓ The NSI policy was updated December 2022, and this saw a NSI awareness campaign across the trust covering key clinical sites (to date currently in process of Policy harmonisation with S&O)

- ✓ The outcome of this awareness and feedback has been positive. HWWB have taken the NSI awareness campaign into key clinical areas which had previously high NSI reporting stats.
- ✓ Supported the organisation with IGAS and MRSA outbreaks, supporting when staff swabbing, and assessment is required.

Key challenges/issues:

- ✓ NSI awareness for certain target groups.
    - Doctors have been difficult to target.
    - Students have been difficult to target.
- ✓ HWWB present on the induction for doctors and preceptorship programme for newly qualified nurses and international nurses re NSI awareness
- ✓ NSI data:
    - Working with Datix on the NSI reporting form and RCA for to ensure data quality is correct and in line with HWWB reportable data.

11. Endoscope Decontamination Unit

The Decontamination Units on both St Helens and Whiston site achieving an amber/green rating in the annual IHEEM/JAG Audit despite ever ageing decontamination equipment**.** The decontamination group reports directly to HIPG bi-monthly this includes reports on water safety, quality of checks and any adverse incidents.

In January 2023 - The new centralised Decontamination Unit at St Helens opened, and the Electronic Endoscope Track and Trace system implemented at St Helens site, this enables a paper free audit trail across both sites.

Providing extra evening and weekend decontamination support for our service users to reduce patient backlogs.

St Helens site becoming a Community Diagnostics Centre (CDC) will see a 60% increase in endoscope throughput during the first 2 years. Historically there has been an annual average increase in endoscope throughput of 6%.

Actions taken.

Ensuring a schedule of planned preventative maintenance is in place for all decontamination equipment.

Fully comprehensive service contracts in place to provide Periodic Service, Validation and Testing of all decontamination equipment.

Installation of 5 endoscope washer disinfectors and water treatment plant to support extra capacity required to provide decontamination support to the CDC.

Gaining accreditation for the implemented ISO 13485 quality management system**.**

Enrol more Decontamination staff onto the Healthcare Science apprenticeships.

12. Estates, Facilities and Non-Clinical Risk

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 patient environment for our patient's staff and visitors is maintained.

This effective partnership continues as we work together to constantly maintain the highest standards possible and meet the requirements of the ever-changing legislation, guidance, compliance, and safety standards of the NHS.

The introduction of the National Standards of Cleanliness, existing Health Technical Memorandums and IPC standards are embedded in the teams' work plans for the coming twelve months. Along with close working with the IPC team as the organisation continues on its biggest capital works programme for some time.

Each section of this report will hopefully demonstrate our continued commitment to the IPC agenda.

Key Achievements:
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

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.
- Identification of areas requiring further investment

Hospital Ventilation Systems

Ventilation systems have been under an increased amount of scrutiny to cope with the evolving guidance and the review of the HTM. However, Vinci facilities continue to complete all ventilation planned maintenance in the agreed service level agreement to ensure standards and compliance were maintained.

As a result of the updated HTM 0301 in August 2021 the Trust has continued with the Ventilation Safety Group to ensure discussion by the multi-disciplinary team to ensure compliance with new schemes with this guidance and identify gaps in compliance. A Ventilation Policy has been produced and agreed and is available on the Trust Intranet

Water Safety Systems

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.

- Vinci and the Estates and Facilities Team have worked collaboratively to ensure a Water Safety Report is submitted to the Water Safety Group. This report identifies all actions taken and results for any works which have been undertaken in regard to water safety. This provides assurance to the organisation that we are compliant with relevant legislation and are providing a safe environment for staff, patients and visitors.

- Water Cooler Audits continued throughout 2022/23 with the predominant issues being limescale and incomplete paperwork. The ward housekeeper and domestic teams are informed of all noncompliance issues.

- The Aspergillus Policy was agreed and is available on the Trusts Intranet

- The flushing of underused outlets by the wards is monitored by the E&F Team on a monthly basis and they record any non-compliance and report this to the ward manager for immediate action.

- As per HTM 04-01 a scalding risk assessment was undertaken across both Whiston and St. Helens Hospital. The risk assessment reviewed the need for the TMV considering the relative risks of scalding. The work to commenced 2022 and completed in 2023.

Waste Management

The waste service has continued to function as normal with some additional waste measures in place when COVID outbreaks occur.

Training materials continue to be used to identify correct disposal of clinical waste (clinical bins/Sharpsmart containers) to ensure staff are following the correct guidelines.

Onsite disposal of our internal offensive (yellow/black stripped) tiger clinical bags continues to be more efficient and ensures that the hospital has enough clinical bins.

A review took place of the Sharpsmart system with the company. This has resulted in a cost avoidance of circa £1,500/month through using the recycling bins instead of purchasing plastic sharps bins. Which in turn has contributed to the reduction of annual carbon emissions by circa 25 tonnes.

FIT Testing Service

The E&F Team continue to support the FIT testing for all clinical teams. The Fit testing service now incorporates students, community practitioners and international nurses. Fit tester managing bookings and fit testing.

Estates and Facilities Audits

The Estates and Facilities audits follow the specification laid out in The National Standards of Cleanliness (NSOC) and the PFI (Private Finance Initiative) Facilities Management contract. The team will audit every room and highlight every patient environment and cleaning issue found. They will work closely with ward staff, Vinci and Medirest to ensure access to rooms was made available to carry out maintenance works, painting and cleaning under very challenging conditions. A score is awarded using the national scoring methodology and a star rating is applied.

A report and action plan are submitted to ward managers, Infection Control, and the cleanliness and maintenance team. Any issues identified are reported to Medirest, Vinci and the Ward Manager as appropriate. The team then follow up on the audit within 1 month and work closely with all involved to ensure the issues found are rectified.

These inspections are carried out in line with the national guidance. e.g. Wards are monitored monthly, Office areas twice yearly.

The Estates and Facilities Audits continued within areas e.g. from March 2023

Ward/Department	Star Rating	Overall % Score
Ward 5C	5	**96.67%**
Ward 5D	5	**98.5%**
Ambulance assessment	5	**96.67%**
Bevan Court 1	5	**97.50%**

Bevan Court 2	5	**96.50%**
Buchanan Suite	5	**99%**
Cardio Diagnostics	4	**97%**
Delivery Suite	4	**97%**
Childrens & Young People OPD	5	**99%**

Ventilation

Due to the demand / requirements of increased air flow or different pressure regimes to help decrease outbreaks the trust and Vinci have found meeting these requirements a key challenge / issue.

It had been highlighted that that attenuation that lines the Ultra Clean Theatre canopy ducts at both Whiston and St. Helens Hospital has started to deteriorate. A proposed solution was agreed by all Stakeholders. However, all involved worked collaboratively and completed the work in 2022.

This working involved our surgical teams working at Ormskirk District General Hospital and the Estates and Facilities team ensure compliance with STHK standards.

Estates and Facilities Capital scheme

The works at Whiston Hospital to provide two new Theatres within the existing footprint of the building to deal with the patient back log and continue proving a high level of patient care has started (commenced August 2023).

CHOBS Scheme is now complete, and the Estates and Facilities team are working to commission the area for occupation.

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 are the identification of patients within the Trust colonised with multidrug resistant bacteria and SARS CoV2 pandemic.

Ends

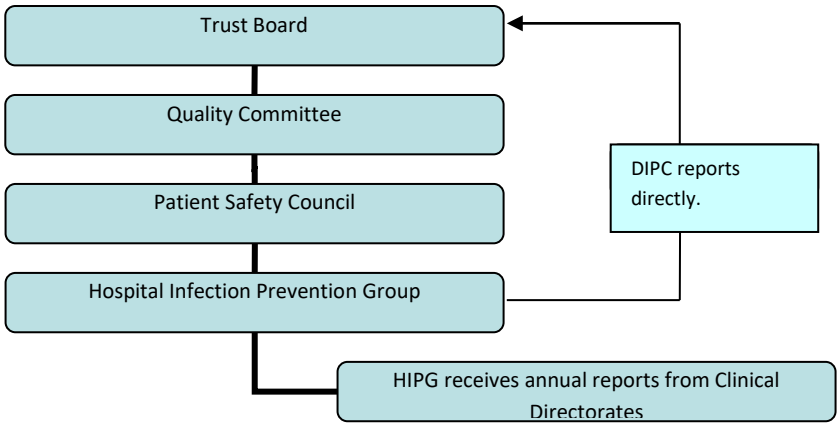
Glossary of abbreviations

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

14.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 regarding 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) • Head of Nursing and Quality for Urgent Emergency Care (matron to deputise if not in attendance) • 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 request 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	At each meeting	Lead IPN

	b. C difficile infection c. MSSA bacteraemia d. Gram negative (E coli/Klebsiella/Pseudomonas aeruginosa) bacteraemia e. SSI orthopaedics		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	At each meeting	Infection Prevention Nurses

	a. Ward audits since last meeting b. Other audits		
	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.		

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

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 the susceptibility of service users and any risks that their environment and other users may pose to them.
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
6	Systems are in place 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	The provision or ability to secure adequate isolation facilities.
8	The ability to secure adequate access to laboratory support as appropriate.
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
	1. Infection Prevention Team Staffing						
	DIPC - Director of Nursing, Midwifery & Governance	Sue Redfern					
	Infection Control Doctor	Dr Kalani Mortimer					
	Lead Nurse IP	Vacant - appointed Claire Chalinor					
	Clinical Nurse Specialist Band 7	2.4 WTE					
	IP Staff Nurse Band 5	2.0 WTE					
	Audit and Surveillance Assistant	1.0 WTE					
	IP Secretary	1.0 WTE					
	Antimicrobial Stewardship Pharmacist	Andy Lewis, Elisha King, Jade Pickup					
	Hospital IPC Group (HIPG)						
	The IPC Team will report to the Board via HIPG						
	HIPG meet six times per year						

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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		To maintain and alert Trust staff to risks associated with pathogenic organisms To provide IPC guidance to minimise the risks to patients, colleagues and visitors.				
	Mandatory Reporting			**Q1**	**Q2**	**Q3**	**Q4**
	MRSA, MSSA, E. coli, Klebsiella, Pseudomonas aeruginosa bloodstream infection	IPC Team, Microbiology, Executive Review Panel	To identify, communicate and instigate investigations with clinical teams for Trust-associated cases. To ensure that lessons learnt are disseminated throughout the organisation and reported to HIPG				
	Clostridium difficile infection (CDI)	IPC Team, Microbiology	To identify, communicate and instigate investigations with clinical teams for Trust-associated cases. To ensure that lessons learnt are disseminated throughout the organisation and reported to HIPG. To undertake a weekly ward round to review patients with CDI.				
	Carbapenem resistant Enterobacterales (CPE)	IPC Team	To monitor screening compliance of at risk patients To manage patients with CPE colonisation as per policy				
	Surgical Site Surveillance (SSI) Total hip and knee replacements	Orthopaedic Surgery	To support the orthopaedic team to review any learning from				
	Respiratory Viruses e.g. influenza, Covid-19, RSV	IPC Team	To provide IPC guidance to minimise the risks to patients, colleagues and visitors.				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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	IPC Team	Report Trustwide Include in IPC Mandatory Training for all Trust staff				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**4. Policies and Patient Information Leaflets**						
	To agree plan for alignment of policies across MWL	DIPC	CDI, MRSA to be aligned in Q2 (Trust integration at the end of Q1)				
	To provide advice and support on policies where IP is an integral component	IPT	Participation in updating relevant IP related policies				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 4, 5 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**5. ANTT/Intravascular Access and Therapy**						
	Monitor Trust wide compliance and increase compliance rates	IPT	Provide updated compliance figures to the relevant care groups and for HIPG				
	Provide Key Trainer training	IPNs, Nurse Consultant ICU	Key trainer training sessions are provided monthly.				
	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 HIPG. Lead IP nurse to co-chair IV Access and therapy Group with Nurse Consultant ICU				
	Undertake annual Trust PIVC audit	IPT	Provide report to HIPG and PSC. Produce an action plan that will be monitored at the IV therapy group.				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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**						
	IPC training to junior doctors, volunteers, student nurses, preceptors.	IPC Team	Ongoing				
	Mandatory training	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				
	ICNs to undertake an AQUA Introduction to Quality Improvement course						
	ANTT Key Trainers	IPT. Nurse Consultant ICU	Monthly				
	Link Personnel	IPT	6 times a year				
	Antibiotic Prescribing	Antimicrobial Management Pharmacists, Medical Microbiologists	Junior doctor training (medical and surgical twice yearly), medical student teaching, medical staff induction.				
	Keep IP staff updated with evidence based practice	IPT	Attend North West/ national Infection Prevention Society/ infection control conferences. Undertake webinars by accredited IP organisation e.g. Hospital Infection Society				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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 committes of adherence to high quality IP practices	IPT	Reported to quality leads, matrons, ward managers, supports services, HIPG and PSC				
	Annual Programme revised annually	IPT	Areas with a suboptimal score are revisited until issues compliant				
	Further audits are undertaken by the IPT as the service requires	IPT	Commodes and dirty utility, flushing audit (augmented areas), Sharpsmart audit, ward kitchen audit, hand sanitiser placement, blood culture audit, deep clean audit				
	Vascular access devices	IPT	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 in IP monthly report				
	Bristol Stool Chart	IPT	BSC completed electronically. Reported in IP monthly report				
	Mattresses	TK	Audited bi-monthly on the warded areas.				
	Blood culture contamination rates	KM	ED rates reported weekly to clinical leads. Trust rates reported monthly in IP report				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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 IVOS (IV to oral switch)	AMT	Report quarterly to HIPG				
	Undertake weekly AMT wardrounds on medical and surgical wards	AMT	Immediate feedback provided on wards, reported in IP monthly report				
	Point prevalence audit of policy adherence, missed doses, antibiotic review and course lengths	Antimicrobial Management Pharmacists	Reported to Trust clincial leads and in IP monthly report				
	Antimicrobial expenditure information	Antimicrobial Management Pharmacists	Reported to HIPG and DTG				
	Develop Trust OPAT service	AMT	Reported to HIPG and DTG				
	Maintenance of Trust 'Microguide' antibiotic guidelines.	AMT	Rolling process with regular reviews of underlying adult/ paediatric and neonatal policies				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 7 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**9. Communications**						
	IPC Monthly Report	IPT, AMT	Unified IP monthly report, combining monthly reports for the medical and nursing staff				
	Communication with other Trusts and agencies such as UKHSA	IPT	To share information, best practice and lessons from incidents				
	IPC intranet website	IPT	To maintain and update Trust intranet site with relevant and up to date information with Trust staff				
	Microguide	AMT	To maintain and update Microguide app in line with changes to Trust antibiotic policy				
	Administration	JD	To provide administrative support including coordination of meetings, dairy management, data collection, minutes, ICNet administration				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:							
1, 3, 4, 5, 8 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	ICNet surveillance and case management system	IPC Team	Continue to use system to manage patients and to run reports. To introduce futher function to the system as they become available e.g. recent addition of outbreak module.				
	Tendable audit platfrom	IPC Team	To optimise the use of this digital platform for IPC audits, uploading a revised general IPC Team audit by end Q3, in collaboration with Quality Matrons.				
	Electronic prescribing	AMT	To optimise the functionality of the EPMA system				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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	Back to Basics Campaign to provide awareness and refresher training to clinical colleagues	Consultant Nurse/ Matron IPC.	October/November 2023				
	Develop IPC Resource Pack for clinical areas	IPC Team	Developed and distributed by Q4				
	Reinvigorate IPC Link network with reps in all clinical depts	Matron IPC	Identify link staff by end of Q3 and invite to Back to Basics event in Autumn.				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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**						
	Care Group/Divisional meetings	ICNs	To provide expert advice and support as required				
	Decontamination	IPT	To attend quarterly scheduled decontamination meetings. To provide expert advice and support as required.				
	Water Safety	KM	Attend Water Safety Meeting				
	Ventilation Safety	KM	Attend Ventilation Safety Meeting				
	Waste Management	IPT	To provide expert advice and support as required				
	Medical Devices Group	IPT	To provide expert advice and support as required				
	Estates & Facilities	IPT	To provide expert advice and support as required, for capital schemes, linen, catering and other elements.				
	Health & Safety	IPNs	To provide expert advice and support as required				
	Emergency Planning	IPT	To provide expert advice and support as required				
	Health, Work and Wellbeing	IPT	To provide expert advice and support as required				
	ICB meetings	IPT	To attend and provde assurance to commissioners related to IPC				
	NW IPC Regional Meeting	IPT	To engage with and share best practice with peers				
	Ad hoc meetings	IPT	To provide expert advice and support as required				

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 October 2023
Agenda Item	**MWL TB23/050 (13.2)**			
Report Title	S&O Infection, Prevention and Control Annual Report 2022/23			
Executive Lead	Sue, Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Sue, Redfern, Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

To present the 2022/23 Infection Prevention and Control Annual Report, to provide assurance that the Trust is taking the necessary action to monitor and prevent hospital acquired infections.

Executive 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 2022/23 and Part 2 (Appendix 1) is the annual work plan for 2023/24 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. 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.
3. The Trust has remained registered with the Care Quality Committee (CQC) and is rated as Requires Improvement .
4. 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.
5. During 2022/23 the IPC performance improved in comparison to the previous year and the following were reported:
   - 48 cases of Clostridium difficile infection (CDI) against an objective of <49
   - Zero cases of Methicillin Resistant Staphylococcus Aureus (MRSA)
   - 33 Methicillin Staph aureus -bacteraemia cases. 28 were hospital onset healthcare associated and 5 were community onset healthcare associated.
   - 49 E. coli bacteraemia cases. 31were hospital onset healthcare associated and 18 were community onset healthcare associated.
   - No cases of hospital acquired Carbapenemase Producing Enterobacterales **(**CPE).
6. During 2022/23 there were nine outbreaks of infection: six were nosocomial (hospital-associated) Covid-19 outbreaks and three were caused by Norovirus.

7. IPC Board Assurance Framework (IPC BAF) was reviewed and highlighted areas for further improvement including estate limitations, staff face fit testing and capacity in the IPC team .
8. 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.
9. Compared to the financial year 2021/22, overall cases of Covid-19 increased by 30% in 2022/23. A higher proportion of cases were diagnosed as hospital associated, The Trust's overall Nosocomial infection (NCI) rate was 31% (hospital onset definitive 17% and probable hospital onset 14%).
10. The IP mandatory training compliance at the end of March 2023 was above 95 %

Part 2 - The IPC forward plan 2023/24, is a combined MWL plan.

Financial Implications
None as a direct consequence of this paper.
Quality and/or Equality Impact
Not applicable
Recommendations
The Board is asked to note the S&O 2022/23 Infection, Prevention and Control Annual Report

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Mersey and West Lancashire Teaching Hospitals NHS Trust

Infection Prevention & Control Annual Report 2022/23

CONTENTS

1. Introduction

The Infection Prevention and Control (IPC) Annual Report is a statutory requirement and outlines the Trust's performance against the ten criteria as outlined in the Health and Social Care Act 2008: Code of Practice on the control and prevention of infections and related guidance.

This is a two-part document, with Part 1 outlining the performance and developments related to Infection Prevention and Control activities during 2022/23; and Part 2 (Appendix 1) is the annual work plan for 2023/24, 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.

A zero-tolerance approach continues to be taken by the Trust towards all avoidable HCAIs. Good IPC practice is essential to ensure that people who use the Trust's services receive safe, clean care. Effective IPC practices must be part of everyday practice and be applied consistently by everyone. The publication of the Trust's annual report is a requirement to demonstrate good governance and public accountability.

There are national contractual reduction objectives for *Clostridioides difficile (C.difficile)* infections and gram-negative bloodstream infections (GNBSIs) and these are included in the six infections that are subject to mandatory reporting to United Kingdom Health and Security Agency (UKSHA) listed below.

- Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia
- Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia
- *C.difficile* infections
- *Escherichia coli* (*E.coli*) bacteraemia
- *Klebsiella* spp. bacteraemia
- *Pseudomonas* aeruginosa bacteraemia

The report acknowledges the hard work and diligence of all 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 several outside agencies as part of its IPC and governance arrangements. This includes NHSE England, Integrated Care Systems (ICS), UKHSA Cheshire and Merseyside and community IPC Teams.

2. Infection Prevention and Control Team

The DIPC is Dr Kate Clark, Executive Medical Director. Andrew Chalmers, Consultant Nurse/Deputy DIPC leads the IPC Team, who work across two acute sites, at Southport and Ormskirk Hospitals. The IPC Team consists of:

- Deputy DIPC/Consultant Nurse (1.0 WTE)
- IPC Matron (1.0 WTE)
- IPC Nurse Specialists (1.8 WTE)
- IPC Healthcare Assistant (1.0 WTE)
- Personal Assistant (1.0 WTE)

The IPCT provides a clinical service during weekdays from 8.30am to 4.30pm and an on-call service 9am to 1pm at weekends. Out-of-hours there is an on-call service provided by medical microbiologists for urgent IPC advice.

3. IPC Governance

The Board of Directors has collective responsibility for keeping the risk of infection to a minimum and for overseeing IPC arrangements in the Trust. The Trust's Director of Infection Prevention and Control (DIPC) role is incorporated into the role of the Executive Medical Director. The DIPC is supported by the IPC Team and the Trust Antimicrobial Pharmacist. There is currently no IPC Doctor in post at SOHT, however, there is a microbiologist at Southport Site, with access to the support of the ICD at St Helens and Knowsley teaching hospitals NHS Trust(STHK), due to the mutual laboratory arrangements, which are hosted at STHK.

The DIPC delivers an Annual HCAI Report to the Board of Directors and the HCAI Annual Plan based on national and local quality goals. The Executive Committee and Care Group clinical leads receive monthly updates on patients with *Clostridioides difficile* infections, MRSA and MSSA, and gram-negative bacteraemia as outlined in the NHS Standard Contract 2022/23. Infection Prevention and Control Assurance Group (IPCAG) provides a strategic meeting to support the delivery of a zero-tolerance approach to avoidable HCAIs.

3.1 Board Assurance Framework

The IPC Board Assurance Framework (BAF) was developed to support healthcare providers to effectively self-assess their compliance with the National Infection Prevention and Control Manual (NIPCM)[1] and other related infection prevention and control guidance. It is structured around the ten criteria set out in the Code of Practice on the prevention and control of infection[2] which links directly to CQC Regulation 12[3]. The BAF is reviewed at IPC Assurance Group, approved at Quality and Safety Committee, and then submitted to the Trust Board.
Since the publication of the updated IPC BAF in September 2022, a full review has been undertaken of compliance against each Key Line of Enquiry.

Areas identified for further improvement relate to:

- Estates limitations / lack of side rooms – however mitigations are by the use of Gama Redirooms which are available for use in most clinical areas.
- Staff Fit Testing records.
- Capacity within the IPC Team following the retirement of the Consultant Nurse in October 2022 and long-term sickness. However, there has been the appointment of a Consultant Nurse on 12-month secondment (start date June 2023). A trainee IPC nurse secondment is due to start in May 2023.

To ensure that actions are sustained, the framework will be regularly revisited in 2023/24 to monitor progress and mitigation regarding gaps and compliance against any new or updated guidance.

4. Mandatory Surveillance

The IPCT undertakes surveillance of target organisms and alert conditions. Pathogenic organisms or specific infections, which could spread, are identified from microbiology reports

[1] https://www.england.nhs.uk/publication/national-infection-prevention-and-control/
[2] Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk)
[3] Regulation 12: Safe care and treatment - Care Quality Commission (cqc.org.uk)

or from notifications by ward staff. The IPCT advises on the appropriate use of infection control precautions for each case and monitors overall trends.

The Trust has used the ICNet surveillance system for many years. In addition to submitting data to support the national HCAI objectives for *C. difficile* infection, MRSA bacteraemia and gram-negative bacteraemia (GNBSIs) including *E. coli, Klebsiella* spp. and *Pseudomonas aeruginosa,* the Trust also submits data to the UK Health Security Agency (UKSHA) on these infections, as well as MSSA. The data is submitted monthly to UKSHA via an online Health Care Associated Infection Data Capture System (DCS).

Achievements against the national HCAI thresholds

The NHS Standard Contract 2022/23 includes quality requirements for NHS trusts to minimise rates of both C. *difficile* and GNBSIs to threshold levels set by NHS England and NHS Improvement[4]. They are inclusive of all healthcare associated cases (community onset healthcare associated, and hospital onset healthcare associated).

The thresholds are derived from a baseline of the 12 months ending November 2021. The 2022/23 thresholds set for SOHT are below.

- C. *difficile* ≤ 49
- E. coli ≤ 51
- Klebsiella ≤ 17
- Pseudomonas ≤ 7

A zero tolerance to MRSA bacteraemia also remains. A reduction in MSSA bacteraemia is not stipulated within the national guidance.

5.1 *Clostridioides difficile* infection

In 2022/23 there were 48 healthcare associated *C.difficile* cases against the objective of no more than 49 cases. SOHT was the only non-specialist adult acute care provider in Cheshire and Merseyside that met its objective in year.

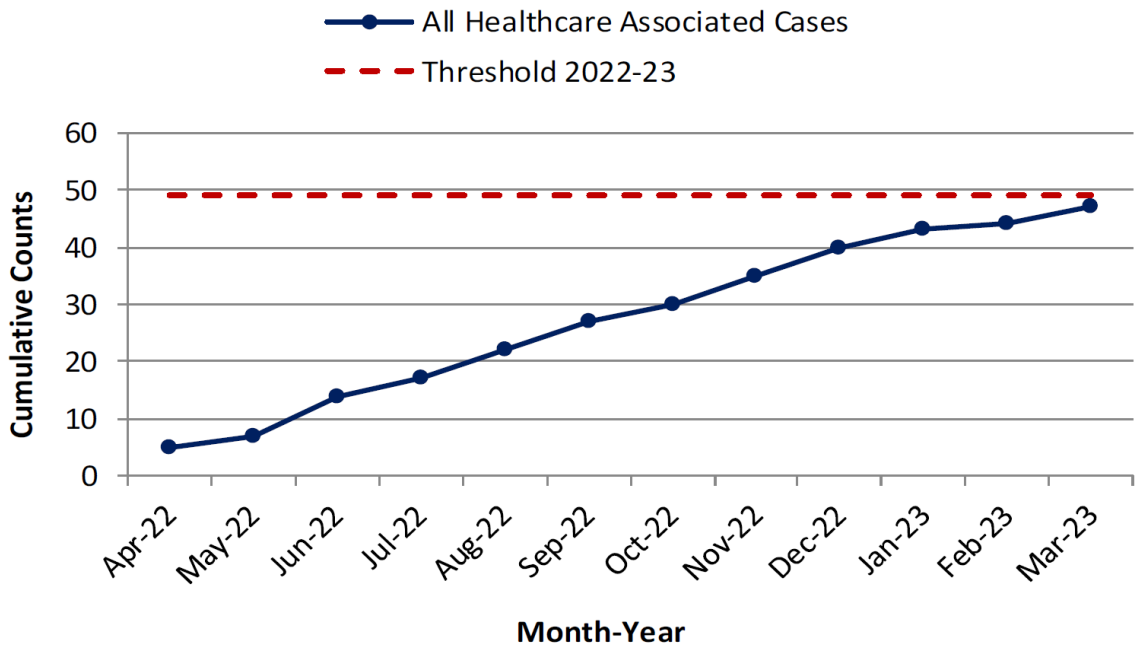
Since April 2017, Trusts were asked to provide information on whether patients with *C.difficile* infection had been admitted to the reporting Trust within the three months prior to the onset of the current case. This was to allow for greater granulation of the healthcare association of cases.

Cases are classified as follows:

Hospital-onset healthcare-associated (HOHA) - Date of onset is ≥ 3 days after admission (where day of admission is day 1).

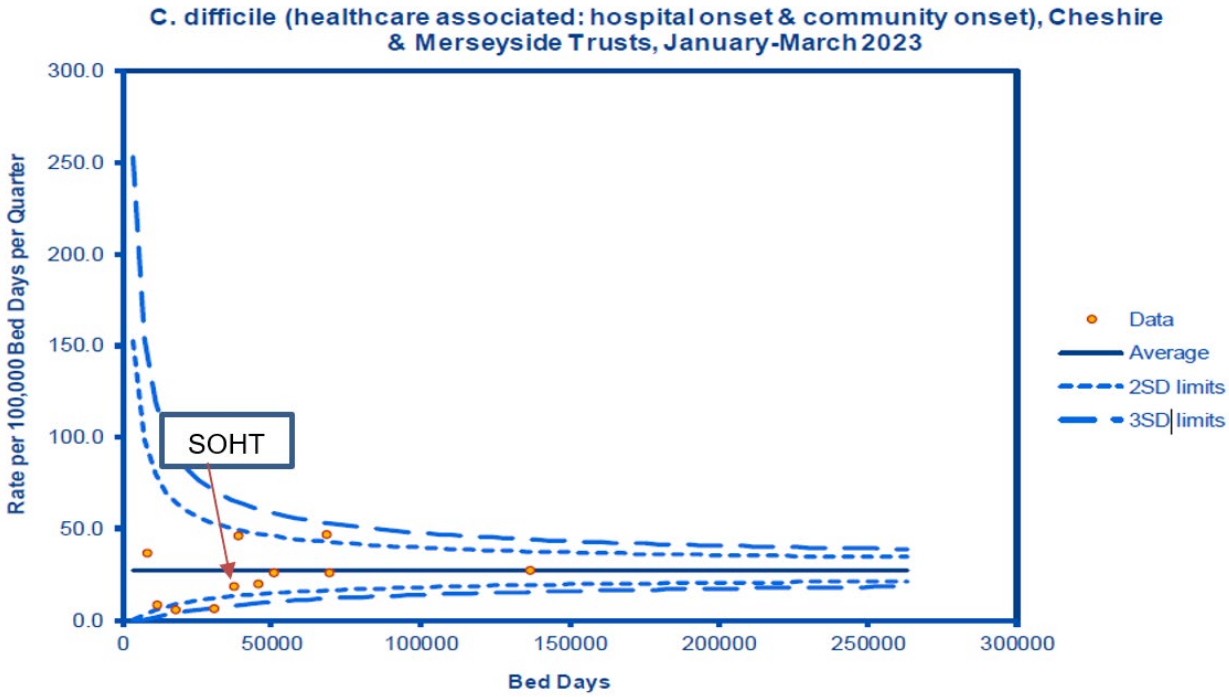
Community-onset healthcare-associated (COHA) - Date of onset is < 2 days after admission and the patient was admitted to the trust in the 28 days prior to the current episode.
Figure 1. *C. difficile* healthcare associated (COHA and HOHA) cases 2022/23

[4] B1314-standard-contract-2223-minimising-clostridioides-difficile-and-gram-negative-bloodstream-infections.pdf (england.nhs.uk)



Recent UKSHA data indicates that the rate of C.*difficile* infection at SOTH in Quarter 4 (Jan 23–April 23) was 18.7 per 100,000 bed days compared to the quarterly Northwest rate of 26.3 (Figure 2).

Figure 2. Healthcare associated C.*difficile* (COHA and HOHA): Northwest Trusts, January–March 2023.



RCAs were undertaken by clinical teams on cases of hospital-associated CDTs. Each case has been investigated by the clinical teams using a standardised root cause analysis (RCA)

process and fed back to all clinical areas. Any RCA lessons and key actions are discussed and delivery of improvements monitored through the Trust's Infection Prevention and Control Operational Group.

Approximately half of cases had no specific lessons identified, with SIGHT (timely testing and isolation) being followed and appropriate antibiotic prescribing. Learning from other cases identified improvements required in stool testing and isolation, and appropriate antibiotic prescribing for patients with a history of C. difficile infection.

Lessons learnt have been disseminated Trust wide through the IPC Monthly Compliance Report, Team Brief, IPC Link staff and through teaching for antimicrobial prescribers and nursing staff.

There were no outbreaks of CDI at Southport and Ormskirk NHS Trust in 2022/23.

5.2 Gram-negative Bloodstream Infections (GNBSIs)

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, and intra-abdominal infection such as biliary infection. Bacteraemia (bloodstream infection) may be caused by these 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* bacteraemia for 2022-2023 were published by NHSE as follows:

- *E coli* bacteraemia – no more than ≤ 51 healthcare associated cases
- Klebsiella species bacteraemia –no more than ≤ 17 healthcare associated cases.
- *Pseudomonas aeruginosa* bacteraemia – no more than≤ 7 healthcare associated cases

5.3 *E. coli* bacteraemia

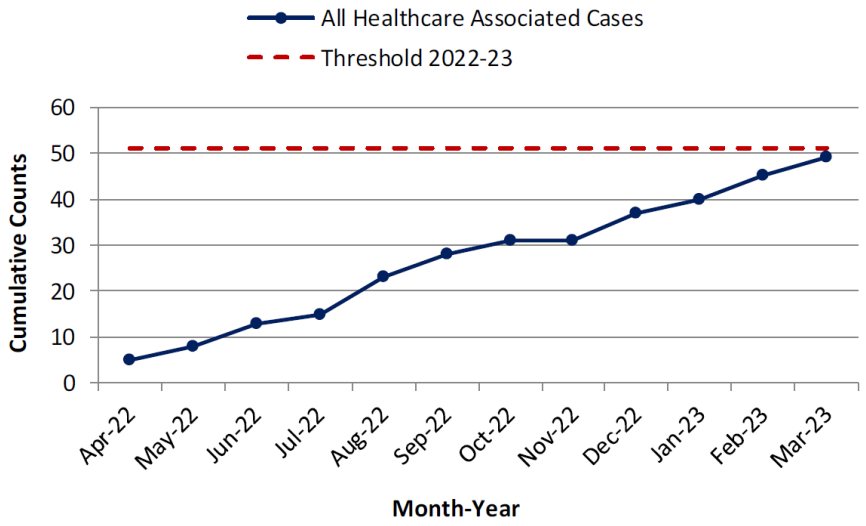
E. coli bloodstream infections represent approximately 55% of all GNBSIs. In 2022/23, the Trust had 49 healthcare associated cases (31 HOHA and 18 COHA) against an objective of ≤51 cases. This is compared to 57 cases in 2021/22. The majority of cases were from a urinary source.

Cases are classified as follows:

Hospital-onset healthcare-associated (HOHA) - Date of onset is ≥ 3 days after admission (where day of admission is day 1).

Community-onset healthcare-associated (COHA) - Date of onset is < 2 days after admission and the patient was admitted to the trust in the 28 days prior to the current episode.

Figure 3. *E. coli* healthcare associated (COHA and HOHA) cases 2022/23

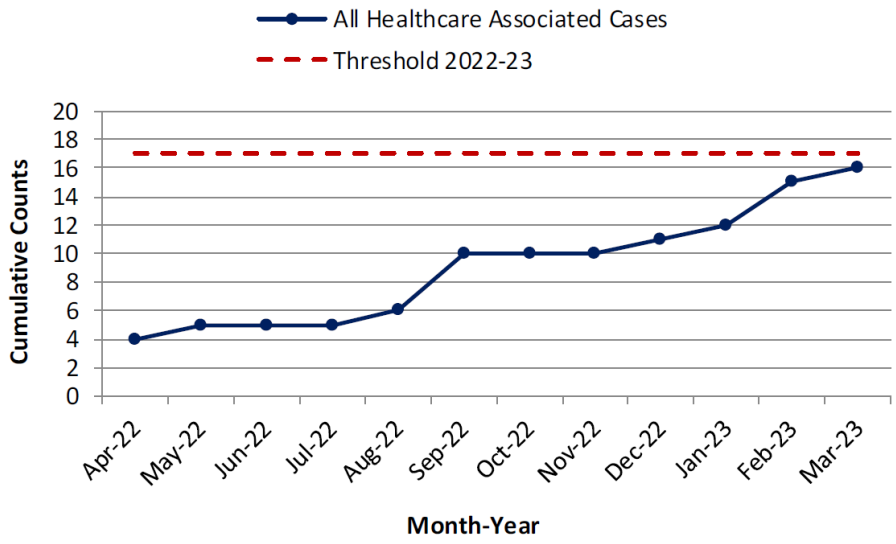


5.4 *Klebsiella* spp. bacteraemia

Klebsiella species belong to the order *Enterobacterales*. *Klebsiella* species are commonly associated with a range of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis.

In 2022/23 SOHT achieved the national objective of ≤17 healthcare associated cases, with 16 cases, including 11 HOHA and 5 COHA. The majority of these cases were from a urinary source; hepatobiliary infection in one case and another from a long-term vascular access device. All cases were reviewed by the clinical team and consultant microbiologist and no lapses in care were identified.

Figure 4. *Klebsiella species* healthcare associated (COHA and HOHA) cases 2022/23

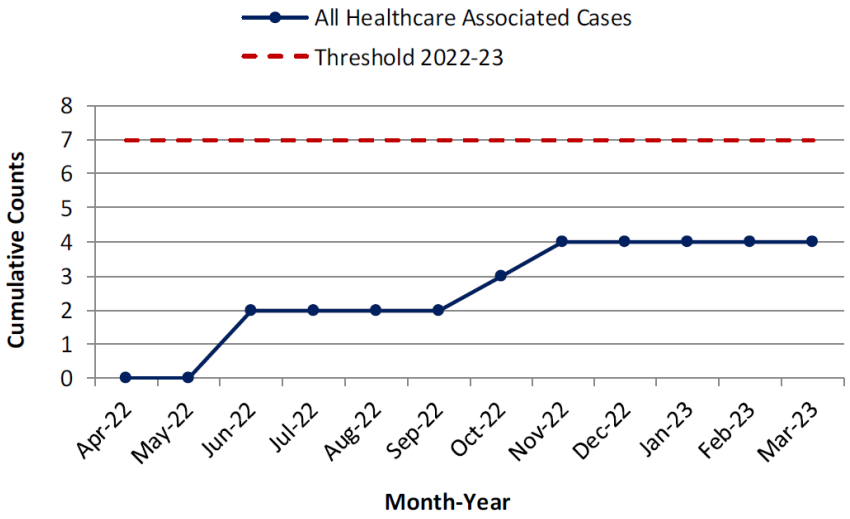


5.5 Pseudomonas aeruginosa

Pseudomonas is a type of bacteria that is commonly found in the environment, including in soil and water. Of the many different types of Pseudomonades, the one that most often causes infections in humans is Pseudomonas aeruginosa, which can cause several significant infections.

In 2022/23 SOTH achieved the national objective of ≤ 7 healthcare associated cases with 4 cases. 2 HOHA 2 COHA. Two cases were related to patients whose chronic leg ulcers were colonised with Pseudomonas, and the remaining sources were the chest and urinary tract (UTI) in complex patients.

Figure 5. *Pseudomonas aeruginosa* healthcare associated (COHA and HOHA) cases 2022/23



5.6 MRSA bacteraemia

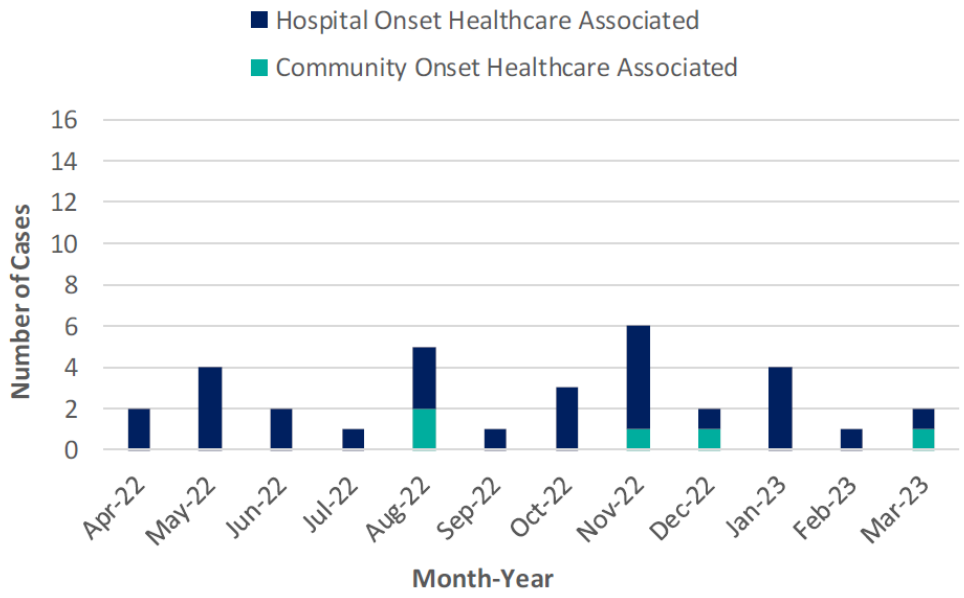
There continues to be a zero-tolerance approach to all MRSA bacteraemia where lapses in care are identified. There were no healthcare-associated cases across SOHT in 2022/23. There was one COCA (community-associated) case. The IPC Team supported community colleagues to complete at PIR on the case. No specific lessons were identified for SOTH.

The UKSHA published data indicates that from January to March 2023, the rate of MRSA bacteraemia at SOHT is zero compared to the Cheshire and Merseyside rate of 0.7 per 100,000 bed days. SOHT was the only acute non-specialist provider with no healthcare-associated cases in year.

5.7 MSSA bacteraemia

There is no national objective set for MSSA bacteraemia, however the Trust participates in the national mandatory surveillance of MSSA bacteraemia. There were 33 cases of healthcare associated cases of MSSA bacteraemia in 2022/23 (28 HOHA and 5 COHA).

Figure 6. MSSA healthcare associated (COHA and HOHA) cases 2022/23



There were 33 healthcare associated cases (28 HOHA, 5 COHA). Surveillance is undertaken on all healthcare-associated cases and the main source of infection is from skin and soft tissue e.g., leg ulcers. Two cases may have been linked to vascular access devices, and two were related to deep sources including endocarditis and discitis.

Patients known to be colonised with MSSA in wounds or devices are routinely treated with suppression therapy (the same as for MRSA colonisation) to reduce the risk of invasive infection.

As this is an organism that contaminates vascular access devices the Trust had determined that cannula care, placement, management would be a priority for 2022/23. This included a change of peripheral cannula with education and support provided by the manufacturer.

5.8 MRSA Screening

The Trust continues to screen new admissions for MRSA colonisation. Typically, more than 95% of eligible patients are screened either preadmission for elective patients, or in ED if an emergency admission. Missed screens are identified by the IPC team who request the ward to complete the screen if so required. Following the IPC team's implementation of, writing in the patient's case notes each new case of MRSA colonisation using a florescent label, subsequent audits have found high levels (>95%) of adherence to prescribing MRSA suppression treatment.

5.9 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 infections.

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 to other patients.

In 2022/23, there were no Trust-associated VRE bacteraemia. There were 24 hospital onset cases of VRE (non-bacteraemia) with most cases being asymptomatic colonisation detected on routine screening.

5.10 Carbapenemase Producing Enterobacterales (CPE)

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 bloodstream. The antibiotics available to treat such infections are limited which increases the risk of treatment failure.

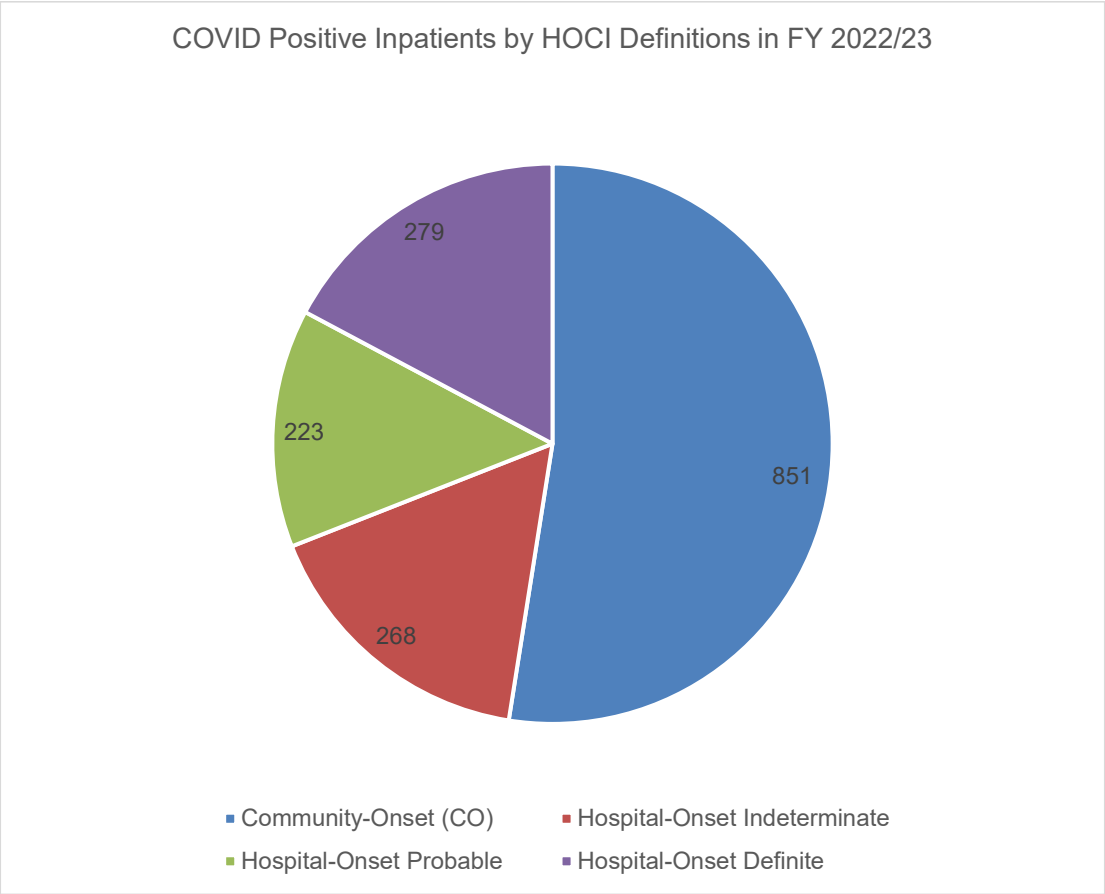
There were no CPE bacteraemia in 2022/23 (hospital or community acquired) or in the previous financial year.

Patients are screened for CPE on admission to SOHT following transfer from certain high prevalence Trusts. During this year 569 CPE admission screens were obtained from patients who were identified as being at increased risk of CPE colonization. There was one patient in 22/23 who was identified as having hospital-associated CPE colonisation.

5. Nosocomial COVID

The Covid-19 pandemic, cause by the SARS-CoV2 virus, was recognised in December 2019. Like previous pandemics the SARS-CoV2 pandemic has presented in ‘waves’ of infection. SOHT and the surrounding community have witnessed six distinct waves of infection often associated with modifications, or variants, of the original virus.
National testing strategies have varied throughout the pandemic, and particularly in the reporting year, reflecting prevalence, vaccination uptake and changes in the clinical impact of the virus.
Figure 8 outlines the Covid-19 positive cases in year by HOCI definition (Hospital-onset Covid Infection). This breakdown divides the cases into those most likely to have acquired their infection in the community (Community-onset and Indeterminate) and cases that were most likely to have acquired their infections in hospital (the last two groups). The chart also shows the percentage of cases that were likely to have acquired their infection in hospital (Probable and Definite).

Figure 8. Covid-19 positive cases by HOCI definition 2022/23



When compared to financial year 2021/22, overall cases of Covid-19 increased by 30% in 2022/23. A higher proportion of cases were diagnosed as hospital-associated, however the approach to screening had changed and was prioritising symptomatic patients for testing.

Figure 9. Covid-19 positive cases by HOCI definition Financial Years 21/22, 22/23

Financial Year	Hospital onset DEFINITE healthcare associated	Hospital onset PROBABLE healthcare associated	Hospital onset INDETERMINATE healthcare associated	COMMUNITY onset	Total Covid cases
2021/22	77 (7%)	61 (5%)	124 (11%)	852 (76%)	1114
2022/23	279 (17%)	223 (14%)	268 (17%)	851 (52%)	1621

The Trust uses Gama Redirooms (mobile isolation rooms) and inter-bed space clear blinds between patient bed spaces, to facilitate timely isolation of symptomatic or positive patients, and to reduce the risk of droplet spread of infection between patients in shared bays. Due to the limitations on ventilation within the Trust, particularly on the Southport site, air purifiers were installed in the wards and bays where space was particularly limited.

5.1 Outbreaks

There were 9 confirmed hospital outbreaks in 2022/23 – 6 were nosocomial (hospital-associated) COVID-19 outbreaks and 3 were caused by Norovirus. Outbreak meetings were held with clinical colleagues, with outbreak measures and action plans implemented with the support of the IPC Team.

6. Education and training

All staff, including those employed by support services, must receive training in infection prevention and control. Infection Prevention and Control is included in induction programmes for new staff, including support services. IPC Mandatory Training is delivered by e-learning. Level 1 training must be undertaken by all staff and Level 2 by clinical staff. Compliance with this training is monitored and is >95%.

Due to resource constraints within the IPC Team the plan to reinvigorate the link practitioner network could not be realised. However, the IPC Team continues to provide clinical advice and conveys key messages via email and Trust Comms.

7. Audit Programme

Audits of practice and the clinical environment were undertaken by the IPC Team on a regular schedule. There is an IPC audit plan in place which includes audits undertaken by the clinical staff on their wards. The results are feedback to the Care Groups monthly.

Figure 10. Audit Programme 22/23

Audit programme 2022-23	Lead	Frequency	Progress update
Hand hygiene	IPCT Link practitioners	Monthly	Reported monthly
MRSA screening compliance for elective & emergency admissions	IPCT	Monthly	Reported monthly
Compliance with MRSA Pathway	IPCT	Weekly	Reported monthly
Compliance with C. difficile Pathway	IPCT	Weekly	Reported monthly
Commode cleanliness	IPCT	Weekly	Reported monthly
Hand gel availability	IPCT	Bi-weekly	Reported monthly
Antibiotic audits	Antimicrobial Pharmacist	Monthly	Reported Monthly
Antimicrobial point prevalence audit	Antimicrobial Pharmacist	Quarterly	Reported quarterly
PPE audit	IPCT	monthly	Reported monthly
IPC Ward and department IPC inspections	IPCT	Revolving programme	Reported monthly

8. 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. The Trust undertakes continuous surveillance of for total hip and total knee replacements.

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.

2022/23 data indicated that:

- There were 122 total hip replacement operations performed, of which 1 infection was reported (0.81%).
- There were 104 knee replacements completed of which 1 infection was reported (0.96%).

The national rate for SSI in 2022/23 has yet to be published to allow a comparison to be made with the SOTH rate. These data and any learning identified from clinical reviews of patients with infection are shared with orthopaedic colleagues to identify if any changes to practice are required.

9. Antimicrobial Stewardship

An Antimicrobial Stewardship (AMS) Programme is a key component in the reduction of healthcare associated infections and contributes to slowing the development of antimicrobial resistance. The Antimicrobial Stewardship programme in the Trust is developed and implemented by the Antimicrobial Stewardship Committee which met quarterly through 2022/23. The meetings were all quorate and minutes were escalated through the Infection Prevention and Control Assurance Committee and Drugs and Therapeutics Committee to ensure governance at Board level.

Point prevalence surveys (PPS) were carried out quarterly throughout the financial year. Ward antibiotic prescribing audits were carried out using the Tendable App for more rapid and responsive audits of antimicrobial prescribing. Ward pharmacists were given access to the App and received training on how to carry out audits on their wards.

Antibiotic use prevalence was averaged at 32 per 100 patients who received at least one antimicrobial on a given day during the surveys. On average 86% of the antibiotics prescribed were appropriate in accordance with guidelines or advice from microbiology consultants. Figure 11 shows that antibiotic consumption has increased at the Trust in the 2022-2023 financial year and is now similar to that of the pre-pandemic years.

There continues to be two Consultant Microbiologist vacancies with only one Consultant Microbiologist Southport site. To mitigate this, two speciality doctors have been appointed and are both based at Southport Hospital site. The antimicrobial pharmacist in post was on a fixed-term contract until March 2023 but has now obtained a substantive post in a different role in the trust.

Education regarding AMS is taught by the consultant microbiologist and the AMS pharmacist. The Antimicrobial Pharmacist also delivered teaching sessions to junior doctors during induction, as feedback following *C. difficile* RCA meetings and following Tendable antibiotic prescribing audits.

Figure 11. Total antibiotic consumption April 2017-March 2023

	1	2	3	4
Total DDD 17/18	72491	144924	223172	301999
Total DDD 18/19	71747	141829	220764	307038
Total DDD 19/20	73845	147664	230634	307732
Total DDD 20/21	54886	113727	175552	237645
Total DDD 21/22	63374	131180	207542	268674
Total DDD 22/23	72864	146789	234188	308355

Antibiotic ward rounds continue on high-risk areas including Critical Care Unit, Spinal Unit, orthopaedic ward and for patients with *C. difficile* infection. Virtual MDT meetings for outpatients on antibiotic therapy (OPAT) have taken place once weekly during the period covered by this report.

In preparation for organisational integration, the SOHT and St Helens and Knowsley NHS FT (STHK) antimicrobial formularies were reviewed with a view to aligning them into a single formulary. An antibiotic resistance report was completed for the period January 2022 to December 2023 that was used to determine the appropriateness of antibiotics selected as SOHT prepared to merge guidelines with STHK.

11. Health, Work and Wellbeing

The Health, Work and Wellbeing Service (HWWB) provides pre-employment health assessments including immunity and provides vaccinations for new staff. An annual audit is undertaken to ensure that new starters have had the appropriate pre-employment assessments and vaccinations where required. The OH COHORT system then automatically notifies HWWB when staff vaccinations are next due.
The service also supports with advice and treatment in the event of outbreaks or incidents requiring staff screening or treatment. The Trust met the CQUIN target for staff flu vaccination in year. The Head of HWWB provided monthly updates to the IPC Operational Meeting throughout 2022/23.

11.1 Inoculation Injuries (Sharps)

An annual audit of inoculation injury (including needlesticks) is performed per calendar year, covering January-December 2022. It identified an increase in inoculation injuries, although none were deemed to be high risk exposures, necessitating post exposure prophylaxis. Despite this the results of the audit showed that there was good compliance across the trust with the management of inoculation injuries.

A task and finish group was subsequently established to further understand the issues underlying this, and the following actions have been taken:

- Increased communications in Trust News and highlighted in Trust Brief
- Posters distributed to all clinical areas for display.
- Small credit card size cards developed signposting staff to procedure and distributed to staff.
- Blood Borne Virus ‘making every contact count’ during health education/promotion activities.
- Review of management of exposure to body fluids and sharps injury policy
- Established that the increase is consistent with other Trusts in the area.

12.Decontamination

12.1Sterile Services

All decontamination and sterilisation of reusable medical devices is carried out on site at Ormskirk Hospital, by the Trust’s Sterile Services and Endoscopy Departments. All equipment in both Sterile Services & Endoscopy departments is maintained, tested, and validated in accordance with the relevant HTM's. This is audited by the independent Authorising Engineer for Decontamination AE(D). Both departments are ISO 13685:2016 & EEC MDD production Quality Assurance registered and are audited annually by an external notified body.

The governance and assurance are reported to the Trust Decontamination Steering Group quarterly meetings. The membership of which includes the Trust Decontamination Lead, the Decontamination Manager, the Infection Control Team, or Deputy Director of Infection Control (Dep DIPC) and Trust AED and other interested parties.
The Group will assess decontamination requirements and consider what aspects of Best Practice will be prioritised and should be implemented, based on improving patient outcomes, decontamination benefits, efficiencies, and risks.

The Trust Decontamination Policy has been reviewed and updated to ensure that it meets and interprets appropriately the guidance of Health Technical Memorandum (HTM) 01-01(2016). It should also be noted that since the United Kingdom opted out of the European Union in 2021, the European Directives & Medical Devices Directives will be replaced by the UK Conformity Assessed (UKCA)

12.2 Endoscopy Decontamination Services

Flexible endoscopes are complex reusable instruments that require unique consideration with respect to decontamination. In addition to the external surface of endoscopes, their internal channels for air, water, aspiration, and accessories are exposed to body fluids and other contaminants. In contrast to rigid endoscopes and most reusable accessories, flexible endoscopes are deemed as 'heat labile and therefore, specialist chemical or cold decontamination processes must be undertaken as these devices cannot be autoclaved by steam at high temperatures in the same way as surgical instruments and other invasive medical devices are reprocessed.

In addition to the cold sterilisation, the Trust has Ultraviolet radiation to decontaminate Nasendoscopes & Transoesophageal echocardiography probes.

Currently, the Endoscopy suite is undergoing a 3-phase refurbishment which includes the replacement of the Reverse Osmosis plant & 6 new Automated Endoscopic Reprocessors.

12.3 Instrument Tracking and Traceability

In December 2022, the Trust completed a large piece of work in which the existing instrument Tracking and Traceability system was retired. Following a robust tendering exercise as part of a wider collaboration across Cheshire and Merseyside, the Healthedge was installed and went live across both the endoscopy areas and within the Sterile Services Department. This system is already being widely used across several neighbouring Trusts, providing the ability for each Trust to have instruments reprocessed at any facility as part of improved system resilience. This minimises any risk of patient cancellation or delays.

13. Estates and Facilities

13.1The National Standards of Healthcare Cleanliness (NSOC)

The National Standards of Healthcare Cleanliness (NSOC) were released in 2021, replacing the National Specifications for Cleanliness 2007. These new standards are applicable to all healthcare settings with the aim that the new process will create an opportunity to review the Trusts cleaning policy to ensure that it meets the minimum safe standard.

The new standards provide a directive for all cleaning tasks using a collaborative approach between cleaning services, nursing, non-clinical staff, including housekeepers, Infection, Prevention Control and Estates and Facilities to drive improvements in cleanliness standards, whilst being flexible to meet the different complex requirements in the healthcare environment.

The standards emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met in every healthcare institution.

Work is currently being undertaken to review both sites to identify the areas that do not meet the revised NSOC frequencies. This will also include additional resources to meet the new auditing requirements and frequencies.

13.2 Patient-Led Assessments of the Care Environment (PLACE)

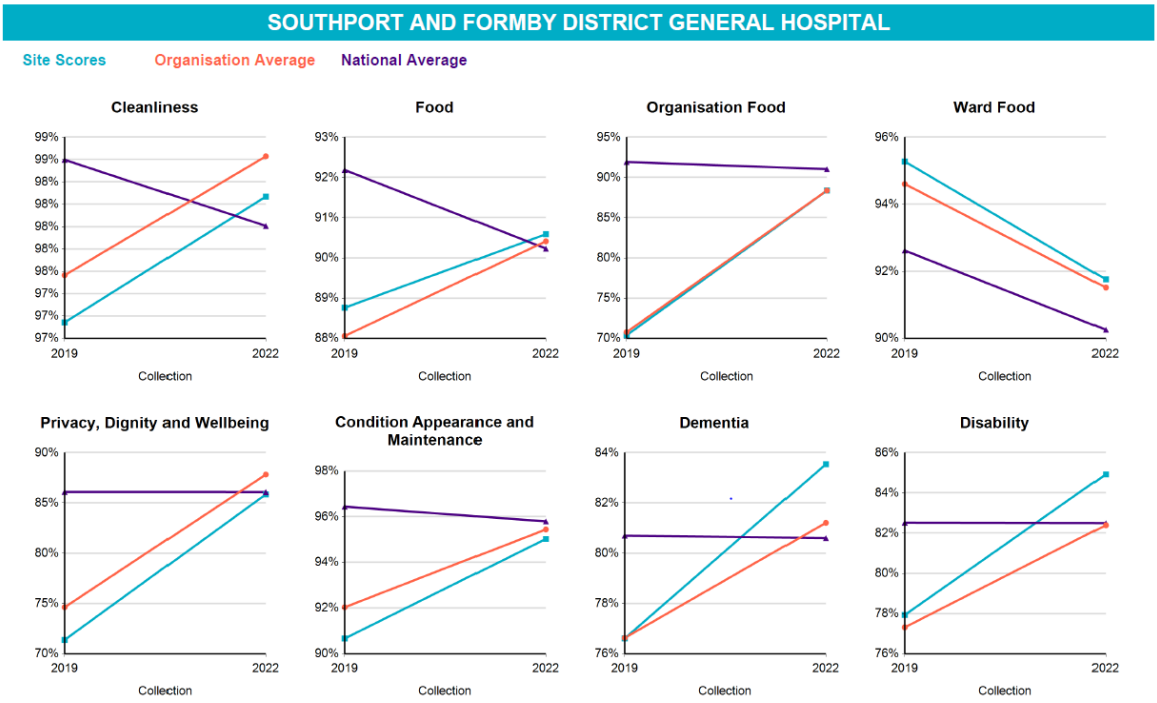
PLACE assessments are an annual appraisal of both non-clinical and clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The team must include a minimum of 50 per cent patient assessors.

PLACE assessments provide a framework for assessing quality against common guidelines and standards to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

PLACE assessments were undertaken within the Trust in 2019, however paused during the pandemic. Assessments recommenced in Autumn 2022 with the deadline for submitting findings in January 2023.

Figure 12. PLACE Scores Ormskirk Site 2019 and 2022 Comparison

Figure 13. PLACE Scores Southport Site 2019 and 2022 Comparison



The work completed to comply with the requirement of PLACE 2022 includes.

- Recruited required numbers of patient led assessors.
- Implemented training session for all assessors.
- Undertook assessments at both SDGH & ODGH in October 2022
- Implemented a PLACE Action tracker, reviewed, and updated within Estates and Facilities and IPC Governance Meetings.

13.3 Hospital Ventilation

The Engineering Safety Group was established in April 2022, to review on a quarterly basis; that the operation of all Engineering Services including ventilation within the Trust is compliant with legislation, guidance, and best practice.

Theatre ventilation validation audits are undertaken annually with contracts in place to conduct planned preventative maintenance on air conditioning. The Trust's inhouse team maintains air handling units.

A survey was completed in 2022/23 to determine what current ventilation flow rates are from all existing supply and extract grills. The next step is to carry out a full review of the ventilation at Southport and Ormskirk sites to determine the current level of ventilation and if it is in alignment with HTM03-01.

13.4 Water Safety

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.

The flushing of underused outlets with wards is undertaken by Domestic/Estates teams and monitored by the Estates and Facilities compliance Team on a weekly basis, with any issues escalated to the Water Safety Group members for immediate action.

In 2022/23 a Procurement exercise was undertaken to carry Water Safety Risk assessments at both Southport and Ormskirk sites, and contracts have been awarded for Water Safety risk assessments to be undertaken in 2023/24

13.5 Waste Management

Waste management legislation prohibits the mixing of waste to safeguard members of staff, contractors and members of the public who may encounter waste. It was identified that the Trusts facilities for the storage of waste necessitated the mixing of different waste streams, therefore a capital scheme has been completed to redesign the waste storage throughout both Southport and Ormskirk hospitals in order that waste streams can be segregated to in line with HTM07-01 recommendations. External and internal signage has been added to each waste cupboard to ensure all staff can easily identify the correct waste cupboard to deposit each waste stream.

Healthcare waste pre acceptance audits were completed at Southport Site in January 2023 and at Ormskirk Site in March 2023. Good practice at the Trust was identified as follows.

- Trust waste policy is available on the intranet for all staff.
- Staff are trained in segregation on induction.
- Sites have an internal waste programme.
- Controlled drugs are denatured prior to disposal in blue lidded sealed units.
- Offensive waste was implemented.
- Waste yard was locked and secure.

15.Risk Register

There were two IPC risks on the risk register in 2022/23. One was a low risk related to a reusable breast-feeding pump, due to concerns about the traceability label being completed between users. This risk is now closed.
The second risk related to a medical wards inability to separate storage of sluice equipment from clean consumables. A permanent estates solution has yet to be implemented. To mitigate, the IPC Team have supported wards to safely segregate these items.

Appendix 1. IPC Assurance Group TOR

TERMS OF REFERENCE FOR THE INFECTION PREVENTION AND CONTROL ASSURANCE GROUP MEETING

1 Authority

1.1 The Quality and Safety Committee hereby resolves to establish a meeting group of the Trust to be known as the Infection Prevention and Control Assurance Group (IPCAG).

1.2 The IPCAG has the delegated authority to:
a) seek any information it requires from any employee of the Trust in order to perform its duties as set out below.
b) obtain, within the limits set out in the Trust Scheme of Delegation, outside professional advice on any matter within its terms of reference.
c) call any employee to report to the IPCAG as and when required.

1.3 Approved meeting minutes of the IPCAG are circulated to the Quality and Safety Committee for information at the first formal Quality and Safety Committee meeting following approval. The Chair of the meeting escalates items to the Quality and Safety Committee as appropriate.

1.4 The meeting operates within the Trust Standing Orders and Standing Financial Instructions.

2 Purpose

2.1 The IPCAG is established to:

2.1.1 Provide strategic Leadership on infection prevention and control of Healthcare Associated Infection (HCAI) for the organisation to ensure risks posed by transmission of avoidable infection is minimised.

2.1.2 Provide a key role in monitoring the organisation's performance against the Trust's Infection Prevention and Control Strategy including externally set objectives/targets and compliance with the Health and Social Act 2008: Code of Practice on the Prevention and Control Infections (2015)

2.1.3 Ensure there is a strategic organisational response to new legislation and national guidelines and be responsible for determining the Trust's strategic direction for infection prevention and control activities throughout the organisation.

2.1.4 Ensure there is adequate learning from infection-related incidents and health economy issues to minimise impact on patient safety/Trust business.

2.1.5 Ensure that the use of resources is maximised in order to achieve the most efficient methods to achieve safe practice.

2.1.6 Agree the education and training framework for infection prevention and control for the Trust, ensuring compliance with infection prevention and control standards.

2 Principal Duties

The IPCAG will meet bi-monthly and:

2.1 Receive a bi-monthly report from each CBU on performance against key HCAI performance indicators using the agreed framework.

2.2 Receive a quarterly report regarding antibiotic prescribing audits and antimicrobial prescribing policy compliance by each CBU.

2.3 Receive a bi-monthly report from the Head of Soft FM on compliance with the National Standards of Healthcare Cleanliness 2021.

2.4 Accept reports from short-term issue specific groups as necessary.

2.5 Receive bi-monthly reports from the Infection Prevention Team against national and local HCAI targets including progress against the Code of Practice on the Prevention and Control of Infections (2015) and NICE Guidance

2.6 Receive quarterly reports (or more frequently for specific risks) from the Decontamination Lead on compliance with decontamination guidance and decontamination risks in the Trust.

2.7 Receive bi-monthly reports from the Staff Health & Wellbeing Manager on matters relating to Prevention and Control including flu vaccination rates, sharps injuries and incidents requiring post exposure prophylaxis.

2.8 Receive reports from the Trust Water Safety Lead relating to Legionella and pseudomonas risks identified and compliance with national requirements as a minimum quarterly, increasing the frequency if specific risks are identified.

2.9 Receive update reports from outside stakeholders (UKSHA and CCGs)

2.10 Receive and approve the Infection Prevention Annual Report in the first quarter of the following fiscal year prior to submission to the Trust Board and receive quarterly updates.

2.11 Approve, review, and monitor the Infection Prevention Team's Annual Programme of Work/ Annual Report/Code of Practice on the Prevention and Control of Infections (2015) compliance.

2.12 Receive advice from the Infection Prevention and Control Team on new national policy and guidance and its implementation within the organisation, highlighting potential areas of non-compliance.

2.13 Work collaboratively with Commissioners to ensure that the Infection Prevention Strategy and Policy reflects the impact of decisions on the health economy whilst maintaining a healthy economy approach to the prevention of HCAI.

2.14 Provide assurance to the Trust Board through reports of progress against the annual programme, compliance with the Code of Practice on the prevention and control of infections (2015) and performance targets.

2.15 Monitor the Trust's risk register in relation to infection prevention and control of infection risks and receive associated action plans.

2.16 Ratify infection prevention and staff health & Wellbeing policies prior to submission to the Trust Policy Group.

2.17 Address outstanding areas of non-compliance with national accreditation schemes (e.g., NHSI, CQC, UKSHA) and advise the Trust Board/Trust Exec. Team as appropriate.

3 Constitution

3.1 **Chair** – Director of Infection Prevention & Control (DIPC) will chair group meetings. In the absence of the Chair either the Executive Medical Directory (EMD) or Director of Nursing, Midwifery and Quality (DONMQ) will act as Chair.

3.2 **Membership** - The following will be members of the IPCAG.

- Director of Infection Prevention & Control (Chair)
- Executive Medical Director
- Director of Nursing, Midwifery and Quality
- Infection Control Doctor
- Nurse Consultant/Deputy DIPC
- Assistant Director of Occupational Health & Wellbeing
- IPC Leads for West Lancs and Southport & Formby CCGs
- UKHSA Consultant in Health Protection Cheshire & Merseyside (also represents Cumbria and Lancashire)
- Chief Pharmacist/ Antibiotic Pharmacist
- Associate Directors of Nursing for each CBU
- Trust Decontamination Manager
- Associate Medical Directors
- Quality Improvement and Assurance Manager, Sefton & West Lancs CCGs
- Assistant Director of Estates & Facilities Management
- Head of Soft Facilities Management

3.2 Only members of the IPCAG have the right to attend meetings and have a single vote for any decisions to be taken by the group. However, other officers of the Trust may be invited to attend all, or part of any meeting as and when appropriate and necessary.

Members may send a deputy with the relevant level of authority with the Chair's prior agreement.

Co-opted members may occasionally attend the meeting for a specific function.

All members are required to attend 75% of meetings held.

3.3 **Quorum** - A quorum will be a minimum of 6 representatives of which 1 will be the DIPC/DONMQ/EMD and one member of the Infection Prevention Team, plus 1 external representative, in order for the decisions of the committee to be valid the meeting must be quorate.

3.4 **Frequency of Meetings** – The meetings will be held bi-monthly.

3.5 **Organisation** – The Infection Prevention & Control Information Officer will provide secretarial support to the meeting. The agenda for the meeting will be drawn up with the Chair or Deputy

Chair of the meeting. The agenda and papers will be distributed 7 days in advance of the meeting.

3.6 **Review** – The Terms of Reference will be reviewed annually or in light of changes in practice or legislation. This will include a review by the meeting of its own performance.

Approved by: **Infection Prevention & Control Trust Assurance Group**

Date of approval: **March 2022**

Date For Review: **March 2023**

Appendix 2

IPC Audit Plan 2023/24

Inpatient Audits

Audit Title	Completed by	Frequency	Report Presentation
IPC General Audit	IPC	Twice yearly	Report generated on Tendable. Monthly IPC Compliance Report IPC Operational group
Hand Hygiene Audit	Wards IPC	Monthly During Outbreaks/ Quarterly	Monthly IPC Compliance Report IPC Operational Group
Indwelling Devices audit	IPC	Weekly	
Commode cleanliness audit	IPC	Weekly	Monthly IPC Compliance report
SOCASS assessment	IPC Quality Matrons	Depending on SOCASS rating	Quality Meeting
Cannula audit	Ward managers and Matrons	Monthly	Quality Meeting
Catheters	Ward managers and Matrons	Monthly	Quality meeting
Mouthcare	Ward managers/Matrons	Monthly	Quality meeting
MRSA pathway compliance	IPC	Weekly	Monthly Compliance report IPC Operational Group
Ward Kitchen Audits	Kitchen Manager	Monthly	?
Mattress Audit	Clinical Areas	Monthly	?

Theatre Audits

Audit Title	Completed by	Frequency	Report Presentation
IPC Theatre audit	IPC	6 Monthly	Tendable Report Monthly IPC Compliance Report Theatre Operational Group IPC Operational Group

Outpatients

Audit Title	Completed by	Frequency	Report Presentation

IPC General Audit	IPC	6 Monthly	Tendable Report Monthly Compliance Report IPC Operational Group

Community Sites

Audit Title	Completed by	Frequency	Report Presentation
IPC General Audit	IPC	6 Monthly	Tendable Report Monthly Compliance Report IPC Operational Group

Audits in development

Audit Title	**Completed by**	**Frequency**	**Report Presentation**
Neonatal Audit	IPC	6 Monthly	Tendable Report Monthly Compliance Report IPC Operational Group
IPC Community	IPC	6 Monthly	Tendable Report Monthly Compliance Report IPC Operational Group
IPC Clinic Audit	IPC	6 Monthly	Tendable Report Monthly Compliance Report IPC Operational Group

Mersey and West Lancashire Teaching Hospitals NHS Trust

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	
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 the susceptibility of service users and any risks that their environment and other users may pose to them.
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
6	Systems are in place 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	The provision or ability to secure adequate isolation facilities.
8	The ability to secure adequate access to laboratory support as appropriate.
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
	1. Infection Prevention Team Staffing						
	DIPC - Director of Nursing, Midwifery & Governance	Sue Redfern					
	Infection Control Doctor	Dr Kalani Mortimer					
	Lead Nurse IP	Vacant - appointed Claire Chalinor					
	Clinical Nurse Specialist Band 7	2.4 WTE					
	IP Staff Nurse Band 5	2.0 WTE					
	Audit and Surveillance Assistant	1.0 WTE					
	IP Secretary	1.0 WTE					
	Antimicrobial Stewardship Pharmacist	Andy Lewis, Elisha King, Jade Pickup					
	Hospital IPC Group (HIPG)						
	The IPC Team will report to the Board via HIPG						
	HIPG meet six times per year						

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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		To maintain and alert Trust staff to risks associated with pathogenic organisms To provide IPC guidance to minimise the risks to patients, colleagues and visitors.				
	Mandatory Reporting			**Q1**	**Q2**	**Q3**	**Q4**
	MRSA, MSSA, E. coli, Klebsiella, Pseudomonas aeruginosa bloodstream infection	IPC Team, Microbiology, Executive Review Panel	To identify, communicate and instigate investigations with clinical teams for Trust-associated cases. To ensure that lessons learnt are disseminated throughout the organisation and reported to HIPG				
	Clostridium difficile infection (CDI)	IPC Team, Microbiology	To identify, communicate and instigate investigations with clinical teams for Trust-associated cases. To ensure that lessons learnt are disseminated throughout the organisation and reported to HIPG. To undertake a weekly ward round to review patients with CDI.				
	Carbapenem resistant Enterobacterales (CPE)	IPC Team	To monitor screening compliance of at risk patients To manage patients with CPE colonisation as per policy				
	Surgical Site Surveillance (SSI) Total hip and knee replacements	Orthopaedic Surgery	To support the orthopaedic team to review any learning from				
	Respiratory Viruses e.g. influenza, Covid-19, RSV	IPC Team	To provide IPC guidance to minimise the risks to patients, colleagues and visitors.				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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	IPC Team	Report Trustwide Include in IPC Mandatory Training for all Trust staff				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**4. Policies and Patient Information Leaflets**						
	To agree plan for alignment of policies across MWL	DIPC	CDI, MRSA to be aligned in Q2 (Trust integration at the end of Q1)				
	To provide advice and support on policies where IP is an integral component	IPT	Participation in updating relevant IP related policies				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 4, 5 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**5. ANTT/Intravascular Access and Therapy**						
	Monitor Trust wide compliance and increase compliance rates	IPT	Provide updated compliance figures to the relevant care groups and for HIPG				
	Provide Key Trainer training	IPNs, Nurse Consultant ICU	Key trainer training sessions are provided monthly.				
	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 HIPG. Lead IP nurse to co-chair IV Access and therapy Group with Nurse Consultant ICU				
	Undertake annual Trust PIVC audit	IPT	Provide report to HIPG and PSC. Produce an action plan that will be monitored at the IV therapy group.				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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**						
	IPC training to junior doctors, volunteers, student nurses, preceptors.	IPC Team	Ongoing				
	Mandatory training	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				
	ICNs to undertake an AQUA Introduction to Quality Improvement course						
	ANTT Key Trainers	IPT. Nurse Consultant ICU	Monthly				
	Link Personnel	IPT	6 times a year				
	Antibiotic Prescribing	Antimicrobial Management Pharmacists, Medical Microbiologists	Junior doctor training (medical and surgical twice yearly), medical student teaching, medical staff induction.				
	Keep IP staff updated with evidence based practice	IPT	Attend North West/ national Infection Prevention Society/ infection control conferences. Undertake webinars by accredited IP organisation e.g. Hospital Infection Society				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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 committes of adherence to high quality IP practices	IPT	Reported to quality leads, matrons, ward managers, supports services, HIPG and PSC				
	Annual Programme revised annually	IPT	Areas with a suboptimal score are revisited until issues compliant				
	Further audits are undertaken by the IPT as the service requires	IPT	Commodes and dirty utility, flushing audit (augmented areas), Sharpsmart audit, ward kitchen audit, hand sanitiser placement, blood culture audit, deep clean audit				
	Vascular access devices	IPT	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 in IP monthly report				
	Bristol Stool Chart	IPT	BSC completed electronically. Reported in IP monthly report				
	Mattresses	TK	Audited bi-monthly on the warded areas.				
	Blood culture contamination rates	KM	ED rates reported weekly to clinical leads. Trust rates reported monthly in IP report				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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 IVOS (IV to oral switch)	AMT	Report quarterly to HIPG				
	Undertake weekly AMT wardrounds on medical and surgical wards	AMT	Immediate feedback provided on wards, reported in IP monthly report				
	Point prevalence audit of policy adherence, missed doses, antibiotic review and course lengths	Antimicrobial Management Pharmacists	Reported to Trust clincial leads and in IP monthly report				
	Antimicrobial expenditure information	Antimicrobial Management Pharmacists	Reported to HIPG and DTG				
	Develop Trust OPAT service	AMT	Reported to HIPG and DTG				
	Maintenance of Trust 'Microguide' antibiotic guidelines.	AMT	Rolling process with regular reviews of underlying adult/ paediatric and neonatal policies				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 7 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**9. Communications**						
	IPC Monthly Report	IPT, AMT	Unified IP monthly report, combining monthly reports for the medical and nursing staff				
	Communication with other Trusts and agencies such as UKHSA	IPT	To share information, best practice and lessons from incidents				
	IPC intranet website	IPT	To maintain and update Trust intranet site with relevant and up to date information with Trust staff				
	Microguide	AMT	To maintain and update Microguide app in line with changes to Trust antibiotic policy				
	Administration	JD	To provide administrative support including coordination of meetings, dairy management, data collection, minutes, ICNet administration				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:							
1, 3, 4, 5, 8 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	ICNet surveillance and case management system	IPC Team	Continue to use system to manage patients and to run reports. To introduce futher function to the system as they become available e.g. recent addition of outbreak module.				
	Tendable audit platfrom	IPC Team	To optimise the use of this digital platform for IPC audits, uploading a revised general IPC Team audit by end Q3, in collaboration with Quality Matrons.				
	Electronic prescribing	AMT	To optimise the functionality of the EPMA system				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:							
1, 2, 3, 4, 5, 6, 9 and 10	Back to Basics Campaign to provide awareness and refresher training to clinical colleagues	Consultant Nurse/ Matron IPC.	October/November 2023				
Trust Objectives:	Develop IPC Resource Pack for clinical areas	IPC Team	Developed and distributed by Q4				
Care, Safety, Pathways, Systems and Communication	Reinvigorate IPC Link network with reps in all clinical depts	Matron IPC	Identify link staff by end of Q3 and invite to Back to Basics event in Autumn.				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**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**						
	Care Group/Divisional meetings	ICNs	To provide expert advice and support as required				
	Decontamination	IPT	To attend quarterly scheduled decontamination meetings. To provide expert advice and support as required.				
	Water Safety	KM	Attend Water Safety Meeting				
	Ventilation Safety	KM	Attend Ventilation Safety Meeting				
	Waste Management	IPT	To provide expert advice and support as required				
	Medical Devices Group	IPT	To provide expert advice and support as required				
	Estates & Facilities	IPT	To provide expert advice and support as required, for capital schemes, linen, catering and other elements.				
	Health & Safety	IPNs	To provide expert advice and support as required				
	Emergency Planning	IPT	To provide expert advice and support as required				
	Health, Work and Wellbeing	IPT	To provide expert advice and support as required				
	ICB meetings	IPT	To attend and provde assurance to commissioners related to IPC				
	NW IPC Regional Meeting	IPT	To engage with and share best practice with peers				
	Ad hoc meetings	IPT	To provide expert advice and support as required				

Title of Meeting	**Trust Board**		**Date**	25 October 2023
Agenda Item	**MWL TB23/051 (14.1)**			
Report Title	STHK Safeguarding Annual Report 2022/23 (Adults & Children)			
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Sue Redfern, Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) has a statutory responsibility to safeguard children, young people, and adults at risk from harm across all service areas in accordance with Section 11 of the Children's Act 2004 and the Care Act 2014. Safeguarding is everybody's business; to help prevent abuse and to act quickly and proportionately to protect children or adults where abuse is suspected, whether staff are working directly or indirectly with children, young people and parents or carers.

The purpose of this annual report is to provide an overview of safeguarding activity across the Trust for the last financial year (April 2022 – March 2023), to provide assurance to the Trust Board and fulfil the Trust's statutory requirements.

Executive Summary

The report provides information and assurance for all aspects of safeguarding during the financial year 2022/23 including:

- Achievement against 2021-22 Annual Safeguarding plan with 4 of the 7 key objectives achieved, ,2 on track and objective related to the implementation of LPS has been delayed indefinitely delayed nationally and will not be considered within the lifetime of the current Government.
- Governance and reporting: Quarterly reporting internally through the governance processes and Safeguarding KPI's are completed on a quarterly basis; these are scrutinised and reported on by St Helens ICB Designated nurses. In addition, an annual Section 11 audit was completed to provide assurance to the Children's Partnership Board in relation to the Trust compliance with Statutory Safeguarding Children responsibility.
- Safeguarding activity has continued to increase year on year for both adults and children's referrals.
- Safeguarding Training: compliance has continued to improve over the 12 months. The ICB have recognised the ongoing pressures within the Trust and appreciate the additional assurances provided with the safeguarding activity recorded.
- Mental capacity Act and Deprivation of Liberty Safeguards (DoLS): the number of Dols applications have continued to increase year on year, there has been a significant increase over the last 4 years.
- Learning disability, autism and the Leder reviews have recent increased focus over the past 12 months to support patients with additional needs.
- the number of adult patients detained to the Trust has decreased this year; however, the complexities and issues relating to delayed discharge due to unavailability of mental health beds continue to prove challenging. The CAMHS attendance for 22/23 has increased related to children and young people under the age of 18 seeking help for mental health with a total of 675 referrals this year.
- External Reviews: The Safeguarding Team have completed 5 rapid reviews chronologies for the

Local Safeguarding Children Partnerships to inform the decision-making process in relation to completion of a Safeguarding Children Practice Review. No cases have progressed to formal multi agency reviews.

- Audit finding of the Safeguarding Team annual audit plan within the KPIs,
- 2023-24 forward plan.

Financial Implications

No financial implications resulting from this report.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to the progress made with safeguarding activity at STHK and to approve the legacy STHK Safeguarding Annual Report 2022/23 (Adults & Children)

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Safeguarding Annual Report
April 2022 – March 2023

Author:

Anne Monteith

Assistant Director of Nursing Safeguarding

Contents

1. Introduction

St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) has a statutory responsibility to safeguard children, young people and adults at risk of harm across all service areas in accordance with Section 11 of the Children's Act 2004 and the Care Act 2014. Safeguarding is everybody's business; to help prevent abuse and to act quickly and proportionately to protect children or adults where abuse is suspected, whether staff are working directly or indirectly with children, young people and parents or carers.

Safeguarding activity is closely monitored by the Care Quality Commission (CQC), NHS England and the Integrated Care Boards (ICB), as well as the Local Safeguarding Children Partnership Boards and Safeguarding Adults Boards.

The purpose of this annual report is to provide an overview of safeguarding activity across the Trust for the last financial year (April 2022 – March 2023), to provide assurance to the Trust Board and fulfil the Trust's statutory requirements.

2. Safeguarding Team Update

Following authorisation of a business case by the Trust Board in August 2022, the capacity within the Safeguarding Team has been increased. This was in response to significant increases in activity and the complexity of cases requiring a safeguarding response, support from the time. The newly created positions were all recruited into by March 2023.

3. Key Achievements

The actions referred to in last year's annual report are listed below with progress marked against them. It is very pleasing to note the progression made, which will be further referenced within the report.

Identified next steps 22/23	Update	Status
Review and increase the staffing within the Safeguarding Team	A business case was completed and authorised in August 2022. Following allocation of funding and a recruitment process, the Team has increased with 2.4 WTE additional band 7 specialist nurses / midwife and 1 WTE Band 6 LD Nurse.	Complete
Prepare for implementation of LPS including improved compliance with the	The implementation of LPS has been delayed indefinitely and will not be considered within the lifetime of the current Government; however, the Safeguarding Team continue to work to	Ongoing

Mental Capacity Act and quality and Timeliness of DoLS applications.	improve compliance with the MCA and implementation of DoLS and have seen significant improvement.	
Continue to improve Training Compliance	The Safeguarding Team continues to monitor training compliance and send reminders to staff. Although significant improvement has been noted 90% compliance has not been achieved in all areas	Ongoing
Review Training Needs Analysis to include mandatory Leaning Disability Training	The TNA has been reviewed and ratified.	Complete
Implement E Learning for Adult and Children Safeguarding Training	The Assistant Director worked with virtual college to design an E learning package for level 2 adult and children training. This has been fully implemented	Complete
Review Management of Allegations Process to ensure all concerns are dealt with in a timely way using a consistent process.	The allegations management process has been reviewed. The Assistant Director of Safeguarding is involved in all cases where staff may pose a risk to children or vulnerable adults ensuring relevant referrals made, risk assessment undertaken, and appropriate action taken.	Complete
Pursue a Service level Agreement to outsource Mental Health Act Administration to Mersey Care Mental Health Trust	Mereycare NHS Trust are currently unable to support an SLA for mental health act administration due to capacity issues; this will be pursued further following the transaction with Southport and Ormskirk.	Ongoing

4. Governance and Reporting Arrangements

4.1 Reporting Arrangements (See Appendix 2)

- Quarterly reports are submitted to the Patient Safety Council, Patient Experience Council and Quality Committee which feeds into the Trust Board. The reporting governance structure is demonstrated in Appendix 1.
- Safeguarding KPI's are completed on a quarterly basis; these are scrutinised and reported on by St Helens ICB Designated nurses. Feedback is captured in Quarterly reports and within the Safeguarding Assurance Meeting agendas.
- An annual Section 11 audit is completed to provide assurance to the Children's Partnership Board in relation to the Trust compliance with Statutory Safeguarding Children responsibility.

4.2 Assurance processes

The following assurance processes are in place to support the Safeguarding Agenda:

- Robust internal governance processes to safeguard children and adults including an Executive lead, a Named Doctor, Named Nurse for Safeguarding Children, Named Nurse Safeguarding Adults and Named Midwife in post.
- Quarterly Trust Safeguarding Assurance Group meetings with invitations to Healthwatch and local ICB for external, additional scrutiny. Meetings continue to be held virtually as this is seen to improve attendance. One meeting was cancelled in January 2023 due to extreme Trust pressures.
- Safer recruitment processes.
- Training of all staff as appropriate for role.
- A suite of Safeguarding policies, providing guidance for staff dealing with any safeguarding issue, concerns regarding mental capacity, allegations against staff and management of domestic abuse (patients and staff).
- Effective supervision arrangements.
- Close partnership working with all key agencies.
- Excellent links with the Complaints Team and Patient Safety Manager where advice will be requested from the Safeguarding Team in relation to cases that may meet the safeguarding threshold.
- The Assistant Director of Safeguarding continues to attend the Serious Incident Review Panel chaired by St Helens providing additional assurance regarding safeguarding process.
- The Safeguarding Children Team provide significant input into the management of child deaths, reporting to and attending CDOP, attending internal review panels and external multi agency meetings, sharing information with community partners and supporting staff.
- Regular safeguarding peer reviews ensure the identification and sharing of learning and good practice.

4.3 Key Performance Indicators

Safeguarding Key Performance Indicators are completed on a quarterly basis and quality assured by St Helens ICB. The areas scrutinised relate to:

- Partnership Working
- Policies and Procedures
- Commissioning standards
- Safeguarding Training
- Looked After Children

Overall compliance during 2022 /23 has provided a rag rating of Amber, this is due to the failure to achieve 90% training compliance in all areas, and breaches in LAC Initial Health Assessments.

5. Safeguarding Activity

The table below shows key activity by the Safeguarding Team. In addition to this there are multiple other meetings across the Organisation which the Safeguarding Team attend, submit information to or support other staff in attending. All MDT meetings continue to be conducted via teams and this appears set to continue, this is seen as a positive as it increases efficiency and enables attendance at more meetings as no travel time required.

Activity	19/20	20/21	21/22	22/23
Children				
Safeguarding Strategy Meetings	93	137	139	154
Safeguarding Referrals	309	531	416	444
CAMHS	525	517	602	675
Adults				
Safeguarding Referrals	126	280	291	348
Strategy meetings	10	30	11	26

The Safeguarding Team support Hospital Acquired Pressure Ulcer (HAPU) meetings and the Community weekly Patient Safety Panel (PSP) meetings. The Safeguarding Team also attend Falls meetings to review the cases reported via STEIS to support the identification of learning and will refer to Local Authority as required if lapses of care are identified or care cannot be evidenced due to poor documentation.

6. Safeguarding Training

The Trust Safeguarding Training Strategy and Training Needs Analysis has been reviewed and ratified. Except for Level 3 Safeguarding Adult Training, all packages are now available via E Learning accessible via ESR or Moodle.

In response to the amendment in the Health and Social Care Act 2022, Learning Disability Training has been added as a mandatory competency for all staff in the organisation; this element of training ha not yet been included in the KPIs.

6.1 Training Compliance

The table below demonstrates the improvements in safeguarding training compliance, the compliance target set by the ICB is 90% across all safeguarding subjects. The Safeguarding Team is actively following staff up regarding this and highlighting area of low compliance to Directorate Managers, Clinical Leads and Heads of Nursing and Quality. The ICB recognise the ongoing pressures within the Trust and appreciate the additional assurances provided with the safeguarding activity recorded.

	Q1	Q2	Q3	Q4	Trajectory

	22/23				
Safeguarding Adults Level 1	92.9%	91%	92.2%	92.5%	↑
Safeguarding Adults Level 2	86.6%	85.7%	89.0%	88.6%	↑
Safeguarding Adults Level 3	85.3%	83.1%	84.1%	89.6%	↑
Safeguarding Children Level 1	91.9%	91.6%	92.3%	92.9%	↑
Safeguarding Children Level 2	82.4%	83.5%	88.0%	88.4%	↑
Safeguarding Children Level 3	76.8%	79.6%	87.2%	82.3%	↑
PREVENT L1-2	90.7%	90.4%	89.5%	91.9%	↑
PREVENT L3	71.5%	75.8%	80.2%	82.4%	↑
Mental Capacity Act (MCA) Training	Not previously recorded		83.3%	82.5%	↓

7. Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

As per the table below, the number DoLS applications have continued to increase year on year; there has been a significant increase over a 4-year period. This is a testament to the Safeguarding Team who quality assures the applications, amend as required, submit to the Local Authority and pursue follow up when an urgent authorisation expires. The Safeguarding Team are attending wards regularly to identify patients who require a DoLS and provide support and supervision to staff. A DATIX is completed when there has been a delay or failure to implement a DoLS.

	Q1	**Q2**	**Q3**	**Q4**	**Total**
2019/20	**91**	**77**	**116**	**89**	373
2020/21	**126**	**157**	**197**	**212**	706
2021/22	**270**	**297**	**301**	**292**	1160
2022/23	**299**	**291**	**333**	**366**	1289

8. Liberty Protection Safeguards

The implementation of LPS has been suspended and will not be further reviewed within the lifetime of the current government. It is recognised that there are still areas of improvement to be addressed relating to compliance with the Mental Capacity Act within the Trust, including completion of mental capacity assessments, best interest decision making and recording, and implementation of DoLS. The Safeguarding Team continue to deliver training and supervision to practitioners.

9. Learning Disability & Autism

9.1 Support

Patients who attend the Trust with a diagnosis of a Learning Disability or Autism should be able to expect high quality, personalised and safe care. The NHSE/I improvement standards for Acute Trusts include:

- Respecting and protecting rights of those with a Learning Disability, ensuring the Trust meets the Equality Act requirements, provides reasonable adjustments and flagging to identify patients and support the additional care required.
- Inclusion and engagement ensuring the patient, family and carers are all empowered and included in the care provided as a partnership
- Ensuring the workforce is resourced and skilled to care for those with a Learning Disability

The Learning Disability Team continues to maintain clear communication pathways between Community LD teams and the Safeguarding Team.

Support for patients admitted to the Trust includes an initial visit by the LDSN to assess the level of the learning disability and the likely support required from the Learning Disability Specialist Nurse; there will be a review of the records and care plan ensuring that any reasonable adjustments required are in place. Reasonable adjustments are also included in the STHK Health Passport. The LDSN will ensure there is communication with the family/ care providers regarding the patient and that they are involved with issues such as DoLS applications or DNA CPR decisions.

9.2 Death Reporting and Review process

During 22/23 24 patients who died within the Trust were coded as having a diagnosis of LD / Autism; 4 of these were coded incorrectly; the remaining 20 were all referred to the LeDER review process, this is the learning from deaths review programme which aims to identify gaps in health care for patients with a Learning Disability with a view to improving health outcomes. As per internal mortality review process, all deaths for LD patients receive a Structured judgement review. No significant gaps in care have been identified to the LD Team.

9.3 Patient Data

The table below highlights the number of patients supported by the LDSN during the reporting period, with apparent increases when compared to the previous year. Due to the increased requirement for support a Band 6 LD nurse was recruited into the team in March 2023.

	Inpatients	Outpatients	Information sharing only	Total
2021/22	418	170	58	646

2022/23	585	133	163	881

10. Mental Health

10.1 Mental health Act Detentions

The Safeguarding Team currently carry out the Mental Health Act administration process for all patients detained to the Trust. As this is a specialist role and takes significant resource from the Team a request for funding was made by the Assistant Director of Safeguarding to support an SLA with Mersey Care to provide this role. Funding was granted, however Merseycare do not currently have the capacity to support this.

As per the table below the number of patients detained to the Trust has decreased this year; however, the complexities and issues relating to delayed discharge due to unavailability of mental health beds continue to prove challenging.

2018/19	66
2019/20	109
2020/21	111
2021/22	118
2022/23	102

10.2 Tribunal Applications

There have been five formal requests for a tribunal by patients detained to the Trust, 3 of the patients were transferred prior to panels being held. Contributing to this process is challenging for the Safeguarding Team given the lack of Mental Health Act administration support.

10.3 Children and Adolescent Mental health Services (CAMHS)

CAMHS attendance for 22/23 are detailed in the table below, there has been increased attendances for children under the age of 18 seeking help for mental health with a total of 675 referrals this year, attendances for the previous year recorded as 602.

	Q1	Q2	Q3	Q4	Total
CAMHS Attendances	185	176	158	156	675

The Paediatric Department has continued to face challenges, particularly relating to discharge of Looked After Children admitted with mental health problems. Cases have required to escalation

within the Trust as well as externally due to issue in sourcing suitable placement. This situation often leads to a significant escalation of challenging behaviour and a significant impact on staff and other patients and families. The Director of Nursing and Named Nurse Safeguarding Children continue to raise these concerns with local and regional commissioners, local authorities, and Partnership Boards. The Trust Legal Team also provide valuable input to these cases.

There is a plan to improve CAMHS provision in 2023/4 with an increase in the CAMHS Response provision for children and young people attending via the Emergency Department. The response time will be reduced from 24 hours to 4 hours and a 24-hour service will be provided. This should result in a significant reduction in admissions.

11. PREVENT

There has been 1 referral made this year under the PREVENT agenda (preventing radicalisation / terrorism); this resulted in no further action by police, but the case was managed via the Allegations process. The Safeguarding Team attend the monthly Knowsley and monthly St Helens Channel panel where those at risk of radicalisation are discussed. The Trust shares information as required for those being discussed as a concern.

12. Management of Domestic Abuse

12.1 Risk assessments and referrals

A MERIT risk assessment is completed when a patient or staff member discloses a history / incident of domestic abuse. A referral is made to MARAC when the risk is scored as high, and a multi-agency response is required. For those cases assessed as lower risk, relevant advice and support is offered to the victim.

The number of MERIT risk assessments completed has increased significantly during 22/23, this provides significant assurance that staff are able to recognise the indicators of domestic abuse and respond appropriately to disclosures.

	18/19	19/20	20/21	21/22	22/23
Total Number of MARAC referrals	**76**	**89**	**96**	**96**	**128**
Total Number of MERIT risk assessments completed	**168**	**173**	**189**	**173**	**246**

12.2 Supervision and Support

- The Safeguarding Team continue to deliver additional ad hoc training to key areas such as the Emergency Department, Maternity, Sexual Health and the UTC
- Support has also been given to Trust staff and / or Managers where domestic abuse is a feature of personal relationships.

- The Safeguarding Team attend fortnightly MARAC meetings within St Helens. Meetings in other adjoining boroughs are attended when a case has been referred; however, information is shared on any other cases to be discussed. Warrington. Alerts are added to records of any victim known to the Trust highlighting the fact that they are deemed to be high risk.

13. Community Services

13.1 General Contract

- The safeguarding team provide advice and support to all services provided within the Community contract.
- The Named Nurse Safeguarding Adults attends the weekly Patient Safety Panel where community staff review incidents and pressure ulcers from the community. There has also been opportunity to address patients who cross between community and the acute.
- The safeguarding children team provide regular planned supervision to staff within the UTC, Sexual health, Community Paediatrics and Marshall Cross surgery. This provides opportunity to discuss key topics, review cases and share learning.

13.2 Looked After Children

STHK is commissioned to complete the Initial Health Assessments (IHA) for St Helens children new into care or children from other boroughs placed in St Helens. IHAs are a statutory requirement and should be completed within 20 days of a child entering the care system.

During 2022/23 only 49% of the 158 assessments were completed within timescales; most breaches were due to delays in notification from the Local Authority, lack of information provided, or children not brought for appointments. However, there were some issues within the STHK service due to lack of appointments due to gaps in Community Paediatrician provision and within the administration team leading to delays in completing reports. Meetings are held regularly with the Designated LAC Nurse to monitor progress and monthly reporting has been requested until compliance is improved.

An overview of the activity provided in relation to looked after Children is detailed in the table below.

Activity	**Contacts**
Initial Health Assessments –completed when a child is taken into care of the local authority.	158
Adult health Assessments – completed to support the recruitment process for foster carers	156
Adoption medicals – completed as part of the adoption process	66

14. Allegations / Staffing Issues

The Safeguarding Team continue to support the Trust with management of allegations. These cases may be allegations in relation to abuse or neglect of a patient or concerns raised in relation to a staff

member and their suitability to work with children and / or vulnerable adult; this could include criminal activity, drug and alcohol issues or concerns of abuse to a child / family member.

During this reporting period 28 concerns were raised from Lead Employer, 18 of which required referral to the LADO, 33 concerns from the Acute Trust, of which 15 were referred to the LADO An additional 19 cases relating to harm or potential harm to vulnerable adult patients, 8 were referred to the Local Authority Adult Safeguarding Team as per the Care Act guidance. The Safeguarding Adult Team attend any adult strategy meetings held by the Local Authority. A member of the Safeguarding Children Team attends all LADO meetings along with HR colleagues, as well as offering advice and support with what can be very complex cases requiring extensive investigation.

All cases are assessed as a matter of urgency via an internal allegation meeting to consider any immediate restrictions that may be required to ensure patient safety; where applicable cases are progressed via the Trust Disciplinary Policy; referrals to relevant governing bodies and DBS are also considered.

15. Partnership Work

The Safeguarding Team has worked hard to maintain all case specific meeting attendances including strategy meetings, MARAC meetings, MDT's, Channel meetings and Core Groups. Meetings continue to be held via TEAMS which is a positive for the Team.
As an identified key agency, the Safeguarding Team represent the Trust at Children and Adult Partnership Board meetings and several subgroups within St Helens, Knowsley and Halton (see Appendix 3 & 4).

16. External Reviews

16.1 Child Safeguarding Partnership Review

The Safeguarding Team have completed 5 rapid reviews chronologies for the Local Safeguarding Children Partnerships to inform the decision-making process in relation to completion of a Safeguarding Children Practice Review. No cases have progressed to formal multi agency reviews.

16.2 Safeguarding Adult Reviews (SAR)

There have been no Safeguarding Adult reviews commissioned in this reporting period.

16.3 Domestic Homicide Reviews (DHR)

The Safeguarding Team have contributed to 4 DHRs during 22/23, sharing information and attending the panels; Trust involvement has been minimal and there has been no immediate learning identified. Any generic learning for health partners will be disseminated following the publication of final reports.

18. Audits

The Safeguarding Team submit an annual audit plan within the KPIs, the tables below summarise the details and findings, which are reported via the Safeguarding Assurance Group.

17.1 Safeguarding Children Audits

Audit	Summary	Outcome & Recommendations
Audit of Completion of Child Exploitation (CE) Screening Tool	Any child or young person who attends Whiston Hospital Emergency Department (ED) should have a safeguarding proforma completed as part of their assessment. If a CE trigger is met on the safeguarding proforma, a CE screening tool must be completed in order to identify any potential CE. This is vital, as CE difficult to detect, particularly as children and young people often do not view their experiences as exploitation. The aim of this audit was to assess compliance against the Trust Safeguarding Policy and Training content which requires Paediatric ED staff to complete a CE screening tool for any child or young person who attends with a safeguarding concern. A sample of 50 ED records were screened at random for attendances in March 2022 of children and young people who were identified as having attended with a safeguarding concern. All children and young people included in the sample were age between 10-18 years. 13 records were excluded from the sample as the attendances were not deemed to be a safeguarding concern.	**Findings** • 16% of the sample had CE tools completed, compared to a compliance of 29% in the 2021 audit. However, of the 36 attendances, 75% had a safeguarding proforma completed, compared to 66% in the 2021 audit. Therefore, highlighting that whilst staff may require additional training regarding the completion of CE tools, the compliance of completing safeguarding proformas has improved since the last audit. • 72% (26) of attendances were related to mental health • 19% (7) of attendances were related to substance misuse • 8% (3) of attendances were related to assault • Of the 6 CE screening tools that were completed, 5 (83%) were related to a mental health admission • A common theme that was identified was incomplete safeguarding proformas. Most commonly, patient identifiers labelled but no further information filled in on the proforma **Action Plan** • The audit will be repeated in 12 months • Findings of the audit to be shared with Named Nurse Safeguarding Children/Lead Nurse Paediatric ED and to

		be disseminated to all Paediatric ED staff • Findings of the audit to be shared with ED consultants and disseminated to all ED doctors • Safeguarding team to continue to provide support and training to Paediatric ED staff regarding the appropriate proformas to complete when safeguarding issues are identified • Safeguarding team to liaise with ED consultants to provide training to doctors during induction/rotation alongside training for ED doctors
Audit of referrals to Children's Social Care	This audit was completed to review the quality and standard of referrals to Children's Social care. Practitioners make referrals when they are requesting an assessment of a child/unborn and family under the guidance of the Children Act 1989. Referrals are made to request assessment under Section 17 (Chid in Need), Section 47 (Child at risk of significant harm) or when risks are assessed at a lower-level completion of an Early Help Assessment (EHAT). A sample of 40 referrals made during Q3 (October to December 2022) were reviewed, all 40 were included in the findings. The samples included referrals from Acute Paediatrics, Community Services and Maternity.	**Findings** • 100% compliance was not achieved in any of the 14 areas, however, 3 out of the 14 standards did improve from the previous year. • Paediatrics did achieve 100% compliance in 6 areas (full name of child, details of trust involvement, level of need completed, copy of referral sent to safeguarding team and copy placed in records) but overall compliance in 11 out of the 14 was lower from the previous year identifying further input is required to improve referrals and with a focus on those from maternity services. • Main areas for improvement include ensuring both parents details are included on referral, analysis of risk and address of parent/carer if not at the same address. **Action Plan** • Audit findings to be submitted within the Q4 KPIs.

		• The areas of poorer compliance will be highlighted in safeguarding supervision and within Safeguarding Training. • Safeguarding team to increase scrutiny of referrals and provide specific feedback and support for individuals. • The audit will be repeated in 12 months' time. • We will review the audit information further and try to identify any specific staff members or departments that require additional safeguarding support to help improve the compliance with high quality social care referrals
Audit of Special Care Baby Unit (SCBU) Discharge Paediatric Liaison Forms	This audit was completed to review the quality and standard of completed Special Care Baby Unit (SCBU) discharge paediatric liaison forms. These forms are completed by SCBU staff at point of baby's discharge from the unit. Paediatric liaison forms are completed to ensure there is appropriate information sharing from the Trust to the community practitioner responsible to the baby. The aim of the audit was to assess compliance in the adequate completion of these forms which requires staff to complete forms fully with all relevant details including demographics, reasons for admission, overview of stay, any specialist team involvement and discharge plan. A sample of 40 SCBU Paediatric Liaison forms completed during Q3 2022 (October to December 2022) were reviewed, all 40 were included in the findings.	**Findings** • 100% compliance was achieved in 3 areas, baby's name, birth details and reason for admission had been adequate. • Only one form had been completed with 100% compliance in all areas. • The lowest compliance was in relation to the recording of parent's details, where both parents' details were recorded on 15% of the forms. • However, 100% did contain Mum's details. • Safeguarding issues had been recorded on 5 of the 40 Liaison forms, 3 of those 5 forms were completed fully. • 2 forms required Paediatric liaison staff to record additional information on the forms: a) details of the social care referral made, b) details of discharge to foster care, prior to sharing them with the Health Visitor. • Adequate information regarding discharge / discharge planning was seen on 65% of all forms. Main issues identified were

		abbreviations being used, no reasons for Hospital at home involvement and missing clinical information. **Action Plan** • Audit findings to be shared within the Safeguarding and Liaison team. • The areas of poorer compliance will be highlighted in education sessions • Paediatric Liaison team to increase daily scrutiny of forms received and provide specific feedback and support for individuals to aid improvement in the completion of high-quality Paediatric Liaison forms. • Meeting to be planned with SCBU Department Manager in respect of completion of the Paediatric liaison, to explore any barriers to completing forms and the use of the SCBU Badger system reports. • The audit will be repeated in 12 months' time. • Further and try to identify any specific staff members or departments that require additional support in form completion.
Audit of Quality of Antenatal MISF (Maternity Information Sharing Form)	This audit was completed to review the quality of documentation on the maternity information sharing forms (MISF). A MISF is completed when a Midwife identifies issues that other professionals need to be aware of to enable them to provide effective care, i.e., CSC involvement, Mental Health issues, substance misuse, and previous traumatic delivery/sexual assaults. The MISF is shared with Health Visitor, GP and other appropriate professionals as required.	**Findings** • This is the first audit of MISF's, however anecdotally there has been a significant improvement in MISF's being uploaded to Medway and alerts being added, and they are being shared with paediatric liaison, we were unable to audit if they were shared with the GP, as this is by internal mail. • The information being shared was, in the majority of cases, clear, however a plan is not always put in place, or followed up, and this can have significant safeguarding implications

	The MISF should be shared with the GP, paediatric liaison, uploaded to Medway for maternity staff to access and shared with other maternity units as appropriate. They are quality assured by the safeguarding midwives to ensure actions have been followed based on the information being shared and appropriate plans are in place and progressing throughout the pregnancy, therefore the quality of this information is vital. The aim of the audit was to assess the quality of the demographics, information being shared, any plans and if the MISF has been shared appropriately. A sample of 50 MISF's were reviewed, all 50 were included in the findings where applicable, for example, if no other children, they were removed from the audit question about other children.	• Demographics were poor, in particular for partners, children and partners children • Another common occurrence - midwife receives the information from their 'information request' submitted to social care and informed the case is closed – further questions are not being asked, for example, reason for closure as it could be that the child was removed from their care, or history of DV and they had ended the relationship, but now resumed and pregnant again • Common missing information for woman: - NHS number, hospital number, phone number, parity • Common missing information for partner: - Address, DOB, phone number, 1 MISF said 'see Medway' • When MISF's are uploaded to Medway they are not being named as MISF's, which can make locating them in the journey more difficult • Alert should just say MISF on the alert banner on Medway – 'link to alert' is being used on the description of document being uploaded 'filing' rather than in 'plans and referrals' **Action Plan** • The audit will be repeated in 12 months' time. • Audit report to be shared at O&G Clinical Governance meeting • Key Findings to be added to the Maternity newsletter • Safeguarding Midwives to continue to review MISF's to ensure processes are followed and actions completed.
Audit of Safe Sleep Discussions	This audit was carried out to re-audit the compliance with the Merseyside Safe Sleep pathway.	**Findings** • 9 completed assessment tools were not returned to Whiston to enable them to be uploaded to Medway

	This was measured by reviewing the electronic records on Medway Maternity. The purpose of the audit was to further explore how well safe sleep practice was embedded in the core midwifery workforce considering the findings of the initial, and subsequent audit. **Audit criteria** Is there any evidence of a discussion around safe sleep antenatally. Is there any evidence of a discussion around safe sleep prior to discharge from hospital. Is there any evidence of a discussion around safe sleep by the Community Midwife at home. Was the Safe Sleep Assessment tool completed. Was the assessment tool signed by parent. Evidence a room a room thermometer provided. Was there evidence that viewing the baby's sleeping arrangements was offered. Was an action plan completed if required. Is there any evidence that the Safe Sleep messages were discussed again prior to discharge from the Community Midwife Is there any evidence that the action plan was revisited (if applicable) prior to discharge from community midwife A sample of 30 electronic records were reviewed, all 30 were included in the findings. 11 from St Helens, 10 from Halton and 9 from Knowsley locality	• 40% (4) assessments were completed in Halton, and none were returned to Whiston for uploading – it has become apparent the Halton community midwives were not initially advised to complete the safe sleep assessment tool or to return them to Whiston **Since the 2019 audit,** • Discussion around safe sleep antenatally had reduced from 71% to 17% • Discussion on discharge from hospital was similar 70% as opposed to 73% - if documented 'discharge pack given', these were included in the audit • Discussion by the community midwife at home increased from 82% to 96% and 77% of assessment tools were completed, which remained the same • It appears that fewer sleeping arrangements were viewed 43%, as opposed to 82% - this may be due to the assessment tools not being returned to Whiston, so evidence not available **Action Plan** • The audit will be repeated in 12 months' time. • Findings of the audit to be shared with Head of Midwifery and Maternity Matrons and further disseminated to all midwifery/obstetric staff • Community Midwives, ANC and FMAU midwives to have the safe sleep discussion at least once during the antenatal period • Unit Midwives to ensure safe sleep discussion is held prior to discharge and document on Medway Workflow, and provide the Lullaby Trust leaflet

		• Community Midwives to be reminded to complete the assessment tool and return to the community office in Whiston, safeguarding administrator will upload to Medway • Safeguarding Midwives to continue to discuss as part of the midwifery study day / new starter training • Safe sleep materials are no longer available via CDOP, with the exception of the Safe Sleep thermometer, these need collecting on a regular basis from CDOP in Liverpool to be available for the midwives.

17.2 Safeguarding Adults Audits

<table>
<tr><th>Audit</th><th>Summary</th><th>Outcome & Recommendations</th></tr>
<tr>
<td>Safeguarding Adult Team Contacts</td>
<td>This audit has been carried out to review the quality and standard of contact into the Safeguarding Adult Team.

The aim of the audit is to assess the number of contacts to the Safeguarding Team which progress to a referral to the local authority in accordance with the Care Act.

A sample of 73 contacts during a two-week period of Q3 2022 were reviewed and categorised into the following classifications:

<table>
<tr><td>Safeguarding</td></tr>
<tr><td>Advice to professionals</td></tr>
<tr><td>Complex cases</td></tr>
<tr><td>Concern for patient</td></tr>
<tr><td>Lasting Power of Attorney</td></tr>
<tr><td>Domestic Abuse</td></tr>
<tr><td>Care Concern</td></tr>
</table>
</td>
<td>Summarised findings from the audit demonstrated that a large proportion of the cases did not meet the criteria for a safeguarding referral to the local authority however, contacts into the team continue to increase and it is recognised that STHK staff are considering safeguarding.

Recommendations:

• Safeguarding training continues to enable to staff to correctly identify safeguarding issues and raise them with the safeguarding team.
• To improve visibility of safeguarding team on wards offering ad hoc supervision particularly when safeguarding issues are identified by the team.
• Careflow Connect referrals are a new way to contact the safeguarding team. STHK staff can now contact the safeguarding team via Careflow Connect. Information required on the connect referral include situation, background, assessment and recommendation.</td>
</tr>
<tr>
<td>Mental Capacity Act & DoLS</td>
<td>This audit was completed to ensure patients' rights are met in line with requirements of good practice and STHK's legal obligation to safeguard patients right and to continue to promote the importance of MCA and embed into practice.

• To establish the number of DoLs applications received in August 2022</td>
<td>There is evidence that the Mental Capacity Act and DoLS do not appear to be fully embedded into practice. Targeted training has been provided to Preceptorship Students and bespoke sessions have been delivered to ward staff. However there continues to be a limited understanding and knowledge about the MCA 2005 and confidence in applying it to clinical practice.</td>
</tr>
</table>

	• To establish the number of Mental Capacity assessments received in August 2022 • To establish if DoLs application were submitted in a timely manner • To evaluate if information provided by the wards meets legal requirements and good practice • To inform future practice in relation to future developments, particularly the implementation of Liberty Protection Safeguards (LPS)	Limited evidence of capacity assessments submitted with DoLS application The majority of DoLS Form1 submitted do not include how the 'acid test' is met; there are also omissions about the level of care and intervention provided to the patient; sometimes an impairment of the mind or brain is not indicated. Positively, the majority of DoLS forms are submitted in a timely manner. **Recommendations:** • Safeguarding team to attend wards regularly to support staff with the recognition of and completion of DoLS authorisations. • DATIX to be completed for late referrals • MCA training compliance to be monitored monthly • Ad Hoc training to be offered to ward areas where compliance is highlighted as an issue

18. Next Steps 2023/24

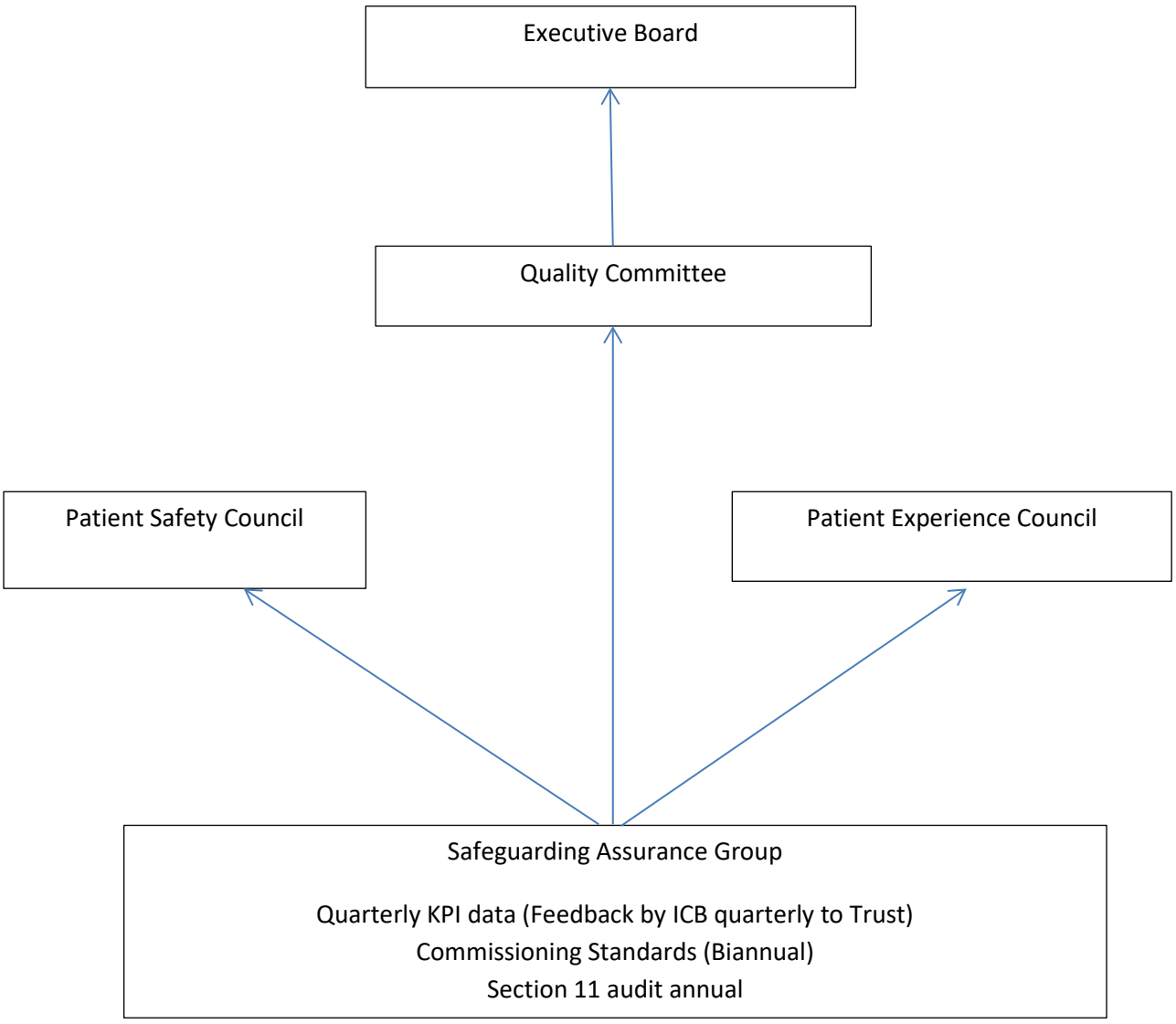
The following actions will form the basis of the Safeguarding activity in the coming year:

- Continue to improve training compliance with a view to achieving 90% across all areas.
- Continue to improve compliance with the Mental Capacity Act including best interest decision making and recording and implementation of DoLS.
- Review and harmonise safeguarding policies and processes to support the transaction with Southport and Ormskirk hospitals.
- Improve implementation of learning from Safeguarding Adult Incidents investigated by the Local Authority.
- Utilise digital technology within the current IT systems to streamline and improve referral processes into the Safeguarding Teams.

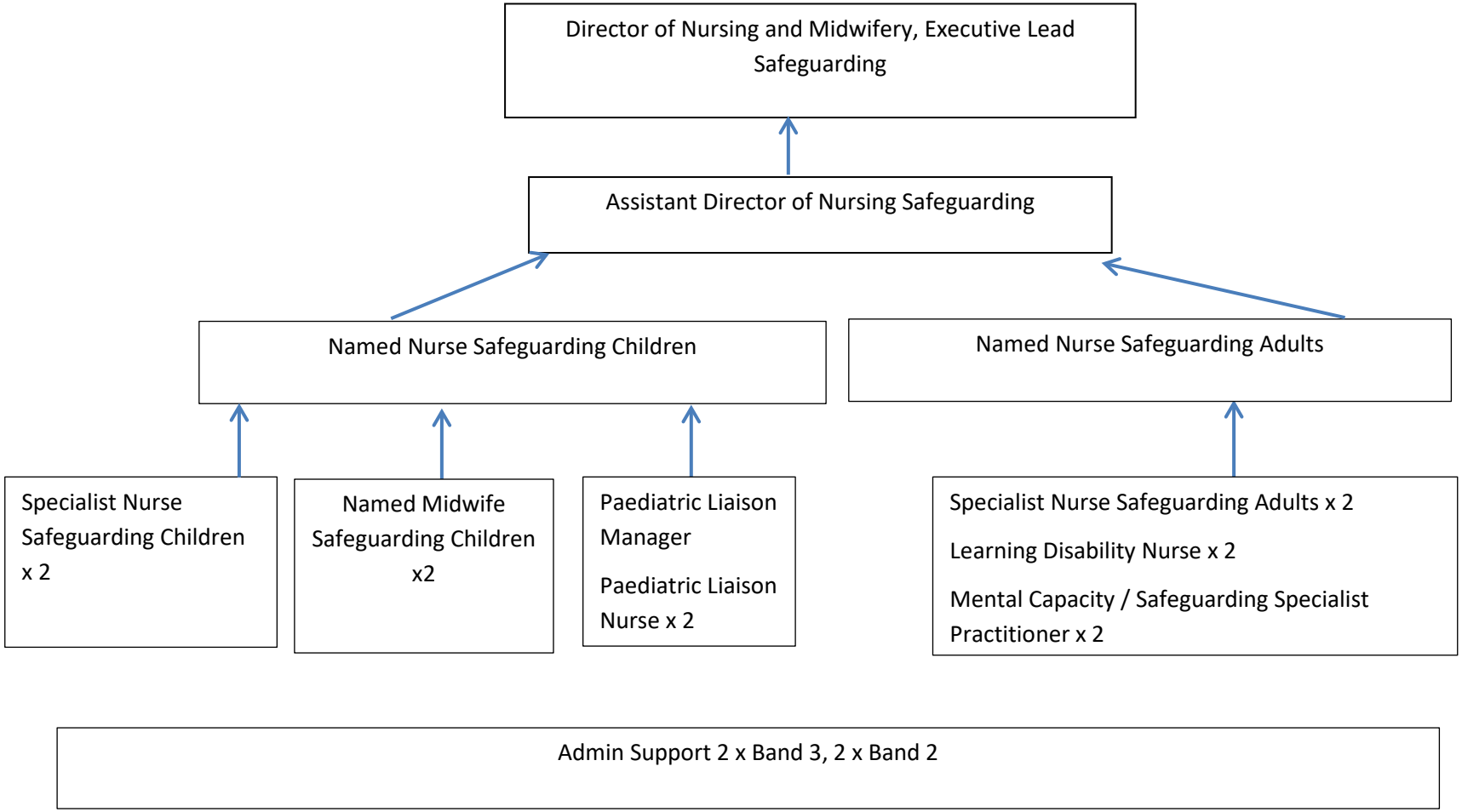
19. Glossary

Acronym	Meaning
CDOP	Child Death Overview Panel
CAMHS	Children and Adolescents Mental Health Services
CQC	Care Quality Commission
CYPMHS	Children and Young People Mental Health Services
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DOLS	Deprivation of Liberty Safeguards
ED	Emergency Department
HAPU	Hospital Acquired Pressure Ulcer
ICB	Integrated Care Board
KPI	Key Performance Indicators
LADO	Local Authority Designated Officer
LD	Learning Disability
LDSN	Learning Disability Specialist Nurse
MACE	Multi Agency Child Exploitation meeting
MARAC	Multi Agency Risk Assessment Conference – for high risk / gold domestic abuse cases.
MeRIT	Merseyside Risk Identification Tool – for domestic abuse cases, indicates whether support services are required or referral to MARAC, although professional judgement can overrule scoring to make a referral to MARAC.
MSP	Making Safeguarding Personal
NHSE	National Health Service England
NSPCC	National Society for the Prevention of Cruelty to Children
PSP	Patient Safety Panel (Community)
RAG	Red / Amber /Green rating
Section 11	Section 11 audit - places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children
STHK	St Helens and Knowsley Teaching Hospital NHS Trust
TNA	Training Needs Analysis
UTC	Urgent Treatment Centre

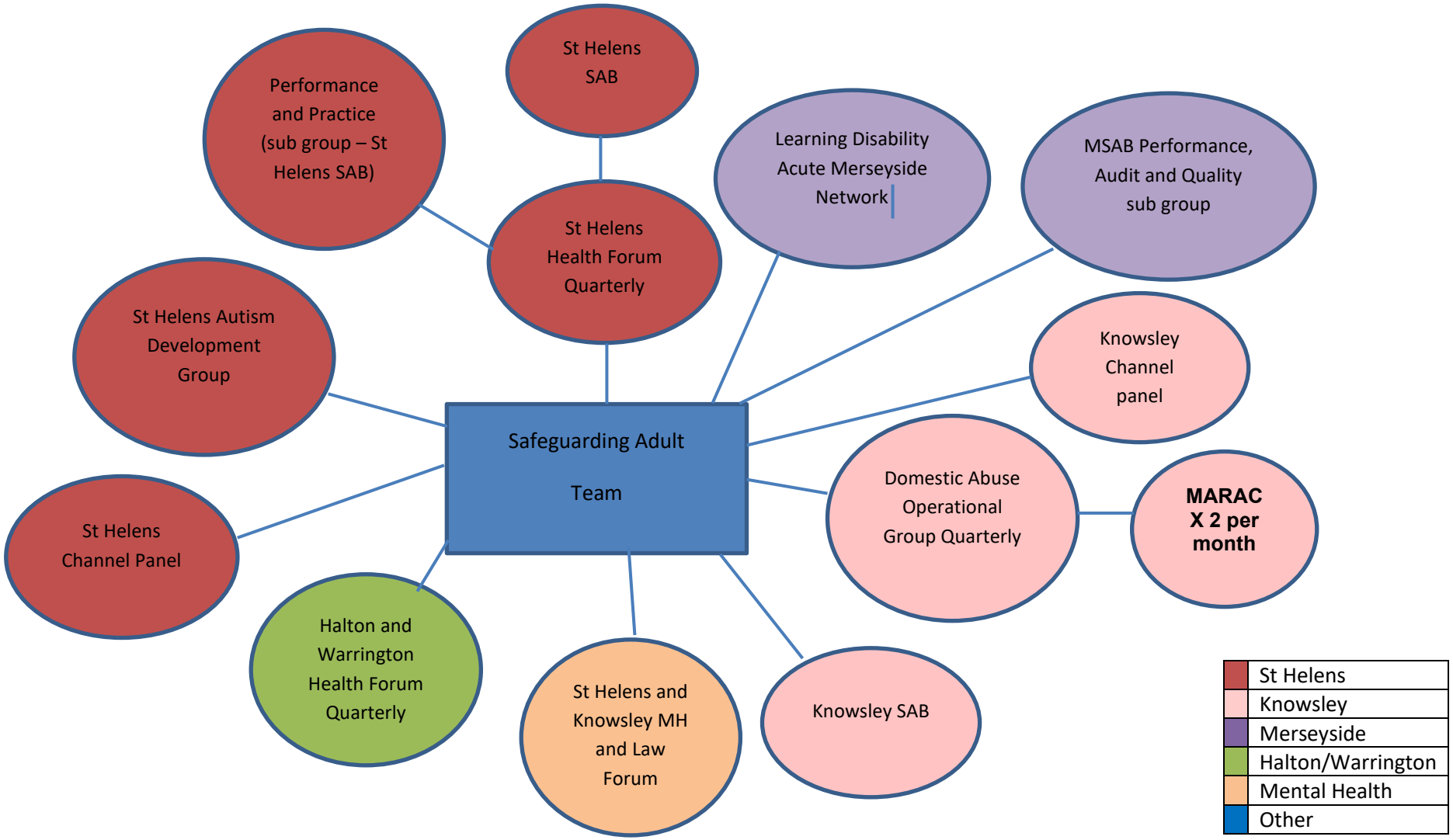
Appendix 1 Safeguarding Governance Structure



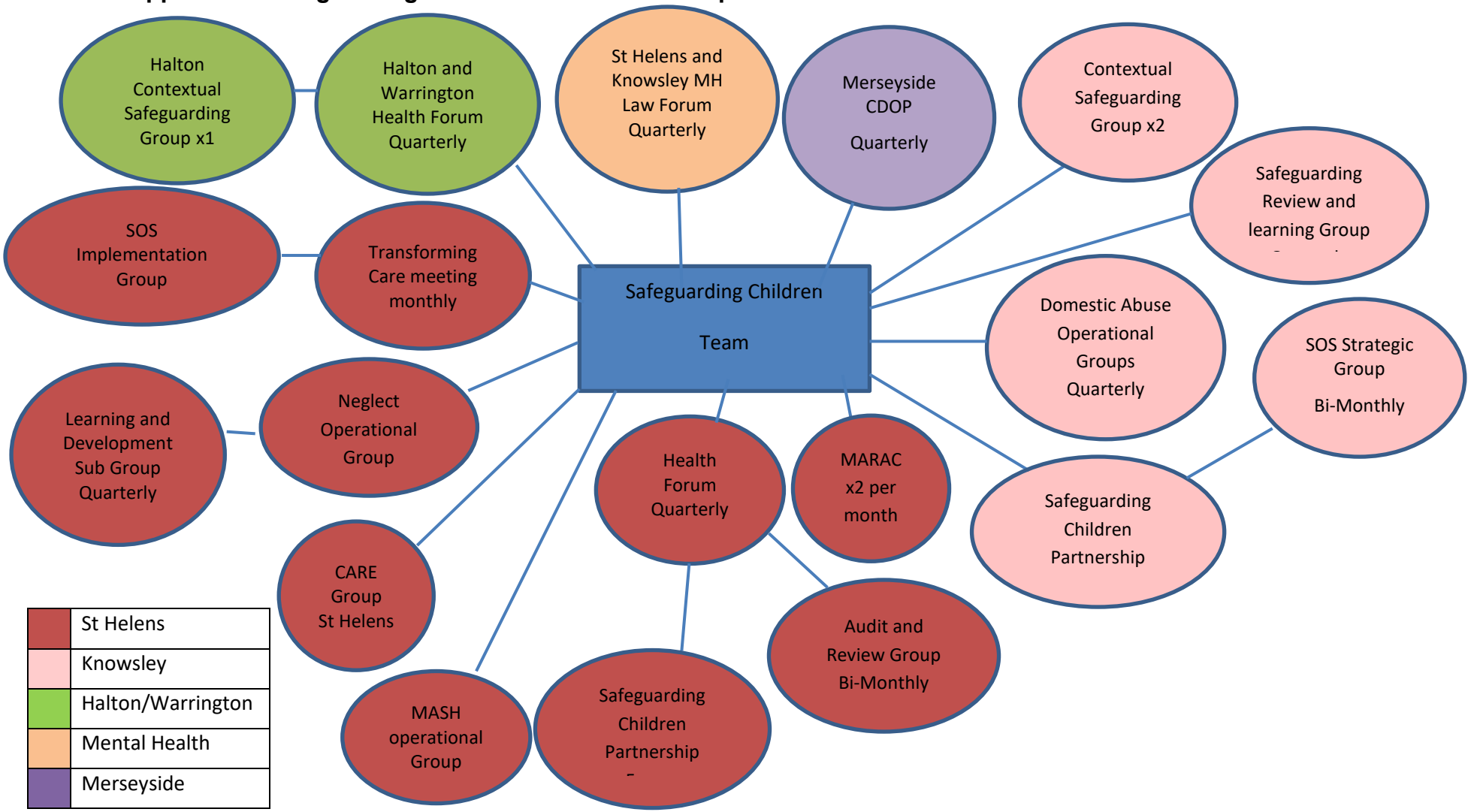
Appendix 2 Safeguarding Roles and Structure



Appendix 3 Safeguarding Adults Partnership Work



Appendix 4 Safeguarding Children Team Partnership Work



Title of Meeting	**Trust Board**		**Date**	25 October 2023
Agenda Item	**MWL TB23/051 (14.2)**			
Report Title	S&O Safeguarding Annual Report 2022/23 (Adults & Children)			
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Sue Redfern, Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

The Trust (S&O) has a statutory responsibility to safeguard children, young people, and adults at risk from harm across all service areas in accordance with Section 11 of the Children's Act 2004 and the Care Act 2014. Safeguarding is everybody's business; to help prevent abuse and to act quickly and proportionately to protect children or adults where abuse is suspected, whether staff are working directly or indirectly with children, young people and parents or carers.

The purpose of this annual report is to provide an overview of safeguarding activity across the Trust for the last financial year (April 2022 to March 2023), to provide assurance to the Trust Board and fulfil the Trust's statutory requirements.

Executive Summary

The report provides information and assurance for all aspects of safeguarding during the financial year 2022/23 including:

Key achievements in 2022-23.

- Governance and reporting: Quarterly reporting internally through the governance processes and Safeguarding KPI's are completed on a quarterly basis; these are scrutinised and reported on by Sefton Place Designated nurses. The Trust's safeguarding policies are currently all in date.
- Engagement with external partners
- Training: A compliance of greater than >90% was achieved consistently throughout the year other than in level 2 adult training which was maintained at an average of 89.3% across this year. Q4 saw an unexpected drop in the children's L3 training.
- Safeguarding activity has continued to increase year on year for both adults and children's referrals. In 2022/2023 there has been 1034 safeguarding concerns, including 174 for domestic abuse and 213 for sexual abuse, this is a 22% increase from 2021/22.
- Safeguarding Training: compliance has continued to improve over the 12 months. The ICB have
- Mental capacity Act and Deprivation of Liberty Safeguards (DoLS): the number of Dols applications have continued to increase year on year. This year has seen an 8.4% increase in the number of referrals for a DoLS authorisation to 1857,
- In 2022/2023 the children's team were involved with 1208 referrals including Children's Social Care (CSC), early help, information sharing and courtesy calls.
- Learning disability, autism and the Leder reviews have recent increased focus over the past 12 months to support patients with additional needs.
- The CAMHS attendance for 22/23 has increased related to children and young people under the age of 18 seeking help for mental health.
- Audit finding of the Safeguarding Team annual audit plan within the KPIs,
- 2023-24 forward plan.

Financial Implications
No financial implications resulting from this report.
Quality and/or Equality Impact
Not applicable
Recommendations
The Board is asked to note the progress made with safeguarding activity at S&O and to approve the legacy S&O Safeguarding Annual Report 2022/23 (Adults & Children)

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Safeguarding Team Annual Report 2022/23

Author: Sharon Seton

Assistant Director of Safeguarding

Contents

Glossary of terms

AED	Accident and Emergency Department
ASC	Adult Social Care
CBU	Clinical Business Unit
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CE	Child Exploitation
CP	Child Protection
CQC	Care Quality Commission
CP-IS	Child Protection Information System
CSC	Children's Social Care
CSAP	Children's Safeguarding Assurance Partnership
CSPR	Child Safeguarding Practice Review
DBS	Disclosure and Barring Scheme
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
EHCP	Education and Health Care Plan
ESR	Electronic Staff Records
FGM	Female Genital Mutilation
GMC	Greater Medical Council
HSVLO	Health sexual violence liaison officer
ICB	Integrated Care Board
ICON	This is a babies cry and it's ok campaign.
IDVA	Independent Domestic Violence Advisor
ISVA	Independent Sexual Violence Advisor
JTAI	Joint Targeted Area Inspection (Ofsted, CQC, IPCC)
KPI	Key Performance Indicator
LD	Learning Disability
LA	Local Authority
LADO	(Local Authority) Designated Officer
LPS	Liberty Protection Safeguards
LSAB	Local Safeguarding Adult's Board
LSCB	Local Safeguarding Children's Board
MACSE	Multi Agency Child Sexual Exploitation
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MHLT	Mental Health Liaison Team
MSP	Making Safeguarding Personal
NHSE	National Health Service England
NHSI	NHS Improvement
NMC	Nursing and Midwifery Council
RAG	Red / Amber / Green
Section 42 Inquiry	Safeguarding Adults investigation coordinated by the Local Authority

1.0 EXECUTIVE SUMMARY

1.1 The safeguarding annual report for 2022 / 2023 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 1st April 2022 – 31st March 2023. The purpose of the annual report is to inform the Trust Board of safeguarding activity, providing assurance that the organisation has robust processes in place to safeguard those who use Trust services, and to highlight areas of challenges in safeguarding provision.

1.2 All NHS bodies have a statutory duty to ensure they make arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse, and support the Home Office Counter Terrorism strategy (CONTEST), which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Some of the key legislative frameworks to support safeguarding include: The Children Act (2004); Working Together to Safeguard Children (2018); Mental Capacity Act (2005); The Human Rights Act (1998); The Care Act (2014); Equality Act (2010).

1.3 The CQC fundamental standards require the Trust to ensure that suitable arrangements are in place to ensure that all service users are protected from the risk of abuse, and that internal processes are in place to reduce the potential for abuse.

1.4 The Trust safeguarding team is responsible for ensuring that robust and effective systems are in place to support the Trust in working effectively to safeguard the un-born, children, young people and adults who are at risk of abuse or neglect.

1.5 The safeguarding team is a multi-functional team providing both operational and corporate responsibilities across the hospital sites, with the adult team based at Southport and the children team based at Ormskirk. The team work closely with both Sefton Metropolitan Borough and Lancashire County Councils and support the work of the Local Safeguarding Boards for Merseyside and Lancashire.

1.6 **Key roles of the team include:**

- We provide support and an extensive safeguarding knowledge to all staff across the Trust.
- We provide daily operational responsibility for safeguarding concerns, recognising when a concern may require referral to external partners.
- We provide a Trust contact for the Local Authorities and all other external agencies, for the process of referrals and for the sharing of relevant information.
- We work with partner agencies to ensure the decisions and processes support the ways of working for an acute Trust.
- We lead and ensure a Trust-wide culture that supports staff in identifying and raising safeguarding concerns.
- We participate with Local Safeguarding Board processes to learn lessons from cases where the un-born, children or adults die, or are seriously harmed because of abuse.
- We ensure engagement with Local Safeguarding Boards and any local arrangements for safeguarding both adults and children.
- We ensure Trust staff access training that is complaint to the intercollegiate documents for safeguarding adults and children; monitoring and improving compliance and escalating as appropriate.
- We ensure the Trust works and is compliant with legislation and statutory responsibilities.

1.7 This report demonstrates the work Southport and Ormskirk NHS Trust has in continuing to fulfil its responsibilities to safeguard the un-born, children, young people and adults, in line with statutory requirements and national standards. The report details the effectiveness of safeguarding arrangements for children, young people and adults. It illustrates continued engagement with key partners and demonstrates compliance with the requirements and key objectives of the Local Safeguarding Children Boards (LSCBs/CSAP), and Local Safeguarding Adult Boards (LSABs).

1.8 From the quarterly submission of key performance indicators (KPIs) to Sefton Place, the Trust achieves a RAG rating of green in relation to Local Authority children and adult referrals, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

1.9 Case scenarios at the end of the report will provide examples of the impact of safeguarding on patient experience, the complexities of cases the safeguarding team become involved in, and the diverse nature of safeguarding work. They will demonstrate how important it is that the Trust staff are professionally curious to understand the reason for attendance at the Trust, and the importance of wider assessment to understand the risks.

2.0 INTRODUCTION

2.1 The team structure is set out in Appendix 1, with the statutory roles of the Named Nurse for Adult's and Named Nurse for Children's reporting directly to the Assistant Director Safeguarding. The statutory role of the Named Midwife reports directly to the Named Nurse for Children's.

2.2 As detailed in the Safeguarding Children and Young People: roles and competencies for healthcare staff intercollegiate document (2018), the Trust has a Named Doctor for child protection. The role incorporates supporting colleagues with safeguarding concerns and undertaking safeguarding training. The enhanced medical training consists of 3 monthly peer review sessions, and 6 monthly peer review of child protection medical reports, which is also included in the new trainee's training. The Named Doctor attends monthly safeguarding huddles with the safeguarding team and attends the Safeguarding Assurance Group.

2.3 In accordance with local safeguarding children's board child death processes and detailed in Working Together to Safeguard Children (2018), the Trust has a Designated Doctor for child deaths, who is a senior paediatrician, and takes a lead role in the child death review process.

2.4 The safeguarding team has continued its journey of improving safeguarding arrangements within the Trust throughout 2022/23. The team continue to strive for continuous and sustained improvement, in relation to the safeguarding policies being in place, training compliance and responding proportionality and in a timely manner to safeguarding concerns.

2.5 Key Achievements in 2022-2023

- We recruited successfully to the post of Named Nurse
- We recruited successfully to three vacant safeguarding practitioner posts (two of the safeguarding practitioners left the Trust for promotion and one re-located).
- We developed and presented a business case for a substantive Learning Disability and Autism Practitioner.
- We recruited to the Learning Disability and Autism Practitioner, and the post holder became integrated into the safeguarding team.

- We provided a secondment opportunity for a member of the paediatric ward staff to support the safeguarding team.
- We made a successful bid to the Ministry of Justice for a Health Independent Domestic Abuse Advisor (HIDVA) for West Lancashire.
- We recruited to an HIDVA, and the post holder became integrated into the safeguarding team.
- We supported Sefton Local Authority with a successful bid to the Ministry of Justice for a Health Independent Domestic Abuse Advisor (HIDVA) for Sefton.
- We supported Sefton Local Authority with the HIDVA for Sefton becoming integrated into the safeguarding team.
- We developed a Memorandum of Understanding with Sefton Local Authority for the provision of the HIDVA at Southport and Ormskirk sites.
- We introduced MAYBO Personal Safety Training for clinical staff.
- We collaborated with Merseycare's Mental Health Act Administration team to ensure patients are detained at the Trust under the correct legal framework and have seen improvements in relation to completion of Mental Health Act (MHA) documentation and patient rights being offered.
- We worked with colleagues in IT and BI to develop a Deprivation of Liberty Safeguard (DOLS) portal, which has streamlined the DOLS process for both clinical staff and the safeguarding administrator.
- We have made improvements to develop the workforce to care for patients with a learning disability and or autism.
- We have made improvements to ensure the Trust is complaint with Learning Disability Improvement Standards by 2023/24.
- We completed and submitted the Liberty Protection Safeguards (LPS) Code of Practice feedback.
- We developed and presented an executive summary for the implementation of LPS.
- We supported the LPS steering groups in both Lancashire and Cheshire and Merseyside.
- We achieved adherence to the S42 Memorandum of Understanding with Sefton Local authority.
- We continued the development of a network of safeguarding ambassadors.
- We sought to maintain training compliance ensuring compliance to the intercollegiate documents.
- We supported the Sefton Children's Social Care with their improvement action plan following the publication of the Ofsted visit.
- We continued to facilitate training for the partnership via the training pool.
- We empowered staff to care for 16- and 17-year-old in an adult setting through the implementation of a Standard Operating Procedure.
- We implemented more drop-in and supervision safeguarding children's sessions in the Adult Accident and Emergency department (AED).
- We implemented attending the daily Paediatric Accident and Emergency Department (PAED) safety huddle.
- We reviewed and streamlined databases to identify relevant trends and themes.
- We reviewed the Termination of Pregnancy procedures following the publication of a CSPR.
- We processed an 8% increase in DoLS authorisations.

- We provided 97% compliance in the MARAC (multi-agency risk assessment conference) process, by attending 35 out of 36 meetings.
- We introduced a safeguarding ambassador forum meeting.
- We supported Paediatric Liaison with development of their processes.

2.6 The team has utilised several methods to communicate and raise awareness across the Trust this includes:

Safeguarding children's link nurse	Attends steering group and links into safeguarding children team
Safeguarding ambassadors	Launched January 2020 across the Trust to support sharing information and disseminate training/lessons learned
Representation at the planned and unplanned governance meetings	Core agenda item at the monthly meeting
Representation at the Paediatric Department meeting	Core agenda item at the monthly meeting
Included in Trust news	7-minute briefings / Local SCB and Local SAB newsletters / /safety notices / safeguarding ambassadors / links to Local SABs
Safeguarding Briefs	Newsletters circulated to all L3 children's leads to disseminate within their teams. External training circulated to all L3 children's leads to disseminate to their teams.

3.0 GOVERNANCE ARRANGEMENTS

3.1 The Trust has a Safeguarding Assurance Group (SAG). The meeting is attended by representatives from the Local Authority, and Designated Nurses from Sefton Place and the safeguarding Lead at Lancashire Integrated Care Board (ICB). The meeting has regular representation from the Associate Directors of Nursing, Midwives and Allied Health Professionals. The meetings have been chaired by the Director of Nursing, Midwifery and Therapies. An advice, alert, assure (AAA) report from the meeting is submitted to the Trust Quality and Safety Committee.

3.2 A quartile KPI report is submitted to Sefton Place, after which Sefton Place provide an assurance report for the Trust. The Assistant Director of Safeguarding undertakes business meetings with the Designated Nurse and Designated Practitioner for Sefton place. The meeting occurs prior to the SAG meeting and the purpose is to review the KPI return for the previous quarter. The KPI return feedback is an agenda item at the Trust Contract & Clinical Quality Review Meeting (CCQRM), which the Assistant Director of Safeguarding attends when requested.

3.3 The children's safeguarding team attends the monthly Paediatric Department Meeting (PDM) and has a monthly children's steering group meeting with attendance from the relevant Clinical Business Units. The Named Nurse for Adult has regular representation at the governance meetings for planned and emergency care and provides a safeguarding report for each of these meetings.

3.4 The Trust's safeguarding policies are currently all in date. Policies are approved by the Safeguarding Assurance Group; governance meeting for planned and emergency care;

department meeting in specialist services; workforce committee as required, before finally being presented through the Trust policy ratification process.

4.0 ENGAGEMENT WITH EXTERNAL PARTNERS

4.1 The Assistant Director of Safeguarding provides membership at both the Lancashire and Sefton Local Safeguarding Adult Boards. In Lancashire and Sefton, the providers do not attend the Local Children's Safeguarding Boards, although the Assistant Director of Safeguarding provides Trust representation at the Safeguarding System Leaders meeting for both Sefton and Lancashire. Membership at the Boards ensures that the Trust is sighted on all aspects of the safeguarding agenda, and attending the Board allows the Trust to influence the local and national agenda. It further allows the Trust to develop policies and practices that are aligned to the Local Safeguarding Boards.

4.2 The Assistant Director of Safeguarding, Named Nurses and Safeguarding Practitioners represent the Trust at both Lancashire and Sefton Local SAB and Local SCB/CSAP sub-groups and at wider safeguarding partnership meeting and this includes the below:

There is representation by a member of the adults safeguarding team at the below meetings:

- Sefton Process, Practice and Messaging
- Sefton Quality and Audit
- Sefton Mental Wellbeing
- Sefton Learning from Review, Development and Skills
- Sefton Communications, quality and process
- Lancashire Voice/MSP Group
- Lancashire Complex Vulnerabilities Group
- Sefton Domestic Abuse Partnership Board
- Sefton Health System Leaders Meeting
- Lancashire Health Providers Forum
- Lancashire Mental Capacity and Deprivation of Liberty Safeguards
- MARAC Sefton
- MARAC Sefton steering group
- Sefton SEND Health Improvement Group
- Lancashire and Sefton SEND champions group
- Sefton Channel Panel
- Sefton and Lancashire LEDER Operational Group
- LEDER Review Panel Meeting
- Sefton and Cheshire and Mersey LPS Implementation Steering Group
- VAWG Strategic Board
- DHR Panel meetings as required

4.3 There is representation by a member of the children's safeguarding team at:

- Lancashire Connectivity meeting
- Sefton MACE
- Sefton Multi Agency Audit group
- Lancashire Multi Agency Audit group
- Lancashire MARAC

- Lancashire MARAC Working Group
- Northwest Named Midwife Regional meeting
- Lancashire CSAP Tactical Group
- Lancashire MASH Q&A
- Sefton training pool
- Sefton Learning and development group
- Sefton Policy and Procedure group
- Sefton CE strategic group
- Lancashire SUDC meeting
- Sefton SUDIC Improvement group
- Lancashire CDOP
- Sefton CDOP
- CSAP Task and Finish group 'Children whose Medical needs are Neglected'
- Sefton MASH Health Meeting
- Lancashire Safer Sleep Group

4.4 Attendance at the groups allows the Trust to have up-to-date knowledge and informs areas for focus within the team's strategic agenda. Membership allows the team to be part of the development of safeguarding across Sefton and Lancashire and ensures that Trust processes are in line with partner agencies. Through these subgroups, the team can be involved in the development of policies, audits, tools and training to meet the standards required by the Local SAB's and Local SCB/CSAP.

4.5 One of the children's Specialist Practitioners is a member of the Sefton 'Training Pool' supporting and delivering safeguarding training across the network, as requested.

4.6 The Named Midwife is a member of the National Maternity Safeguarding Network and attends meetings monthly at Northwest regional Meeting. The Named Midwife is also a member of Northwest Named Midwife Regional Group which meets on the second Wednesday of each month. The Named Midwife is a member of CDOP for both Lancashire and Sefton and is represented on both CDOP panels. The Named Midwife is a member of Early Help Partnership for Sefton. The Named Midwife attends monthly meetings with Sefton & Lancashire Children's Social Care Managers, to discuss and review referrals and open cases in relation to the un-born/new-born. The Named Midwife attends the Children's Safeguarding Connectivity Meeting with designated professionals from Lancashire ICB. The Named Midwife is a member of the Sefton SUDIC Improvement Group & Lancashire SUDC group. The Named Midwife is also a member of Lancashire Safer Sleep group reviewing policies and improving best practice.

4.7 The safeguarding team endeavour to provide 100% representation at all requested strategy meetings, child protection conferences and core group meetings when relevant to attend. Reports for these meeting may be provided verbally, written or via email, as requested. The safeguarding team support the SAR/CSPR process by providing requested chronologies; providing panel membership; ensuring participation at practitioner events. The safeguarding team provide representation at local MACE, CDOP and MARAC meetings. Prior to the meetings the team complete all requests for information within the given timeframe, and subsequent actions from these meetings are completed. The safeguarding team will support clinical staff to complete court reports, and the team ensure all reports are quality assured prior to submission.

4.8 In order to recognise safeguarding concerns the adult team attend the monthly 'regular attenders' meeting at Southport's AED, which includes representation from community Matrons; NWAS; community drug and alcohol service; mental health Liaison team (MHLT); Local Authority. When required the Named Nurses will organise and host multi- professional and multi-agency meetings, to share concerns and discuss specific cases and agree a plan of care.

5.0 TRAINING COMPLIANCE

5.1 A compliance of greater than >90% was achieved consistently throughout the year other than in level 2 adult training which was maintained at an average of 89.3% across this year. Q4 saw an unexpected drop in the children's L3 training. This may be attributed to clinical pressures and strike activity. At this point a trajectory was submitted to Sefton Place and targeted improvements implemented.

5.2 The mental capacity training has not achieved the required 90% in the past 6 months. Level 2 consists of three modules and is undertaken by most clinical staff. Level 3 consists of five modules and is mostly undertaken by the medical staff. Trajectories have been provided to Sefton Place, although the trajectory has not been achieved in this year.

5.3 In Q4 the Executive Board is compliant at 91.7%.

Table 1: Southport and Ormskirk NHS Trust Safeguarding Training Compliance

Overall Trust Compliance	Q1	Q2	Q3	Q4
Safeguarding Adults Level 1	94.5%	93.2%	90.9%	93.1%
Safeguarding Adults Level 2	89.7%	89.7%	88.7%	89.2%
Safeguarding Adults Level 3	96.3%	90.3%	96.3%	93.8%
Safeguarding Children Level 1	93.1%	92.4%	90.5%	93.5%
Safeguarding Children Level 2	91.6%	91.1%	90.2%	89.7%
Safeguarding Children Level 3	90.7%	90%	90.2%	82.1%

5.4 Mental Capacity Act and Deprivation of Liberty Training

The below represents the compliance of MCA level 2 and MCA level 3 training combined.

Overall Trust Compliance	Q1	Q2	Q3	Q4
Mental Capacity	82.4	81%	76%	73.3%

5.5 Each month the Clinical Business Units (CBUs) receive the Trust training report and can monitor their compliance levels. The Associate Directors Nursing, Midwifery and Allied Health professionals are required to present a recovery report to the Safeguarding Assurance Group, should their compliance be below 90% in any one or more levels.

5.6 E-learning is provided for Level 1 and Level 2 safeguarding adults; Level 1 and Level 2 safeguarding children; Mental Capacity Act (MCA); Deprivation of Liberty Safeguards; PREVENT Level 3 -5.

5.7 Face-to-face training has resumed for level 3 children's training, although those staff who are non-compliant can complete a e-reader with additional notes, that is updated each year.

5.8 In addition to the training above the Safeguarding Team delivery bespoke training to:

- Doctors' induction covering general safeguarding and MCA and DoLS
- International Nurses covering MCA and DoLS
- Bespoke sessions to AED, Spinal Injuries and Ward staff covering safeguarding and MCA and DOLS
- Bespoke sessions to AED, Sexual Health and Maternity covering Domestic Abuse and Sexual Abuse

5.9 All relevant Local Safeguarding Board Training is shared through social media, Trust news and the Children's steering group.

5.10 During this year the Safeguarding Ambassadors programme focused specifically on MCA and DOLS. This year to support the release staff the programme was restructured allowing ambassadors to complete enhanced safeguarding training in one session rather than four. It is the ambition of the safeguarding team to have at least one ambassador in all clinical areas who receive additional awareness training in a range of subjects. Topics to date have included: MCA and DoLS; self-neglect; domestic and sexual abuse; children's safeguarding.

5.11 Safeguarding children's training is reviewed yearly and the themes this year have included: Social Care and Early Help referrals; language and documentation; Mental Health, Young People, Suicide and Self-Harm; Neglect, Failure to thrive; Record keeping; Physical Abuse and non-accidental injury; ICON; FGM; CSPRs.

5.12 The safeguarding team attend an array of multi-agency training to maintain their compliance to level 4 training. This year training undertaken includes restorative supervision, trauma informed practice and resilience, child exploitation, sexual abuse referral, and fabricated and induced illness/perplexing presentations.

5.13 The Assistant Director of Safeguarding secured funding to implement 'Personal Safety Training' delivered by Maybo, which commenced in October 2022, with one one-day course and one two-day course being delivered each month. This training provides staff with enhanced knowledge for managing behaviours of concern, understanding the potential reasons for this behaviour, using distraction techniques, and maintaining own safety in the least restrictive manner. This implementation has resulted in collaboration with colleagues at St. Helens and Knowsley NHS Trust (STHK) to review the future of the training across all sites.

6.0 SAFEGUARDING ACTIVITY

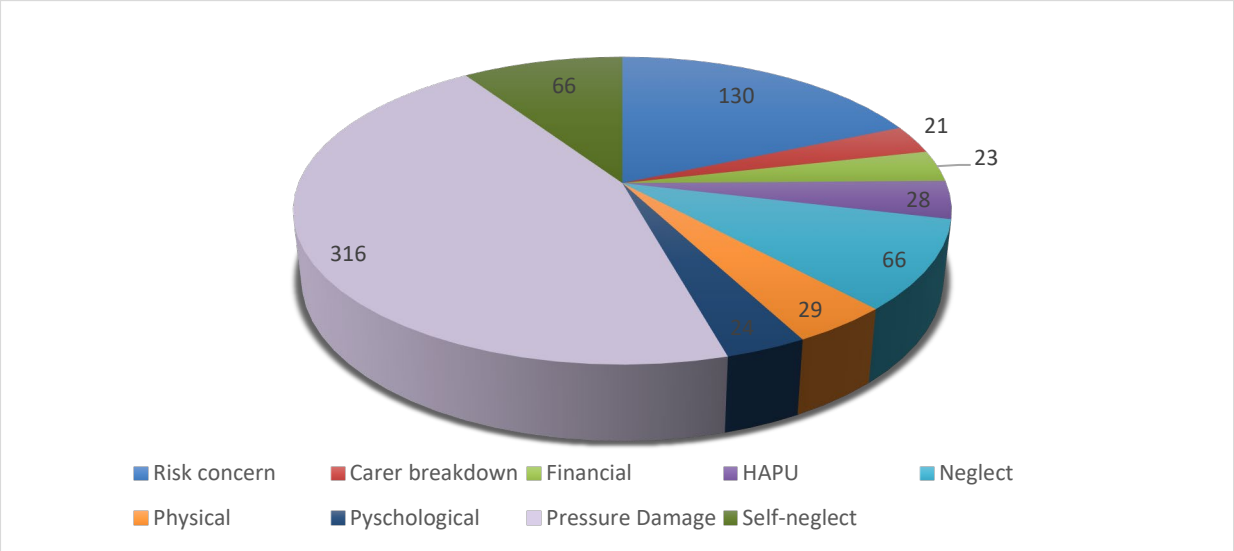
6.1 Adults

6.2 The adult's team collates data regarding safeguarding referrals and safeguarding concerns raised within the Trust. The data is extrapolated from completed datix's and allows the team to identify areas of concern.

6.3 In 2022/2023 there has been 1034 safeguarding concerns (Table 2), including 174 for domestic abuse and 213 for sexual abuse, this is a 22% increase from 2021/22, although it must be noted that some of the domestic and sexual abuse cases are the same individual who has reported both types of abuse.

6.4 In addition, there has been 1857 applications for a DoLS authorisation, an increase of 8.4% compared to 2021/2022. This reflects the year-on-year increase in DOLS which overall has increased by 195% in the past 5 years. Each of these applications is processed and quality assured by the safeguarding administrator.

Table 2: Adult Safeguarding Concerns Concern as reported via Datix (excluding DoLS, Domestic Abuse and Sexual Abuse)



N.B. The category of 'risk concern' includes were safeguarding advise may be sought but does not require further intervention from the safeguarding team.

6.5 Data shows that 157 of the concerns raised (excluding domestic abuse and sexual abuse) required a referral to a Local Authority (LA). It is worth noting that not all referrals to the LA would have progressed to a safeguarding inquiry under S42 of the Care Act, 2014.

6.6 For adult safeguarding referrals, other than in an emergency when the LA 'duty team' will be contacted, staff complete an internal referral form which is then attached to the datix. All safeguarding concerns will be quality assured and checked by the safeguarding team prior to submission to the LA; again, this excludes emergency safeguarding concerns out of hours.

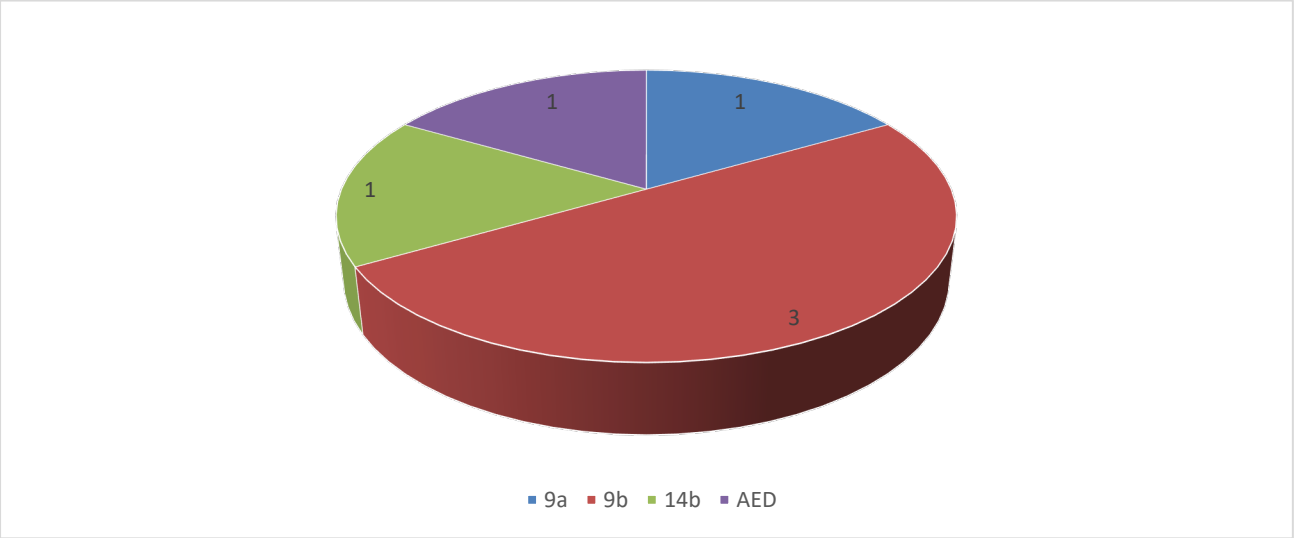
6.7 The adult team oversee two work-streams in terms of safeguarding referrals. The first relates to safeguarding alerts made by frontline staff. The second relates to safeguarding concerns raised

against the Trust. These are investigated by the Local Authority under Section 42 of The Care Act 2014.

6.8 All S42s against the Trust are sent from the Local Authority Safeguarding Team to the Trust's adult safeguarding team, who oversee the investigation and liaise with the Local Authority regarding the outcomes. In 2022/2023 there has been 6, S42 concerns raised against the Trust. This demonstrates a 70% decrease from the previous year in the number of S42's received. This is possibly due to the Memorandum of Understanding that is in place with Sefton Local Authority. This results in the safeguarding team and the Local Authority safeguarding team meeting regularly to ascertain the best course of action for when a safeguarding concern is raised, as not all concerns raised meet the criteria for a S42. With the addition of the safeguarding team providing relevant and timely information the LA are no longer required to undertake a S42 enquiry.

6.9 The themes from the S42s remain relatively consistent and are mostly in relation to concerns raised during the discharge process. All concerns raised against the Trust enter the 'harm-free' care process and are presented at the weekly 'harm-free' care meeting, to provide oversight of the investigation, learning and subsequent actions.

Table 3: Adult Safeguarding Concerns against the Trust (S42)



6.10 Making Safeguarding Personal

Where adults have capacity 'Making Safeguarding Personal' (MSP) allows them to express the outcomes they would want, and to uphold their right to refuse a referral, (where there is no concern regarding the wider public interest, or risk of serious harm to themselves). In accordance with the principal of MSP there were 47 individuals who had capacity to refuse intervention, and a referral was not made. This is an 81% increase from 2021/2022.

6.11 Children and Young People

In 2022/2023 the children's team were involved with 1208 referrals including Children's Social Care (CSC), early help, information sharing and courtesy calls (Table 4). The themes identified in the referrals are detailed in Table 5.

Following a referral and after meeting the criteria for a 'children and family assessment' the child is identified as:

- that the child is not 'In Need'. In this case, Children's Services will take no further action other than, where appropriate, to provide information and advice in accordance with the local Common Assessment Framework.
- that the child is 'In Need', but it has been determined that the child is not suffering, or considered likely to suffer, significant harm. In this case, Children's Services will determine the support which will be provided and draw up a 'Child in Need' plan accordingly.
- that the child is 'In Need' and that there are concerns that the child is suffering, or considered likely to suffer, significant harm. In which case, Children's Services will initiate a Strategy Discussion to determine whether a Section 47 investigation is necessary; and consider whether any immediate protective action is also required.

6.12 CSC do not routinely share the outcomes of referrals; however, this has improved as the team actively chase these outcomes, therefore for 2022/2023 it not known exactly how many of the Trust's referrals proceeded to a 'child in need' and or S47. For the outcomes that have been received 64 proceeded to a children and family assessment (CAF), and 21 referrals resulted in a S47 order. In this year, the Trust undertook 17 child protection medicals, which can be used as part of a S47 investigation. It is worth noting the safeguarding team will the receive the initial outcome but will not know the end outcome of the child and family assessment or S47.

6.13 The team provide 100% attendance at meetings where it is relevant and appropriate for the Trust to be represented. This year the team have provided representation for at least 288 meeting, which is a 48.5% increase from the previous year. These meetings have included but not limited to:

- 100 Strategy meetings
- 32 Child Protection Conferences
- 19 Child in Need meeting
- 40 Core Groups meetings
- 51 Discharge meetings
- 12 Professionals meeting and 9 Planning meetings

<u>Table 4:</u> Safeguarding Referrals (including early help), Information Sharing, Courtesy Calls to Children's Social Care

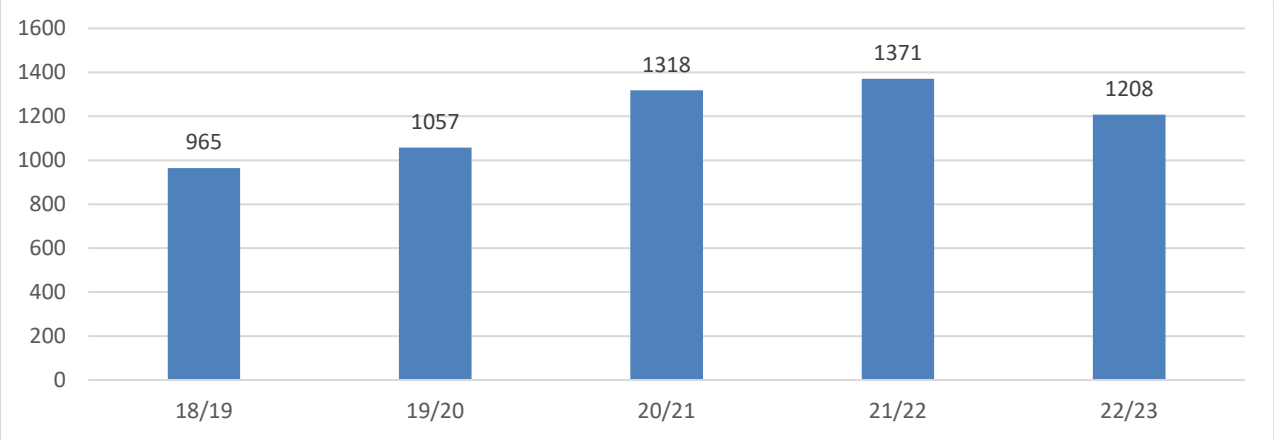
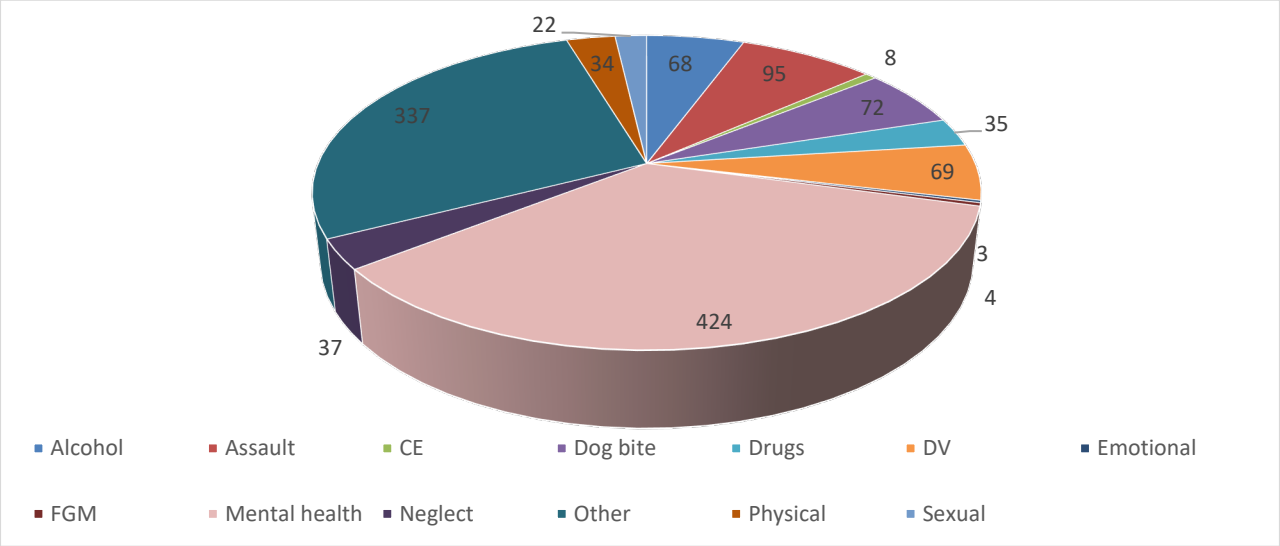


Table 5: Referral Theme by Primary Reason where this is recorded



N.B. The category of 'other' is mostly information sharing and other examples include: additional support needs, CSC are already involved, asylum seekers, early help, CSC currently involved, medical information required.

6.14 This year the themes have remained consistent with no significant increase or decrease in any one area that would require a deeper understanding.

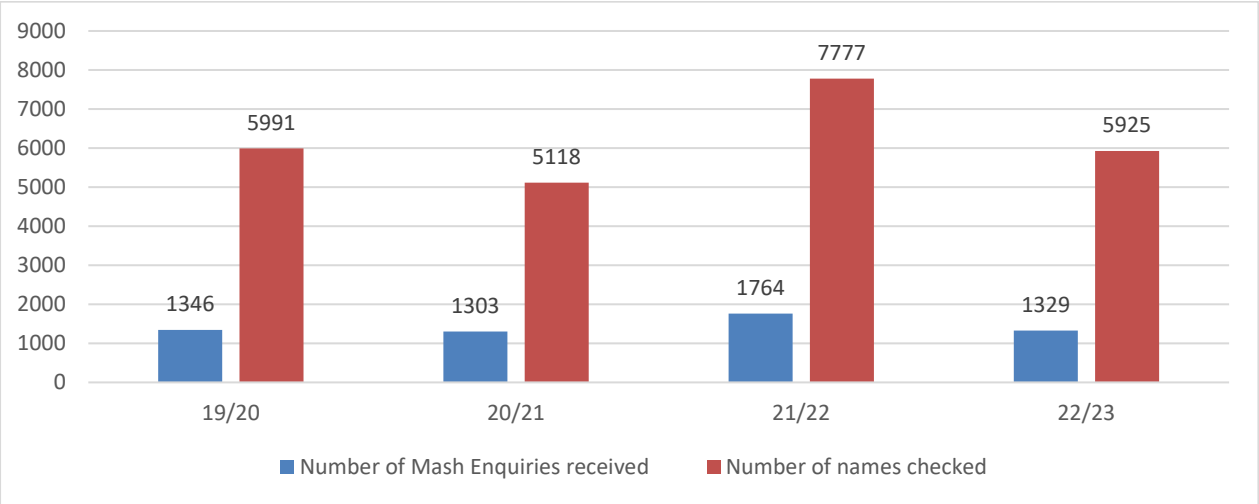
6.15 The children's team have undertaken focused improvement work with AED by presenting weekly short training sessions with staff to discuss the use of the under 18 AED CAS card, the safeguarding process and safeguarding referrals.

6.16 The children's team is required to provide an extensive amount of safeguarding information to external agencies, (Table 6). To deliver this information in a timely manner, the team has a 'duty 1' and 'duty 2,' with one duty responding to internal operational concerns, and the other duty responding to external requests for information. The team has been commended for their responsive and timely return of this information.

6.17 A single request for information can involve searching the clinical records of several patients, as the search can include a child, their siblings, their parents, grandparents and other members of the extended family. Recognising the impact of this, the MASH team had previously streamlined their process by only requesting information for relevant individuals, and by asking

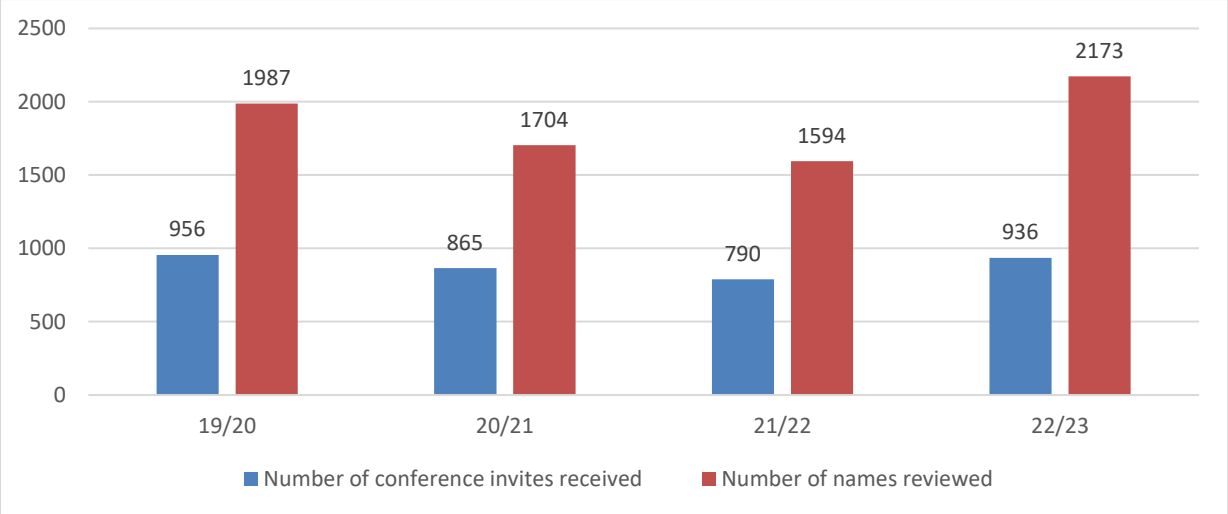
for information only dating back 2 years, (this is reflected in table 6). As an extra assurance the safeguarding practitioners will use their professional judgement, as to whether to disclose information dating back further than 2 years.

Table 6: Multi-agency Safeguarding Hub Requests for information.



6.18 This year the children's team have received invites to over 936 case conferences, (Table 7), resulting in over 2173 children's clinical records being reviewed, this is a 36% increase on the number of clinical records reviewed compared to 2021/2022. It is also worth noting the number of records checked is much higher as this figure does not include the parents' records and significant others records that are also searched.

Table 7: Case Conference Invites and Requests for Information



7.0 CHILD DEATH OVERVIEW PANEL (CDOP)

7.1 The Named Midwife and Named Nurse Children are CDOP Panel Members. The Trust meets its requirements in relation to the Local Safeguarding Children's Board child death processes, for

both Sefton and Lancashire. During this year, the Trust has received 45 child death notifications. This is a 29.7% decrease from the previous year.

7.2 Of these children, 11 were known to the Trust. In accordance with the CDOP process, all requests for further information were returned within timeframe, whether the child was known or unknown.

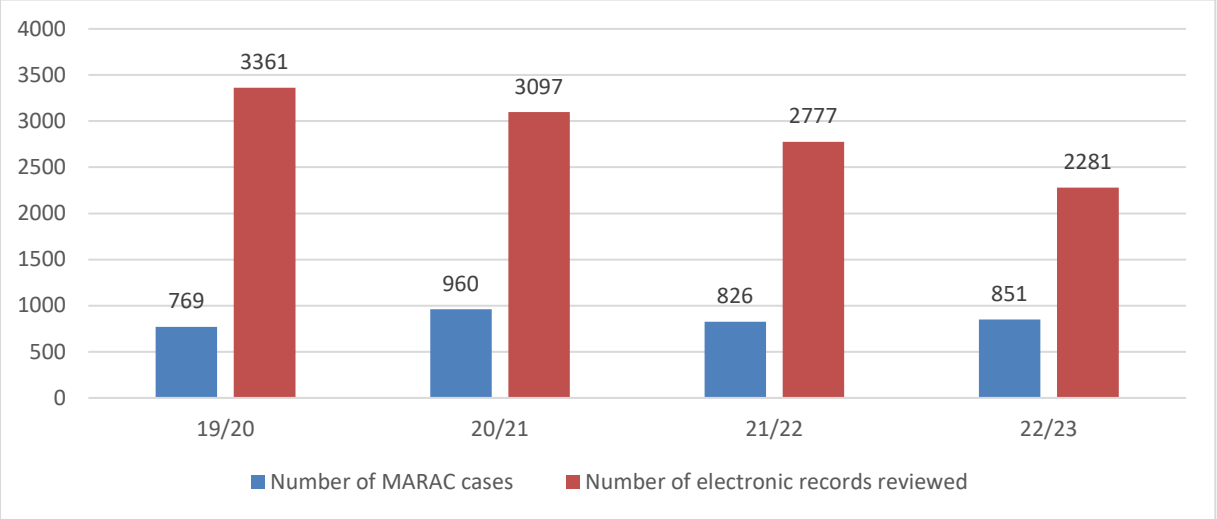
8.0 DOMESTIC ABUSE and SEXUAL ABUSE

8.1 There is recognition that domestic abuse (DA) covers a range of behaviors, and relationships, and domestic abuse is recognised under The Care Act 2014 with its own category. In 2020 there were 2.3 million adults aged between 16-74 who experienced domestic abuse (ONS, 2020). The Domestic Abuse Act 2021 came into force following the Domestic Abuse Bill being agreed by the House of Commons and the House of Lords 2022. The Domestic Abuse Act is the first act to provide a legal definition of 'Domestic Abuse'. The Act allows for wider recognition in relation to domestic abuse related crimes as well as recognition to victims, survivors, and perpetrators. It emphasises that Domestic Abuse is not just physical violence, but it can also be emotional, controlling, coercive and economic abuse. Following the publication of the Act, the team updated the Domestic Abuse Policy accordingly.

8.2 The Trust had 97% attendance (35 out of 36 attended) at the MARAC meetings in this year for Lancashire and Sefton. For the one MARAC meeting not attended relevant information was provided prior to the meeting to support decision making. The Trust continues to achieve100% compliance with adding the relevant alerts to the patient's clinical records within the 7-day timeframe, and there is a process in place to remove the flag if in 12 months no further incidents regarding the individual are referred to MARAC.

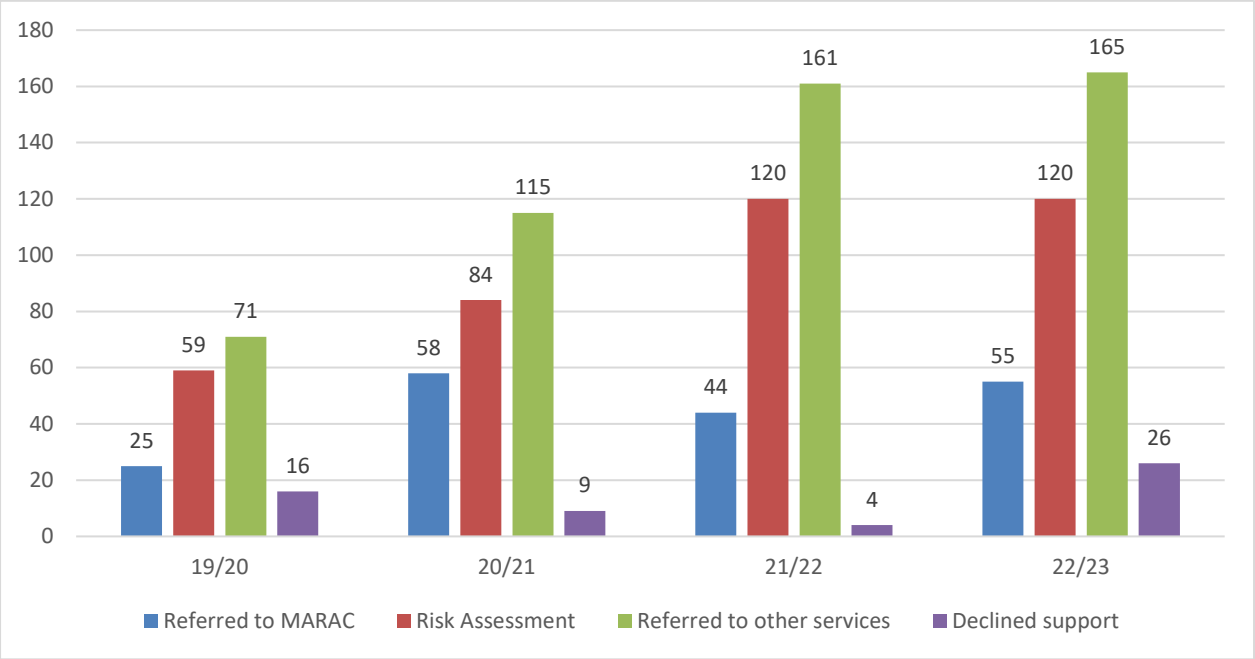
8.3 In 2022/2023 there were 851 MARAC cases, representing a 3% increase compared to the previous year. This resulted in 2281 electronic patient records being reviewed, (Table 8), as each case requires the patient's and their significant others electronic patient record to be searched, in order that relevant and proportionate information is shared during the MARAC meeting.

Table 8: MARAC requests for information



8.4 In incidents and or disclosure of actual or suspected domestic abuse, staff use the domestic abuse risk assessment to determine the most appropriate referral, (Table 9). This year the number of risk assessments completed has remained consistent. The referral to MARAC is undertaken by the safeguarding team, following a review of the datix and the risk assessment, and after the engagement of the person disclosing the abuse, and this year has seen a 25% increase to MARAC, indicating an increase in the number of 'high risk' cases being disclosure.

Table 9: Risk assessments and referrals to MARAC

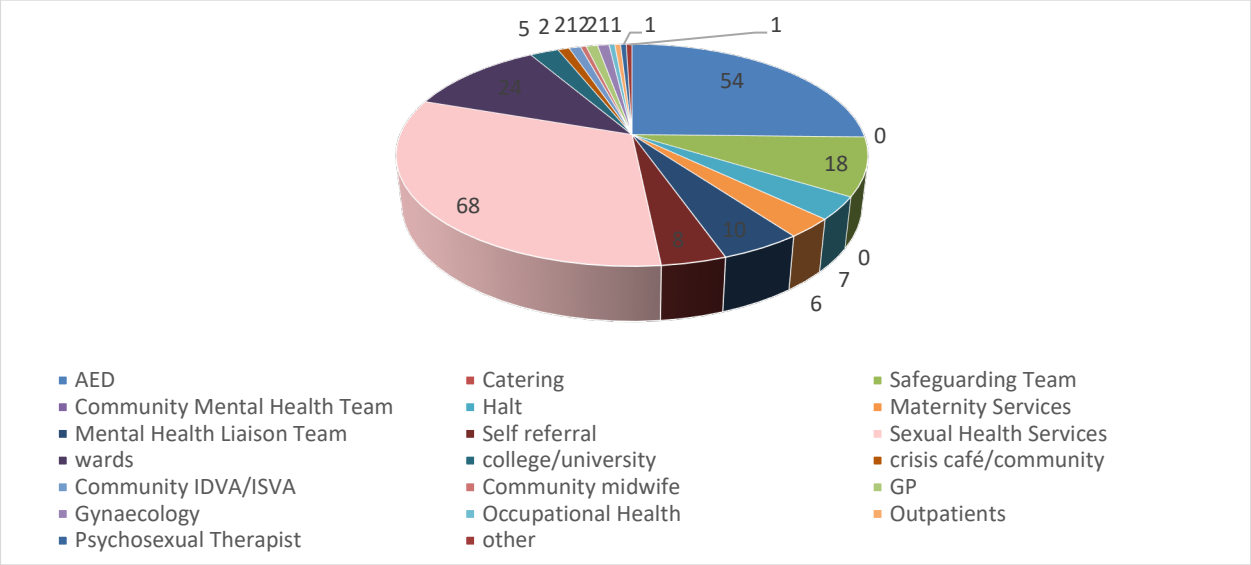


8.5 The safeguarding Team further provides support to staff who are the victim of domestic abuse.

8.6 **Health Independent Sexual Violence Adviser (ISVA)**

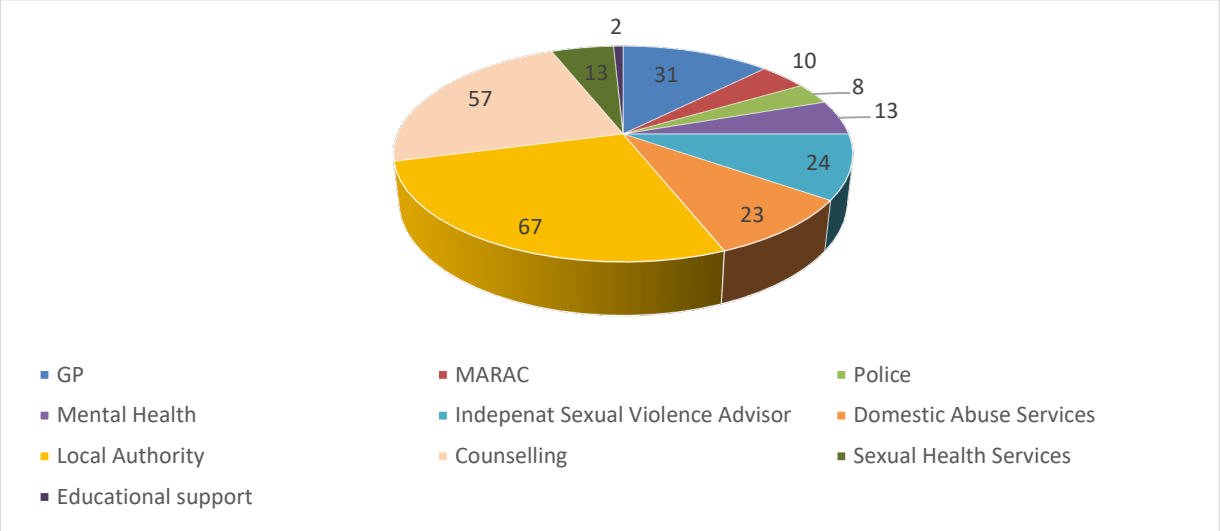
8.7 The Health Independent Sexual Violence Adviser (ISVA) is based within the safeguarding team (although employed by Blackpool Teaching Hospital). The role provides specialised support to victims of sexual abuse, male or female, aged 16 years and above, who have recently or in the past been subjected to any form of sexual abuse. In this year there have been 213 referrals made from a range of sources, (Table 10).

Table 10: HISVA Referral Source



8.8 Between April 2022 to March 2023 the percentage of patients not open to any Sexual Abuse Services prior to HISVA engagement was 80%, and the percentage of patients who had experienced recent sexual abuse (in last 10 days) was 26%, with 71% experiencing non-recent sexual abuse.

Table 11: Referrals to Support Services



9.0 DOMESTIC HOMICIDE REVIEWS (DHR's)

9.1 During 2022/2023 the Trust has been involved in 5 DHR's, which includes providing extensive chronologies (one dating back 25 years); undertaking individual management reports (IMR); providing Trust representation for all panel meetings.

9.2 The DHR's produce a final published report that the panel members approve, and the recommendations for each agency are included in report. To date the yet unpublished recommendations for the Trust include the provision of and Independent Domestic Violence Advisor (IDVA), ensuring routine enquiry at key moments, and staff undertaking professional curiosity.

10.0 SERIOUS CASE REVIEWS (SCR) and CHILD SAFEGUARDING PRACTICE REVIEWS (CSPRs)

10.1 The Named Nurse for Children's Safeguarding attends the Lancashire Safeguarding Practice Review Business Meeting, and the Sefton CSPR Group as requested. The Assistant Director of Safeguarding and the Named Nurses attend and support both SAR and CSPR panel reviews for both Lancashire and Sefton, as requested.

10.2 This year the children's Safeguarding Practitioner has supported the panel for 3 CSPRs, and the Trust has been directly involved with the two of the children. Appropriate learning has been shared internally and actions for sexual health services, from one of the CSPRs, have been completed.

10.3 This year the Trust has not been required to provide information for any rapid reviews for a CSPR.

10.4 Members of the safeguarding team and clinical staff have attended practitioner learning events in relation to local learning reviews. Actions from these reviews have been followed up and learning shared as appropriate. The safeguarding team has applied any learning ensuring this is included in level 3 children's training, and processes and policies updated, as required.

10.5 Learning from further CSPRs will be shared via the LSCB/CSAPs and the Learning and Development Subgroups, where the Trust provides representation.

10.6 SAR referrals are submitted to the LSAB, who triage and decide if to undertake a local panel to complete the SAR. The Trust has not been required to provide information to support any SARs in 2022/2023.

10.7 The safeguarding team review all learning from Lancashire and Sefton SARs and CSPRs, and as a result will adapt processes and policies, documentation, training and share information to relevant staff.

11.0 MENTAL CAPACITY ACT and DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

11.1 The Mental Capacity Act 2005 (MCA) is an integral piece of legislation used by healthcare professionals.

11.2 In 2009, DoLS was bolted onto the MCA 2005 to create a procedure enshrined in law to deprive people, who are assessed as lacking capacity, of their liberty (in their best interest). In 2014, the case 'Cheshire West' created the acid test to enable practitioners to define whether a

person is deprived of liberty. Under the acid test, any patient over the age of 18, who lacks capacity to consent to their arrangements (i.e. admissions to hospital), who is subject to continuous and effective supervision and control and is not free to leave, is defined as 'deprived of liberty,' and therefore a DoLS is required to safeguard their human rights. The impact for an acute Trust is that all patients who lack capacity and are in the acute hospital setting as an in-patient, require a DoLS authorisation.

11.3 This poses a challenge not only to S&O as an acute Trust but has also placed a heavy burden on the Supervisory Body (Lancashire and Sefton's County Council), who are required to complete Best Interest Assessments and authorise a considerable number of DoLS in the community, as well as the hospital setting. As a result, after 14 days patients are deprived of their liberty under the principal of best interests.

11.4 This is detailed in the Trust risk register which refers to patients who are placed under an urgent 14-day DoLS authorisation, which expires before the Supervisory Body has been able to complete a best interest assessment.

11.5 This year has seen the implementation of the DOLS portal where staff complete the DOLS authorisation electronically. Prior to completing the DOLS authorisation staff are required to electronically record the patients 2-stage capacity assessment. Throughout the document there are mandated fields ensuring accurate completion of the authorisation. The portal has streamlined the process for staff as they are no longer required to complete a datix, as the authorisation is automatically emailed to the safeguarding team. On receiving the completed DOLS authorisation the Safeguarding Administrator will directly email to the relevant Local Authority.

11.6 The portal and the DOLS proforma in Careflow has enabled colleagues in BI to develop a report that has replaced the DOLS database. This has provided a detailed report of all patients currently with a DOLS authorisation in place and when this expires. The BI report has improved the ease of access to data relating to DOLS.

11.7 The safeguarding team still have a robust system for monitoring the DoLS process: all DOLS authorisations are checked and quality assured; if required the authorisation is adjusted before submission to the Supervisory Body. Ward staff are required to review and record daily the restrictive practices in place to ensure these are the least restrictive and proportionate.

11.8 The team sends an email regularly to the Supervisory Body, advising of patients who no longer require a DoLS, and the patients who are awaiting a Best Interest Assessment. When the team is aware they further escalate to the Supervisory Body, any patient who needs an urgent Best Interest Assessment for example, they strongly object to being in hospital, they are subject to a high level of restrictive practice, or they have been an inpatient for significant period.

11.9 This year has seen an 8.4% increase in the number of referrals for a DoLS authorisation to 1857, (Table 12).

- 1081 Sefton / 739 West Lancashire / 29 Other

11.10 Those that are not authorised by the Supervisory Body are due to the patient being discharged before the assessment is undertaken; patients regaining capacity; patients who have

deceased; the urgent authorisation lapses due to no assessment being undertaken by the Supervisory Body, (Table 13).

Table 12: Deprivation of Liberty Safeguards Applications

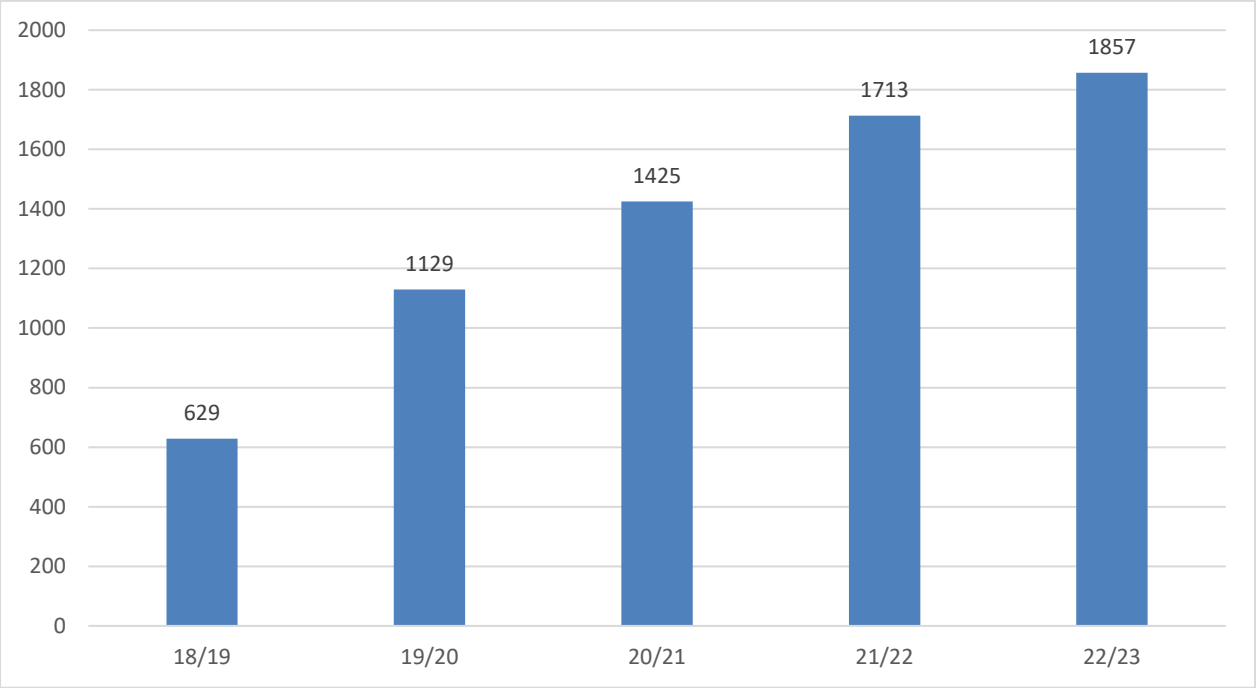
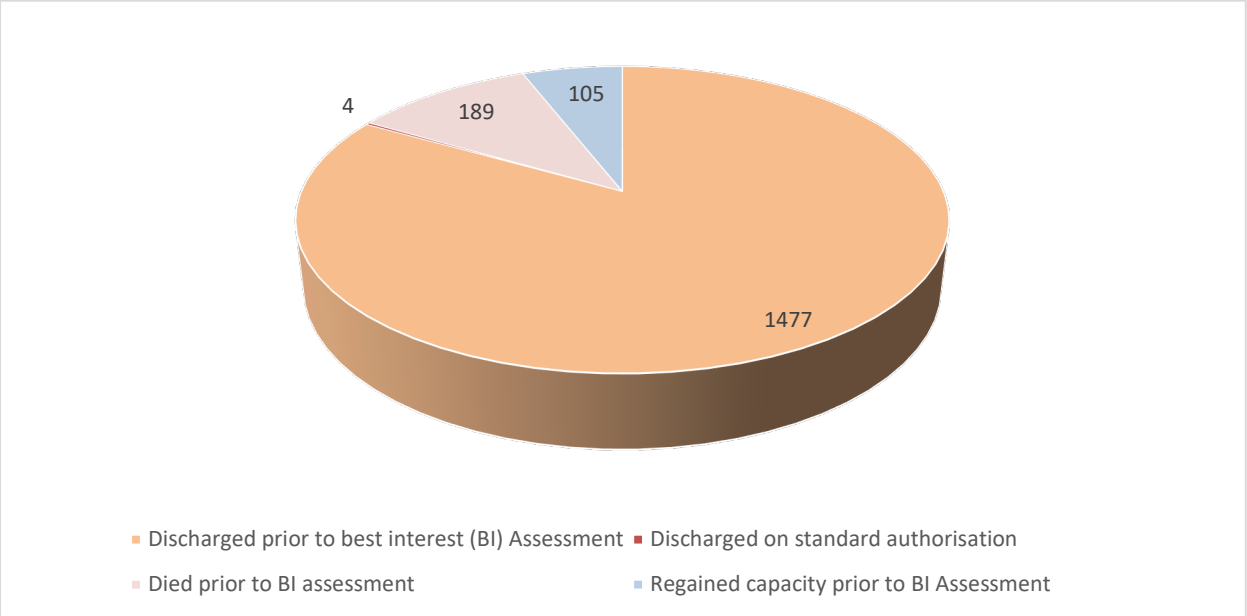


Table 13: Outcomes of DoLS Applications



11.11 Liberty Protection Safeguards (LPS)

11.12 In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards, (although the term is not used in the Bill itself). The target date for implementation was spring 2020, later revised to October 2020, and due to the pandemic October 2023.

11.13 The LPS will have significant implications for acute NHS Trusts, as the authorisation of the LPS will be the responsibility of the hospital and not the LA, as in the current arrangements.

11.14 In March 2022 the Code of Practice was released for a 16-week public consultation. The Assistant Director of Safeguarding provided both a Trust response and collaborated with partners to develop the responses for Lancashire and Cheshire and Mersey.

11.15. Since the draft Code of Practice, the Government has released a statement that LPS will not be implemented in the time of the current government. As a result, LPS working groups have been stood down until further time frames are provided by the next Government.

12.0 LEARNING DISABILITY

12.1 The Royal College of Nursing (RCN) 'Connecting for Change Report' (2016 and 2021), recommend 'Every acute hospital should employ at least one Learning Disability Liaison Nurse, and by 2020/21 all acute hospitals should have 24-hour Learning Disability Liaison Nurse cover.'

12.2 People with learning disabilities may experience multiple co-morbidities and chronic health problems. In the Confidential Inquiry (Heslop et al, 2013), 17% of the sample had four or more health conditions. Due to their experiences of both acute and chronic illness, people who are learning disabled have an increased attendance and admittance to acute general hospitals, and the demand from people with learning disabilities, their families and carers on specialist and general health service is expected to increase significantly in the future (Gates, 2011, as cited in Phillip, L. 2018).

12.3 The Learning Disability and Autism Practitioner (LDAP) became a substantive post in July 2022. Since commencing the post has demonstrated extensive value in relation to patient and care experience and providing staff support. In this time the current post-holder has shown the value of developing relationships with the patient's family, and or carers, and maintaining daily/weekly communications with the family. This has resulted in freeing the time of the ward-based nurses in conversations that can often be emotional and lengthy, and requiring a deeper level of experience and understanding of the needs of a patient with a learning disability and or autism.

12.4 The LDAP has provided an extensive amount of support to ward staff; supporting ward-based care; the provision of reasonable adjustments; facilitating a timelier discharge; providing ad-hoc learning disability and autism awareness sessions. They have established strong communications with community-based learning disability services, ensuring a collaborative approach to meeting the patient's care needs.

12.5 The LDAP has:

- Increased the number of patients with an LD alert by 17.4% to 635 compared to the 2022 benchmark, and by 207% compared to 2021 benchmark.
- Increased the number of patients with an autism alert by 416% from 12 to 50.
- Secured funding for the 'Autism Bus Reality Experience' to be provided at the Trust for a further 6 occasions during 2022/23, with 144 staff attending to date.
- Recruitment of one LD volunteer who has supported an array of events.
- Joint working with 'Live to Learn Musical Theatre Choir' to perform several musical performances at the hospital to enhance communication and integration of people with Learning Disabilities and Autism.
- Launch of the LD and autism champions, 10 staff trained to date.
- Revised the LD and autism policy.
- Teaching staff the use of Makaton.
- Developed new processes to monitor waiting times of those with a LD and or autism.
- Developed processes to provide LD and autism expertise to complaints and incidents involving those with a LD and or autism.
- Delivered face to face training to over 300 staff, using the Cheshire and Mersey LD and Autism training package.
- Supported the LD awareness week campaign – raising awareness of LD and Autism through daily posts and information boards, working collaboratively with the LD volunteer and Sefton Community LD Team.
- Represented the Trust at Sefton Parents and Carers Forum, which was attended by clients, parents and carers of children and young people with special educational needs.
- Developed and introduced social stories.

12.6 The LDAP supports the Learning from lives and deaths – People with a learning disability and autistic people **(LeDeR)** agenda. The LDAP ensures the Trust reports, within the required timeframe, the deaths of those with a learning disability and or autism. The LDAP liaises with the LeDer reviewer to provide the required information and following the review feedbacks recommendations into the Trust Mortality Operational Group. The LDAP provides representation at both Lancashire and Sefton LeDeR steering groups, ensuring the Trust is sited on improvements required to improve the lives, and prevent unavoidable deaths of those with a learning disability and or autism. The Assistant Director Safeguarding provides Trust representation at the LEDER review panel meetings for Sefton.

12.7 This year the Trust submitted 15 LEDER notifications

12.8 The annual NHS E/I submission learning disability and autism benchmark was completed and submitted in March, within the required timeframe, and the Trust are awaiting the results.

12.9 The LDAP represents the Trust at the SEND Improvement Programme Meeting and the SEND Champion meetings and has established links with the SEND Leads in both Lancashire and Sefton. In anticipation of SEND CQC inspection the Trust completed the SEND self-assessment to Sefton Place.

13.0 PREVENT

13.1 Prevent is part of the Government's counter terrorism strategy, and as the name suggests it is the part of the strategy designed to identify people who may be vulnerable to radicalisation, before they commit any crime. It therefore operates in the pre-criminal stage and essentially requires professional groups, particularly in the public sector, to be aware of the signs that an individual may be being radicalised, and then to refer such concerns onto the proper authorities

to make the necessary interventions. Local Authorities, Health, Education and the Police amongst others form the CHANNEL Panel, which considers every case referred, and determines which professionals should be engaged to intervene in addressing the individual's needs. The Named Nurse Adult is the only health representation at the Sefton CHANNEL Panel Group.

13.2 There remain 2 tiers of training aligned to staff role. All new staff receive a Prevent awareness leaflet in their welcome pack, and this is also available on the Trust intranet. For the e-learning level 3 and 5 PREVENT training, a trajectory was developed and submitted to Sefton Place, as compliance was <90%, the compliance was achieved in Q4 ahead of trajectory.

Table 15: Prevent Training Compliance

Overall Trust Compliance	Q1	Q2	Q3	Q4
PREVENT Level 1 and 2	95.2	95.1	93.8	93.7
PREVENT Level 3 and 5	88.8	89.1	89.2	90.6

13.3 The Trust has made no PREVENT referrals this year.

14.0 MANAGING ALLEGATIONS

14.1 There has been 30 reports that led to consideration for evoking the allegation policy. This is a 36% increase from the previous year, which may in part due to greater compliance with the policy.

14.2 In all cases the CBUs have taken responsibility for responding to the allegation raised and undertaken the required strategy meetings for an informed decision making in managing the allegation.

15.0 SAFEGUARDING AUDITS

15.1 The safeguarding team have undertaken a number of audits this year including:

Quality of child protection medicals
Paediatric Accident and Emergency Documentation Audit
Use of the under 18 AED card
Completion of safeguarding documentation for children attending the Paediatric Department and identified as being at risk of deliberate self-harm
Paediatric Safeguarding Audit - triangulating completed documentation against referrals and other information
The quality of children's social care referrals from Paediatrics, Maternity and adult AED referrals
Antenatal Home assessment visits including numbers of referrals
The completion of MCA and DoLS documentation - full site audit
The quality of adult safeguarding referrals
Completion of safeguarding documentation in AED for those attending with mental health and indicators of domestic abuse
SOCASS MCA & DoLs Audit- all Adult Wards
SOCASS Safeguarding Knowledge- All in-patient and outpatient areas

15.2 Quality of adult referrals audit.

This audit offered significant assurance. It was apparent that staff are not always providing details of the dependants. This is mitigated as the referral to the online Local Authority portal is completed by the safeguarding team who will undertake an advanced search to identify dependants and provide this information. The internal referral form has been adapted to support staff in completing this information.

15. 3Quality of Children's referrals audit.
This audit offered significant assurance. Again, further assurance is provided as the safeguarding team quality assure all referrals and if required provided additional information to the Local Authority.

15.4 Completion of MCA and DOLS documentation whole site.
The audit offered significant assurance that patients lacking capacity have a completed 2-stage capacity assessment, and an urgent DoLS authorisation completed. Regarding the completion of the daily restrictive practice review, although it has not achieved significant assurance this seen a 109% increase compared to the result in 2021.

15.5 Child Protection Medical Audit
The assurance level is significant for this audit. This is a clear improvement on the original audit and indicates that the recommendations and additional training and discussions of the importance of the process has been beneficial.

15.6 MCA knowledge transfer audit.
This is audited as part of the Trust Southport and Ormskirk Clinical Assessment and Accreditation Scheme SOCAAS. The knowledge audit is demonstrating staff have an underpinning knowledge of MCA and safeguarding.

15.7 Paediatric Accident and Emergency (PAED) Documentation Audit
The audit provided full assurance for the safeguarding questions considered in the audit, with all questions achieving 90% - 100%

15.8 Antenatal home visits
This audit relates to the undertaking one home visit during the ante-natal period. From the cases reviewed 59% had a home visit undertaken. The audit will be repeated as it was felt that not all staff would be aware that the ante-natal home visits have recommenced post pandemic.

15.9 AED Documentation compliance audits
These two audits are essentially documentation audits, to demonstrate if staff are completing the safeguarding question set on their documentation. The audits offered limited assurance that staff are completing the safeguarding documentation. To offer some reassurance the team reviewed another 10 cases where referrals had been made to the safeguarding team. In all but one (90%) staff had made a referral to the safeguarding team in the absence of completing the safeguarding documentation. The Safeguarding concerns raised were in fact documented elsewhere in the AED documentation. This would indicate that staff are considering safeguarding in the absence of completing the safeguarding questions. This could be seen as a positive and considered that staff are not requiring the prompts of the safeguarding questions to consider safeguarding, although this would need to be demonstrated further.

15.10 Completion of safeguarding documentation for children attending the Paediatric Department and identified as being at risk of deliberate self-harm

This audit offered significant assurance; however, further improvements have been noted regarding the risk assessment documentation, and this is included in the work plan.

15.11 <18 CAS Card use

This audit is now undertaken on a regular basis by the CBU, and compliance has increased to 70%.

16.0 COMMISSIONING STANDARDS

16.1 The Trust submits a quarterly update to Sefton Place as part of the KPI submission. The requirement has been for an updated commissioning standards action plan to be submitted each quarter, to demonstrate progress against the action plan developed against the previous self-assessment. All actions in the commissioning standards were achieved in Q4 2021/2022. The Trust awaits the publication of the revised commissioning standards which will be standardised across Cheshire and Mersey.

17.0 RISK REGISTER

17.1 There are 2 risks relating to safeguarding in 2022/23:

17.2 DoLS- Lancashire Local Authority is not undertaking Best Interest Assessments; therefore, the Trust may be depriving patients of their liberty without the necessary legislation in place. This has been escalated via the Lancashire Safeguarding Board, and the Local Authority has a process for prioritising their waiting list. This has been mitigated as detailed in section11.

17.3 The Trust currently does not have a clinical photography team; as a result, photographs provided by the Trust for the purpose of child protection and criminal investigation processes and wound or pressure ulcer management do not represent the injury/harm/wound/pressure ulcer accurately. The Assistant Director of Safeguarding and colleagues from STHK presented a business case to the Executive Team. Expanding the service to Southport and Ormskirk is recognised as a cost pressure and will be considered under the new organisation.

18.0 THE SAFEGUARDING TEAM's WORK PLAN 2023/2024

- We will align safeguarding processes and practice across the new organisation with STHK and develop ways of working across the teams.
- We will ensure the safeguarding team undertake Trauma Informed Training, incorporating the principals into their practice.
- We will develop and embed the role of the HIDVA and increase staff awareness in relation to domestic abuse and the potential opportunity for support during health appointments and attendances.
- We will ensure the Trust is compliant with the requirements of the Domestic Abuse Act (2021).
- We will ensure the Trust is compliant with the Serious Violence Duty (2022)
- We will ensure compliance with the NICE Guidance 'Integrated health and social care for people experiencing homelessness,' (2022)
- We will ensure the Trust is meeting its statutory responsibilities of the SEND agenda.
- We will develop an internal process for identifying patients who are homeless or at risk of homelessness to ensure the trust is fulfilling its "Duty to Refer" requirements.
- We will implement the Oliver McGowan e-learning for all staff.

- We will review the continued provision of Personal Safety Training engaging with colleagues at STHK to ensure this is across all sites.
- We will collaborate with the Sefton MASH Team to streamline information sharing.
- We will provide partner support to the Sefton Children's Social Care Improvement plan.
- We will support Lancashire's review and implementation of new MARAC process.
- We will become a member of the Pre-Birth Protocol task and finish group in Sefton, supporting the 'Building Attachment and Bonds Service' (BABS).
- We will work with the BI Team to streamline the process for identifying and following up patients with LD and or autism who have missed an appointment.
- We will undertake a review of the S42 Memorandum of Understanding with Sefton Local Authority.
- We will increase staff awareness of advocacy and other services such as IMCAs.
- We will undertake a review of the mental capacity training to improve compliance.
- We will provide tools to support staff to complete 2 stage capacity assessments.
- We will develop a suite of pathways to support clinical staff in safeguarding decision making and referrals
- We will revise the mental health risk assessments used in Paediatric departments.
- We will continue to improve the completion of the safeguarding documentation and assessment in AED.
- We will continue to ensure the development of a network of safeguarding ambassadors.
- We will seek to maintain training compliance ensuring compliance to the intercollegiate documents.
- We will work with IT colleagues to develop and implement digital streamlined process.
- We will review the ways of working of the team and make improvements that will support the safeguarding agenda.

19.0 CONCLUSION

19.1 Significant progress has been made in the journey towards safeguarding being embedded in to practice and considered everyone's business. The team work operationally within the Trust and engage extensively with external partners, given the nature of safeguarding being a multi-agency and multi-professional practice.

19.2 The Safeguarding team oversee and monitor key areas to ensure appropriate referrals and actions are made to safeguard the un-born, children, young people and adults at risk of abuse. This has been enhanced by the additional roles of the LDAP, the HIDVAs and the HISVA. The safeguarding team will continue to improve and simplify processes, embed training into practice, ensuring quality referrals are made, and enable staff to use their time with patients effectively to identify and manage safeguarding concerns.

20.0 RECOMMENDATIONS

20.1 The Committee is asked to recognise the achievements made by the Safeguarding Team this year outlined in the report and agree the work plan for the year ahead.

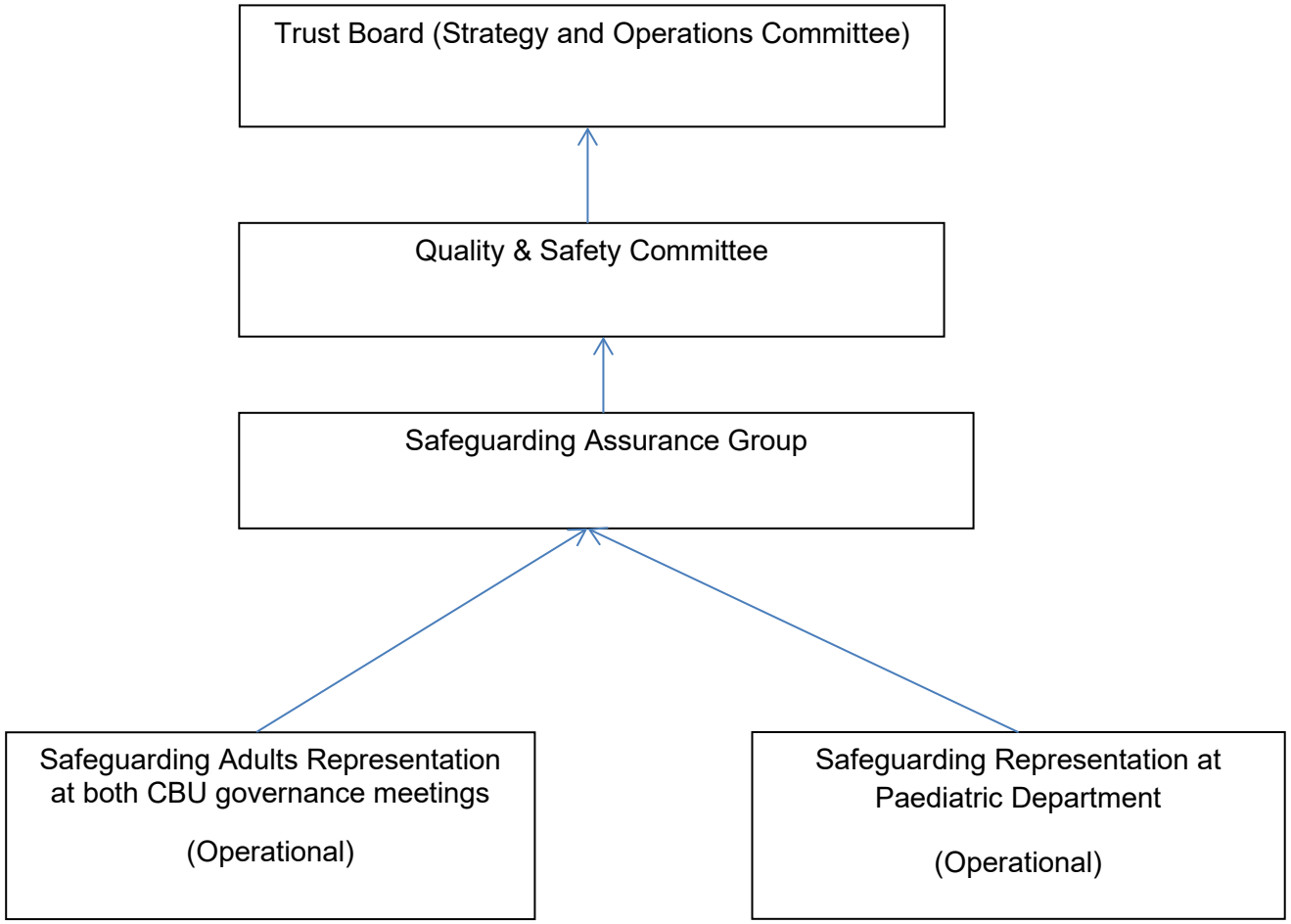
21.0 CASE STUDIES

21.1 The 5 case studies below provide examples of the role of the safeguarding team and value in safeguarding the un-born children, young people and adults at risk of abuse. In all names have been changed.

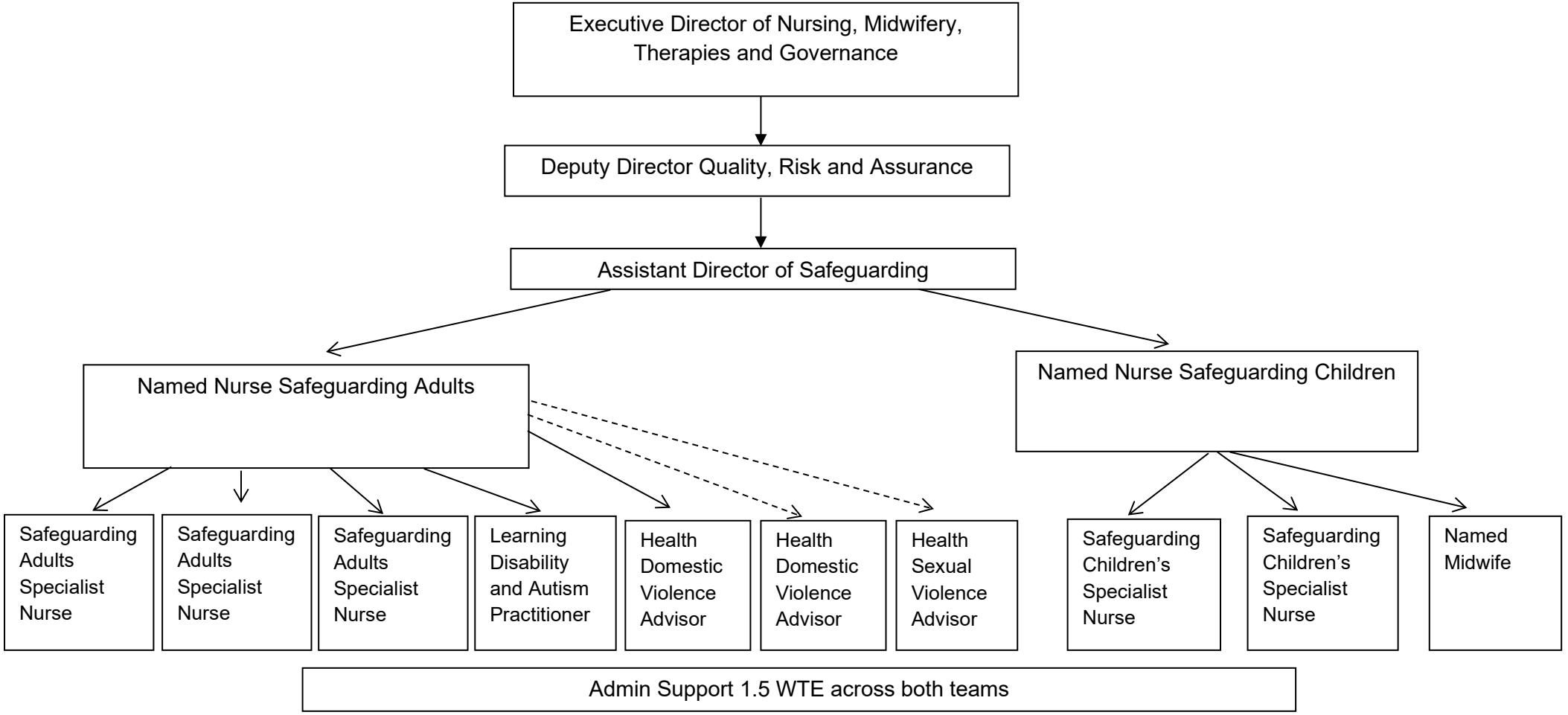
21.2 Given the sensitive and emotional content of the case studies and protecting confidentiality, the case studies have been removed for meetings with external and public membership.

21. 3 The case studies related to the disclosures of domestic abuse, sexual abuse and financial abuse by both female and male adults and children.

Appendix 1: Governance Arrangements



Appendix 2: Southport and Ormskirk Trust Safeguarding Structure



Appendix 3: **Commissioning Standards Action Plan**

Status	
Red	Significantly Delayed and/or of high risk
Amber	Slightly delayed and/or of low risk
Green	Progressing on Schedule
Blue	Completed

Ref	Meeting Date	Standard	Agreed Action	Owner	Forecast Completion	Status Outcomes	Status
	Month – year	Title of item as shown on agenda	Details of Action	Initials	Month year	Month year; update	colour
1.3	July	The Trust board regularly reviews safeguarding across the organisation	Provide evidence that annual reports have been shared with MASA/LSAB	Sharon Seton (SS)	Sept 19	 Annual Safeguarding report for Southport	
2.3	July	The policy and procedures have been reviewed since the introduction of Working Together 2018 and are Care Act 2014 compliant and includes reference to NICE guidelines (NG75 & CG89)	Ensure SG policies are up to date and contain all relevant information relating to Working Together 2018 and are Care Act 2014 compliant and includes reference to NICE guidelines (NG75 & CG89)	Eileen Allen (EA) Sue MacDonald (SM)	End Aug 19	Policy has been updated since Working Together 2018/Care Act 2014 but only contains some of the elements. Safeguarding Children's Policy in Process of updating. Adult policy is in date. **3rd Jan 2020** Completed and awaiting approval at SAG **Oct 2020**	

						Approved by all CBUs and final formatting for upload to the intranet	
2.6	July	The policy and procedures help staff to recognise the additional vulnerability e.g. children with disabilities; spiritual or religious beliefs; migrant children; child victims of trafficking; domestic abuse; bullying; child exploitation (CSE/CCE), unaccompanied asylum seeking children (UASC).	Review and update the SG polices to include all elements noted in the self-assessment	EA/SM	End Aug 19	Policy defines and details vulnerable status as in Working Together 2018. Safeguarding Children's Policy in Process of updating and will include elements described in self-assessment **3rd Jan 2020** Completed and awaiting approval at SAG **Oct 2020** Approved by all CBUs and final formatting for upload to the intranet **Jan 21** Sent to be published on the intranet	
2.7	July	The organisation has effective complaint policies and systems in place for professionals and service users, which reference safeguarding children and adults at risk	Gather greater understanding of the complaints procedure by undertaking a gap analysis in relation to the below: Complaint policy to form wider part of participant inclusion in asking for	Heather Buckland (HB)	Oct 19	HB has confirmed the policy has the details of the children's policy. The trust's Concerns, Complaints and Compliments RM 19 policy refers to the CQC Regulation 13. The policy details the linked policy Corp	

			positive and negative feedback. Outcomes and lessons to be fed back into practice and Service Development Plans for improvement. Complaint procedures are to be service user orientated and adapted to their needs and understanding. Develop subsequent action plan where gaps are identified			77 Safeguarding Adults at Risk Policy. To enhance the policy it should include Corp 74 Safeguarding and child protection. SS to request this. The trust has a robust complaint procedure managed by the 'patient experience and complaints team.' The policy sites a number of ways the patient and service user can provide feedback, and the services available to support the patient and the service user through the process. The policy sites that the procedure includes a face to face meeting with the complainant and further clarifies the timeframes in which a response must be provided. The policy details the lessons learnt and the process for delivering these back to the CBU. All complaints are managed through the trust incident	

						reporting systems 'datix' and reported to the CEO or designated individual on a regular basis. **14th Jan 2020** Author of complaints policy emailed re above to action. Timescale for completion requested. **Jan 2021** To check added to the policy	
2.9	July 19	The organisation has effective allegation policies and systems in place for professionals and service users, which is compatible with MASA/LSAB Procedure and Guidance, including guidance on Person in a Position of Trust (PiPoT) guidance	Review of process to ensure this is child orientated and adapted to their needs. Review of process for sharing lessons learnt from allegations	SS	Dec 19	**April 2020** This has been delayed due to current situation. The current policy is in date but the ADo SG wanted to review and update accordingly **3rd Jan 2020** Allegations are managed by the ADo SG although the policy requires updating in line with the PIPOT policy and standardised documentation added. **Oct 2020** Current policy remains in date **Jan 2021** The policy is now in process of review	

						<u>April 2021</u> Policy revised and sent to the CBU's and HR for approval **<u>July 2021</u>** Approved by policy ratification group	
2.11	July 19	All incidents, allegations of abuse and complaints are recorded, monitored and available for internal and external audit.	Develop process and database to actively demonstrate reporting of allegations this includes monitoring quantity, timescales, outcome satisfaction, and action implementation. Review procedure to improve service	SS	Dec 19	**<u>3rd Jan 2020</u>** Allegations are recorded through datix and all relevant documentation and statements attached. Actions and outcomes will be detailed in the incident report. A SG file further keeps all records of the allegation, documents and actions taken Outcomes are provided to the senior managers who need to be made aware of the allegation. Where appropriate referrals are made to the LADO, DI and police.	
2.12	July 19	All incidents, allegations of abuse and complaints are dealt with in an appropriate manner in line with policy and procedure.	Review of the policy and process to manage an allegation and to develop standardised documentation to support the process; which can then be monitored.	SS	Dec 19	**<u>April 2020</u>** Allegations are managed in an appropriate manner in line with policy and the current policy is in date but the ADo SG wants to review and update accordingly. This will hopefully be completed in Q1 20/21	

						3rd Jan 2020 Allegations are managed by the ADO SG although the policy requires updating in line with the PIPOT policy and standardised documentation added **Oct 2020** Current policy remains in date **Jan 2021** The policy is now in process of review **April 2021** Policy revised and sent to the CBU's and HR for approval **July 2021** Approved by policy ratification group. Needs uploading to the intranet	
4.1/5.2	July 19	Service plans consider how the delivery of services will take account of the need to safeguard and promote the welfare of children/adults at risk	Review the service plan development process and how this incorporates safeguarding in each part of the organisation undertaking a gap analysis	SS	Oct 19	The trust has a business case approval (BDISC) process which provides governance for the development of service plans and or business cases. The main priority for the BDISC is to 'ensure that that all investments (this covers	

			Develop action plan accordingly to address any gaps			business cases, investments, service developments, divestments, service transformations, commissioner requests and service level agreements) irrespective of the level of spend are scrutinised and considered on a transparent and consistent basis.' This board report directly to the Hospital Management Board. Prior to the submission of a business case a statement of case is submitted which includes a quality impact assessment (QIA), and an equality and diversity assessment. The QIA ensures that consideration is given to the welfare and safeguarding of children/YP and adults at risk. (See evidence) Following the statement of change the trust has a detailed process detailing all the information to be provided for the submission of the business case. This includes financial considerations; workforce requirements; training requirements; estates and	

						facilities; informatics; capital; impact on other parts of the organisation and community; user engagement, risks; benefits realisation. This process aims to ensure that business cases will maintain the expected standards of care within financial and resource constraints.	
10.6	July 19	Sub contracted/ commissioned services by the organisation who work with Children and are delivering statutory services are Section 11 compliant and have been audited. Other contracts require the organisation to achieve Safeguarding Standards, which are the same as those for Section 11.	To review the process for commissioned services ensuring these are S11 complaint Develop action plan for gaps identified	HB	Dec 19	**October 2020** No identified commissioned services for children's services **3rd Jan 2020** The trust is working with the security team's area service manager to ensure the appropriate level of DBS is in place. The Head of Health and Safety has been asked to review the process for others contractors.	
11.3	July 19	As a minimum the organisation evaluates outcomes from the perspective of the child or young person.	Children's safeguarding team to undertake a qualitative case study to ensure the child's and young persons lived experiences are	SM/LB	Dec 19	**3rd Jan 2020** The 'My life' tool used in paediatric when appropriate. The voice of the child audit reviews that outcomes are	

			evidenced throughout the Trust.			evaluated from the perspective of the child. As part of the Mental Health JTAI a deep dive in to 3 patient's records was undertaken. VOC and the life have been included in level 3 training since April 2019.	
12.5	July 19	Trust can demonstrate implementation of the policy, procedures and access and expert advice and that they are known and utilised by staff.	Audit through the SONAS process of staff knowledge and confidence in applying principles of MCA Undertake improvement actions as a result of the audit	Kerry Anthony (KA) / Laura Mercer	Dec 19	**3rd Jan 2020** The Quality Team undertake the SONAS process on a rolling programme. Following the SONAS the SG team are informed of any concerns regarding the application of MCA. The team will then engage with the ward to improve staff knowledge and application. The MCA documentation has been adapted in order to improve knowledge and application. Digital processes are being explored to support the MCA process. The SG team are implementing a process to visit the wards and provide an expert daily review of all patients who lack capacity, and ensure capacity assessments have been	

						undertaken and understood by staff. The trusts new Dementia Team are further providing expert advice by supporting the MCA process by ensuring dementia patients have had a MC assessment undertaken and this is understood by staff. MCA training is now included in the trusts 2 day older peoples course.	
12.26	July 19	The use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual	Development and introduction of a policy that includes all the below elements: Restraint used is documented, followed by assessment for signs of injury, emotional or psychological impact in line with policy.	SS	Aug 19	<u>April 2020</u> The policy is completed and will be ready next week for dissemination to the CBUs governance meetings **<u>Oct 2020</u>** Policy has been locally and externally approved and awaiting Health and Safety to review before uploading to the intranet **<u>Jan 2021</u>** The policy has been developed and approved and is being launched in Jan 2020	

12.8	July 19	Procedure in place and staff aware of the procedure. Procedure Evidence that named professionals, including MCA leads seek advice and access regular formal supervision in line with trust policy and procedure. Evidence of IMCA referral data collection.	Develop reporting and monitoring mechanism for IMCA referrals.	KA HB	Sep 19	**14/01/2020** –IMCAs are requested for the purpose of Authorising DoLS and this is completed by the BIA appointed by LA. Most other IMCAs are requested by the LA in relation to BI decisions made for those requiring placement on discharge where they are un-befriended. For those patients requiring an IMCA in relation to medical treatment the request would be made at ward level via the LA commissioned service in our case Sefton (voiceability) and not through the safeguarding team. It is therefore not feasible for the safeguarding team to provide this information.	
12.9	July 19	Audit programme in place that demonstrates the inclusion of emerging messages and themes and organisational learning.	Develop audit tool to measure impact of training in relation to key areas relating to MCA. Undertake improvement actions as a result of the audit.	KA/HB	Nov 19	**14/01/20** – Audit tool developed and trialled. Audits completed focusing on clinical areas and leads. To be continued and training to be developed in line with audit findings.	
12.10`	July 19	Progress reports on arrangements for MCA implementation reported to the Board	Review of available forums and mechanisms to share information on a more regular basis.	SS	Sep 19	14/01/20 – as this features as part of the CQC inspection and subsequent action plan, the improvements will be monitored and reportable	

		on more than annual basis	Develop and implement reporting as informed by the above.			through the CQC improvement programme	
12.13	July 19	There is an operational strategy for safeguarding children and adults in place which includes quality indicators to evidence best practice in safeguarding	Review of operational safeguarding strategy and dissemination of any changes	SS	Nov 19	**April 2020** Strategy requires reviewing and will fall in to Q1 20-21 **Oct 2020** This remains an action for the ADo SG to complete with a revised timeline of Dec 2020 **Jan 2021** To be completed after allegations policy completed **April 2021** Review commenced and must be completed before July 2021 in line with the 2 year commissioning standards timeframe **July 2021** Completed and approved by SAG. To be disseminated. Needs uploading to the intranet	
12.15	July 19	There is a process for following up children who "was not brought"	Develop action plan following the recent audit Implement the actions Monitor through re-audit	Alice Derbyshire/SM	End Sept 19	**3rd Jan 2020** The paediatric liaison nurse undertakes an audit annually and reviews a sample of case	

		for an appointment for specialist care				notes. From the audit in July 2019 the results showed for 'known patients' a 73% compliance for letters being sent to the appropriate professionals and 100% for both PLN forms being completed and safeguarding concerns being acted upon. For 'new patients' the results were 78%, 100%, 100% respectively. These results were presented at the Paediatric Department Meeting. The PLN notification form has been adapted to include the referrer to consider if there are any safeguarding concerns.  DNA Audit 2019 - Final copy.docx In out-patient clinic areas there are posters detailing the Was Not Brought Policy and the actions to be undertaken by the Medical Team. Re-audit is required	
12.37/12.39	July 19	The A & E Department has a minimum of 1 Registered Nurse	Although this only meets criteria for Grade 3 there	SS		**<u>April 2022</u>** A check of the roster over an 8-week period shows that on all	

		(children) present at all times.	are plans which mitigate the risk			shifts there was at least one staff with either the APALS or IPLS course. **<u>23.7.19</u>** Paediatric A & E have a registered children's nurse at all times and a safeguarding lead At all times there is a senior nurse in on duty who is trained in paediatric resuscitation and all the Consultants are trained in paediatric resuscitation. There is a safeguarding lead. **<u>3rd Jan 2020</u>** The Consultant has confirmed that all Consultants are trained and all but one middle grade is trained. The PEF is collaborating with the resus team to ensure that all nurses are appropriately trained including band 5 to band 7. Re audit due Q4 20/21 as this has been requested from the AED Consultant **<u>July 2021</u>** Awaiting one further spot audit	

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 October 2023
Agenda Item	**MWL TB23/051 (14.2)**			
Report Title	S&O Safeguarding Annual Report 2022/23 (Adults & Children)			
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Sue Redfern, Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

The Trust (S&O) has a statutory responsibility to safeguard children, young people, and adults at risk from harm across all service areas in accordance with Section 11 of the Children's Act 2004 and the Care Act 2014. Safeguarding is everybody's business; to help prevent abuse and to act quickly and proportionately to protect children or adults where abuse is suspected, whether staff are working directly or indirectly with children, young people and parents or carers.

The purpose of this annual report is to provide an overview of safeguarding activity across the Trust for the last financial year (April 2022 to March 2023), to provide assurance to the Trust Board and fulfil the Trust's statutory requirements.

Executive Summary

The report provides information and assurance for all aspects of safeguarding during the financial year 2022/23 including:

Key achievements in 2022-23.

- Governance and reporting: Quarterly reporting internally through the governance processes and Safeguarding KPI's are completed on a quarterly basis; these are scrutinised and reported on by Sefton Place Designated nurses. The Trust's safeguarding policies are currently all in date.
- Engagement with external partners
- Training: A compliance of greater than >90% was achieved consistently throughout the year other than in level 2 adult training which was maintained at an average of 89.3% across this year. Q4 saw an unexpected drop in the children's L3 training.
- Safeguarding activity has continued to increase year on year for both adults and children's referrals. In 2022/2023 there has been 1034 safeguarding concerns, including 174 for domestic abuse and 213 for sexual abuse, this is a 22% increase from 2021/22.
- Safeguarding Training: compliance has continued to improve over the 12 months. The ICB have
- Mental capacity Act and Deprivation of Liberty Safeguards (DoLS): the number of Dols applications have continued to increase year on year. This year has seen an 8.4% increase in the number of referrals for a DoLS authorisation to 1857,
- In 2022/2023 the children's team were involved with 1208 referrals including Children's Social Care (CSC), early help, information sharing and courtesy calls.
- Learning disability, autism and the Leder reviews have recent increased focus over the past 12 months to support patients with additional needs.
- The CAMHS attendance for 22/23 has increased related to children and young people under the age of 18 seeking help for mental health.
- Audit finding of the Safeguarding Team annual audit plan within the KPIs,
- 2023-24 forward plan.

Financial Implications
No financial implications resulting from this report.
Quality and/or Equality Impact
Not applicable
Recommendations
The Board is asked to note the progress made with safeguarding activity at S&O and to approve the legacy S&O Safeguarding Annual Report 2022/23 (Adults & Children)

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Safeguarding Team Annual Report 2022/23

Author: Sharon Seton

Assistant Director of Safeguarding

Contents

Glossary of terms

AED	Accident and Emergency Department
ASC	Adult Social Care
CBU	Clinical Business Unit
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CE	Child Exploitation
CP	Child Protection
CQC	Care Quality Commission
CP-IS	Child Protection Information System
CSC	Children's Social Care
CSAP	Children's Safeguarding Assurance Partnership
CSPR	Child Safeguarding Practice Review
DBS	Disclosure and Barring Scheme
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
EHCP	Education and Health Care Plan
ESR	Electronic Staff Records
FGM	Female Genital Mutilation
GMC	Greater Medical Council
HSVLO	Health sexual violence liaison officer
ICB	Integrated Care Board
ICON	This is a babies cry and it's ok campaign.
IDVA	Independent Domestic Violence Advisor
ISVA	Independent Sexual Violence Advisor
JTAI	Joint Targeted Area Inspection (Ofsted, CQC, IPCC)
KPI	Key Performance Indicator
LD	Learning Disability
LA	Local Authority
LADO	(Local Authority) Designated Officer
LPS	Liberty Protection Safeguards
LSAB	Local Safeguarding Adult's Board
LSCB	Local Safeguarding Children's Board
MACSE	Multi Agency Child Sexual Exploitation
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MHLT	Mental Health Liaison Team
MSP	Making Safeguarding Personal
NHSE	National Health Service England
NHSI	NHS Improvement
NMC	Nursing and Midwifery Council
RAG	Red / Amber / Green
Section 42 Inquiry	Safeguarding Adults investigation coordinated by the Local Authority

1.0 EXECUTIVE SUMMARY

1.1 The safeguarding annual report for 2022 / 2023 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 1st April 2022 – 31st March 2023. The purpose of the annual report is to inform the Trust Board of safeguarding activity, providing assurance that the organisation has robust processes in place to safeguard those who use Trust services, and to highlight areas of challenges in safeguarding provision.

1.2 All NHS bodies have a statutory duty to ensure they make arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse, and support the Home Office Counter Terrorism strategy (CONTEST), which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Some of the key legislative frameworks to support safeguarding include: The Children Act (2004); Working Together to Safeguard Children (2018); Mental Capacity Act (2005); The Human Rights Act (1998); The Care Act (2014); Equality Act (2010).

1.3 The CQC fundamental standards require the Trust to ensure that suitable arrangements are in place to ensure that all service users are protected from the risk of abuse, and that internal processes are in place to reduce the potential for abuse.

1.4 The Trust safeguarding team is responsible for ensuring that robust and effective systems are in place to support the Trust in working effectively to safeguard the un-born, children, young people and adults who are at risk of abuse or neglect.

1.5 The safeguarding team is a multi-functional team providing both operational and corporate responsibilities across the hospital sites, with the adult team based at Southport and the children team based at Ormskirk. The team work closely with both Sefton Metropolitan Borough and Lancashire County Councils and support the work of the Local Safeguarding Boards for Merseyside and Lancashire.

1.6 **Key roles of the team include:**

- We provide support and an extensive safeguarding knowledge to all staff across the Trust.
- We provide daily operational responsibility for safeguarding concerns, recognising when a concern may require referral to external partners.
- We provide a Trust contact for the Local Authorities and all other external agencies, for the process of referrals and for the sharing of relevant information.
- We work with partner agencies to ensure the decisions and processes support the ways of working for an acute Trust.
- We lead and ensure a Trust-wide culture that supports staff in identifying and raising safeguarding concerns.
- We participate with Local Safeguarding Board processes to learn lessons from cases where the un-born, children or adults die, or are seriously harmed because of abuse.
- We ensure engagement with Local Safeguarding Boards and any local arrangements for safeguarding both adults and children.
- We ensure Trust staff access training that is complaint to the intercollegiate documents for safeguarding adults and children; monitoring and improving compliance and escalating as appropriate.
- We ensure the Trust works and is compliant with legislation and statutory responsibilities.

1.7 This report demonstrates the work Southport and Ormskirk NHS Trust has in continuing to fulfil its responsibilities to safeguard the un-born, children, young people and adults, in line with statutory requirements and national standards. The report details the effectiveness of safeguarding arrangements for children, young people and adults. It illustrates continued engagement with key partners and demonstrates compliance with the requirements and key objectives of the Local Safeguarding Children Boards (LSCBs/CSAP), and Local Safeguarding Adult Boards (LSABs).

1.8 From the quarterly submission of key performance indicators (KPIs) to Sefton Place, the Trust achieves a RAG rating of green in relation to Local Authority children and adult referrals, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

1.9 Case scenarios at the end of the report will provide examples of the impact of safeguarding on patient experience, the complexities of cases the safeguarding team become involved in, and the diverse nature of safeguarding work. They will demonstrate how important it is that the Trust staff are professionally curious to understand the reason for attendance at the Trust, and the importance of wider assessment to understand the risks.

2.0 INTRODUCTION

2.1 The team structure is set out in Appendix 1, with the statutory roles of the Named Nurse for Adult's and Named Nurse for Children's reporting directly to the Assistant Director Safeguarding. The statutory role of the Named Midwife reports directly to the Named Nurse for Children's.

2.2 As detailed in the Safeguarding Children and Young People: roles and competencies for healthcare staff intercollegiate document (2018), the Trust has a Named Doctor for child protection. The role incorporates supporting colleagues with safeguarding concerns and undertaking safeguarding training. The enhanced medical training consists of 3 monthly peer review sessions, and 6 monthly peer review of child protection medical reports, which is also included in the new trainee's training. The Named Doctor attends monthly safeguarding huddles with the safeguarding team and attends the Safeguarding Assurance Group.

2.3 In accordance with local safeguarding children's board child death processes and detailed in Working Together to Safeguard Children (2018), the Trust has a Designated Doctor for child deaths, who is a senior paediatrician, and takes a lead role in the child death review process.

2.4 The safeguarding team has continued its journey of improving safeguarding arrangements within the Trust throughout 2022/23. The team continue to strive for continuous and sustained improvement, in relation to the safeguarding policies being in place, training compliance and responding proportionality and in a timely manner to safeguarding concerns.

2.5 Key Achievements in 2022-2023

- We recruited successfully to the post of Named Nurse
- We recruited successfully to three vacant safeguarding practitioner posts (two of the safeguarding practitioners left the Trust for promotion and one re-located).
- We developed and presented a business case for a substantive Learning Disability and Autism Practitioner.
- We recruited to the Learning Disability and Autism Practitioner, and the post holder became integrated into the safeguarding team.

- We provided a secondment opportunity for a member of the paediatric ward staff to support the safeguarding team.
- We made a successful bid to the Ministry of Justice for a Health Independent Domestic Abuse Advisor (HIDVA) for West Lancashire.
- We recruited to an HIDVA, and the post holder became integrated into the safeguarding team.
- We supported Sefton Local Authority with a successful bid to the Ministry of Justice for a Health Independent Domestic Abuse Advisor (HIDVA) for Sefton.
- We supported Sefton Local Authority with the HIDVA for Sefton becoming integrated into the safeguarding team.
- We developed a Memorandum of Understanding with Sefton Local Authority for the provision of the HIDVA at Southport and Ormskirk sites.
- We introduced MAYBO Personal Safety Training for clinical staff.
- We collaborated with Merseycare's Mental Health Act Administration team to ensure patients are detained at the Trust under the correct legal framework and have seen improvements in relation to completion of Mental Health Act (MHA) documentation and patient rights being offered.
- We worked with colleagues in IT and BI to develop a Deprivation of Liberty Safeguard (DOLS) portal, which has streamlined the DOLS process for both clinical staff and the safeguarding administrator.
- We have made improvements to develop the workforce to care for patients with a learning disability and or autism.
- We have made improvements to ensure the Trust is complaint with Learning Disability Improvement Standards by 2023/24.
- We completed and submitted the Liberty Protection Safeguards (LPS) Code of Practice feedback.
- We developed and presented an executive summary for the implementation of LPS.
- We supported the LPS steering groups in both Lancashire and Cheshire and Merseyside.
- We achieved adherence to the S42 Memorandum of Understanding with Sefton Local authority.
- We continued the development of a network of safeguarding ambassadors.
- We sought to maintain training compliance ensuring compliance to the intercollegiate documents.
- We supported the Sefton Children's Social Care with their improvement action plan following the publication of the Ofsted visit.
- We continued to facilitate training for the partnership via the training pool.
- We empowered staff to care for 16- and 17-year-old in an adult setting through the implementation of a Standard Operating Procedure.
- We implemented more drop-in and supervision safeguarding children's sessions in the Adult Accident and Emergency department (AED).
- We implemented attending the daily Paediatric Accident and Emergency Department (PAED) safety huddle.
- We reviewed and streamlined databases to identify relevant trends and themes.
- We reviewed the Termination of Pregnancy procedures following the publication of a CSPR.
- We processed an 8% increase in DoLS authorisations.

- We provided 97% compliance in the MARAC (multi-agency risk assessment conference) process, by attending 35 out of 36 meetings.
- We introduced a safeguarding ambassador forum meeting.
- We supported Paediatric Liaison with development of their processes.

2.6 The team has utilised several methods to communicate and raise awareness across the Trust this includes:

Safeguarding children's link nurse	Attends steering group and links into safeguarding children team
Safeguarding ambassadors	Launched January 2020 across the Trust to support sharing information and disseminate training/lessons learned
Representation at the planned and unplanned governance meetings	Core agenda item at the monthly meeting
Representation at the Paediatric Department meeting	Core agenda item at the monthly meeting
Included in Trust news	7-minute briefings / Local SCB and Local SAB newsletters / /safety notices / safeguarding ambassadors / links to Local SABs
Safeguarding Briefs	Newsletters circulated to all L3 children's leads to disseminate within their teams. External training circulated to all L3 children's leads to disseminate to their teams.

3.0 GOVERNANCE ARRANGEMENTS

3.1 The Trust has a Safeguarding Assurance Group (SAG). The meeting is attended by representatives from the Local Authority, and Designated Nurses from Sefton Place and the safeguarding Lead at Lancashire Integrated Care Board (ICB). The meeting has regular representation from the Associate Directors of Nursing, Midwives and Allied Health Professionals. The meetings have been chaired by the Director of Nursing, Midwifery and Therapies. An advice, alert, assure (AAA) report from the meeting is submitted to the Trust Quality and Safety Committee.

3.2 A quartile KPI report is submitted to Sefton Place, after which Sefton Place provide an assurance report for the Trust. The Assistant Director of Safeguarding undertakes business meetings with the Designated Nurse and Designated Practitioner for Sefton place. The meeting occurs prior to the SAG meeting and the purpose is to review the KPI return for the previous quarter. The KPI return feedback is an agenda item at the Trust Contract & Clinical Quality Review Meeting (CCQRM), which the Assistant Director of Safeguarding attends when requested.

3.3 The children's safeguarding team attends the monthly Paediatric Department Meeting (PDM) and has a monthly children's steering group meeting with attendance from the relevant Clinical Business Units. The Named Nurse for Adult has regular representation at the governance meetings for planned and emergency care and provides a safeguarding report for each of these meetings.

3.4 The Trust's safeguarding policies are currently all in date. Policies are approved by the Safeguarding Assurance Group; governance meeting for planned and emergency care;

department meeting in specialist services; workforce committee as required, before finally being presented through the Trust policy ratification process.

4.0 ENGAGEMENT WITH EXTERNAL PARTNERS

4.1 The Assistant Director of Safeguarding provides membership at both the Lancashire and Sefton Local Safeguarding Adult Boards. In Lancashire and Sefton, the providers do not attend the Local Children's Safeguarding Boards, although the Assistant Director of Safeguarding provides Trust representation at the Safeguarding System Leaders meeting for both Sefton and Lancashire. Membership at the Boards ensures that the Trust is sighted on all aspects of the safeguarding agenda, and attending the Board allows the Trust to influence the local and national agenda. It further allows the Trust to develop policies and practices that are aligned to the Local Safeguarding Boards.

4.2 The Assistant Director of Safeguarding, Named Nurses and Safeguarding Practitioners represent the Trust at both Lancashire and Sefton Local SAB and Local SCB/CSAP sub-groups and at wider safeguarding partnership meeting and this includes the below:

There is representation by a member of the adults safeguarding team at the below meetings:

- Sefton Process, Practice and Messaging
- Sefton Quality and Audit
- Sefton Mental Wellbeing
- Sefton Learning from Review, Development and Skills
- Sefton Communications, quality and process
- Lancashire Voice/MSP Group
- Lancashire Complex Vulnerabilities Group
- Sefton Domestic Abuse Partnership Board
- Sefton Health System Leaders Meeting
- Lancashire Health Providers Forum
- Lancashire Mental Capacity and Deprivation of Liberty Safeguards
- MARAC Sefton
- MARAC Sefton steering group
- Sefton SEND Health Improvement Group
- Lancashire and Sefton SEND champions group
- Sefton Channel Panel
- Sefton and Lancashire LEDER Operational Group
- LEDER Review Panel Meeting
- Sefton and Cheshire and Mersey LPS Implementation Steering Group
- VAWG Strategic Board
- DHR Panel meetings as required

4.3 There is representation by a member of the children's safeguarding team at:

- Lancashire Connectivity meeting
- Sefton MACE
- Sefton Multi Agency Audit group
- Lancashire Multi Agency Audit group
- Lancashire MARAC

- Lancashire MARAC Working Group
- Northwest Named Midwife Regional meeting
- Lancashire CSAP Tactical Group
- Lancashire MASH Q&A
- Sefton training pool
- Sefton Learning and development group
- Sefton Policy and Procedure group
- Sefton CE strategic group
- Lancashire SUDC meeting
- Sefton SUDIC Improvement group
- Lancashire CDOP
- Sefton CDOP
- CSAP Task and Finish group 'Children whose Medical needs are Neglected'
- Sefton MASH Health Meeting
- Lancashire Safer Sleep Group

4.4 Attendance at the groups allows the Trust to have up-to-date knowledge and informs areas for focus within the team's strategic agenda. Membership allows the team to be part of the development of safeguarding across Sefton and Lancashire and ensures that Trust processes are in line with partner agencies. Through these subgroups, the team can be involved in the development of policies, audits, tools and training to meet the standards required by the Local SAB's and Local SCB/CSAP.

4.5 One of the children's Specialist Practitioners is a member of the Sefton 'Training Pool' supporting and delivering safeguarding training across the network, as requested.

4.6 The Named Midwife is a member of the National Maternity Safeguarding Network and attends meetings monthly at Northwest regional Meeting. The Named Midwife is also a member of Northwest Named Midwife Regional Group which meets on the second Wednesday of each month. The Named Midwife is a member of CDOP for both Lancashire and Sefton and is represented on both CDOP panels. The Named Midwife is a member of Early Help Partnership for Sefton. The Named Midwife attends monthly meetings with Sefton & Lancashire Children's Social Care Managers, to discuss and review referrals and open cases in relation to the un-born/new-born. The Named Midwife attends the Children's Safeguarding Connectivity Meeting with designated professionals from Lancashire ICB. The Named Midwife is a member of the Sefton SUDIC Improvement Group & Lancashire SUDC group. The Named Midwife is also a member of Lancashire Safer Sleep group reviewing policies and improving best practice.

4.7 The safeguarding team endeavour to provide 100% representation at all requested strategy meetings, child protection conferences and core group meetings when relevant to attend. Reports for these meeting may be provided verbally, written or via email, as requested. The safeguarding team support the SAR/CSPR process by providing requested chronologies; providing panel membership; ensuring participation at practitioner events. The safeguarding team provide representation at local MACE, CDOP and MARAC meetings. Prior to the meetings the team complete all requests for information within the given timeframe, and subsequent actions from these meetings are completed. The safeguarding team will support clinical staff to complete court reports, and the team ensure all reports are quality assured prior to submission.

4.8 In order to recognise safeguarding concerns the adult team attend the monthly 'regular attenders' meeting at Southport's AED, which includes representation from community Matrons; NWAS; community drug and alcohol service; mental health Liaison team (MHLT); Local Authority. When required the Named Nurses will organise and host multi- professional and multi-agency meetings, to share concerns and discuss specific cases and agree a plan of care.

5.0 TRAINING COMPLIANCE

5.1 A compliance of greater than >90% was achieved consistently throughout the year other than in level 2 adult training which was maintained at an average of 89.3% across this year. Q4 saw an unexpected drop in the children's L3 training. This may be attributed to clinical pressures and strike activity. At this point a trajectory was submitted to Sefton Place and targeted improvements implemented.

5.2 The mental capacity training has not achieved the required 90% in the past 6 months. Level 2 consists of three modules and is undertaken by most clinical staff. Level 3 consists of five modules and is mostly undertaken by the medical staff. Trajectories have been provided to Sefton Place, although the trajectory has not been achieved in this year.

5.3 In Q4 the Executive Board is compliant at 91.7%.

Table 1: Southport and Ormskirk NHS Trust Safeguarding Training Compliance

Overall Trust Compliance	Q1	Q2	Q3	Q4
Safeguarding Adults Level 1	94.5%	93.2%	90.9%	93.1%
Safeguarding Adults Level 2	89.7%	89.7%	88.7%	89.2%
Safeguarding Adults Level 3	96.3%	90.3%	96.3%	93.8%
Safeguarding Children Level 1	93.1%	92.4%	90.5%	93.5%
Safeguarding Children Level 2	91.6%	91.1%	90.2%	89.7%
Safeguarding Children Level 3	90.7%	90%	90.2%	82.1%

5.4 Mental Capacity Act and Deprivation of Liberty Training

The below represents the compliance of MCA level 2 and MCA level 3 training combined.

Overall Trust Compliance	Q1	Q2	Q3	Q4
Mental Capacity	82.4	81%	76%	73.3%

5.5 Each month the Clinical Business Units (CBUs) receive the Trust training report and can monitor their compliance levels. The Associate Directors Nursing, Midwifery and Allied Health professionals are required to present a recovery report to the Safeguarding Assurance Group, should their compliance be below 90% in any one or more levels.

5.6 E-learning is provided for Level 1 and Level 2 safeguarding adults; Level 1 and Level 2 safeguarding children; Mental Capacity Act (MCA); Deprivation of Liberty Safeguards; PREVENT Level 3 -5.

5.7 Face-to-face training has resumed for level 3 children's training, although those staff who are non-compliant can complete a e-reader with additional notes, that is updated each year.

5.8 In addition to the training above the Safeguarding Team delivery bespoke training to:

- Doctors' induction covering general safeguarding and MCA and DoLS
- International Nurses covering MCA and DoLS
- Bespoke sessions to AED, Spinal Injuries and Ward staff covering safeguarding and MCA and DOLS
- Bespoke sessions to AED, Sexual Health and Maternity covering Domestic Abuse and Sexual Abuse

5.9 All relevant Local Safeguarding Board Training is shared through social media, Trust news and the Children's steering group.

5.10 During this year the Safeguarding Ambassadors programme focused specifically on MCA and DOLS. This year to support the release staff the programme was restructured allowing ambassadors to complete enhanced safeguarding training in one session rather than four. It is the ambition of the safeguarding team to have at least one ambassador in all clinical areas who receive additional awareness training in a range of subjects. Topics to date have included: MCA and DoLS; self-neglect; domestic and sexual abuse; children's safeguarding.

5.11 Safeguarding children's training is reviewed yearly and the themes this year have included: Social Care and Early Help referrals; language and documentation; Mental Health, Young People, Suicide and Self-Harm; Neglect, Failure to thrive; Record keeping; Physical Abuse and non-accidental injury; ICON; FGM; CSPRs.

5.12 The safeguarding team attend an array of multi-agency training to maintain their compliance to level 4 training. This year training undertaken includes restorative supervision, trauma informed practice and resilience, child exploitation, sexual abuse referral, and fabricated and induced illness/perplexing presentations.

5.13 The Assistant Director of Safeguarding secured funding to implement 'Personal Safety Training' delivered by Maybo, which commenced in October 2022, with one one-day course and one two-day course being delivered each month. This training provides staff with enhanced knowledge for managing behaviours of concern, understanding the potential reasons for this behaviour, using distraction techniques, and maintaining own safety in the least restrictive manner. This implementation has resulted in collaboration with colleagues at St. Helens and Knowsley NHS Trust (STHK) to review the future of the training across all sites.

6.0 SAFEGUARDING ACTIVITY

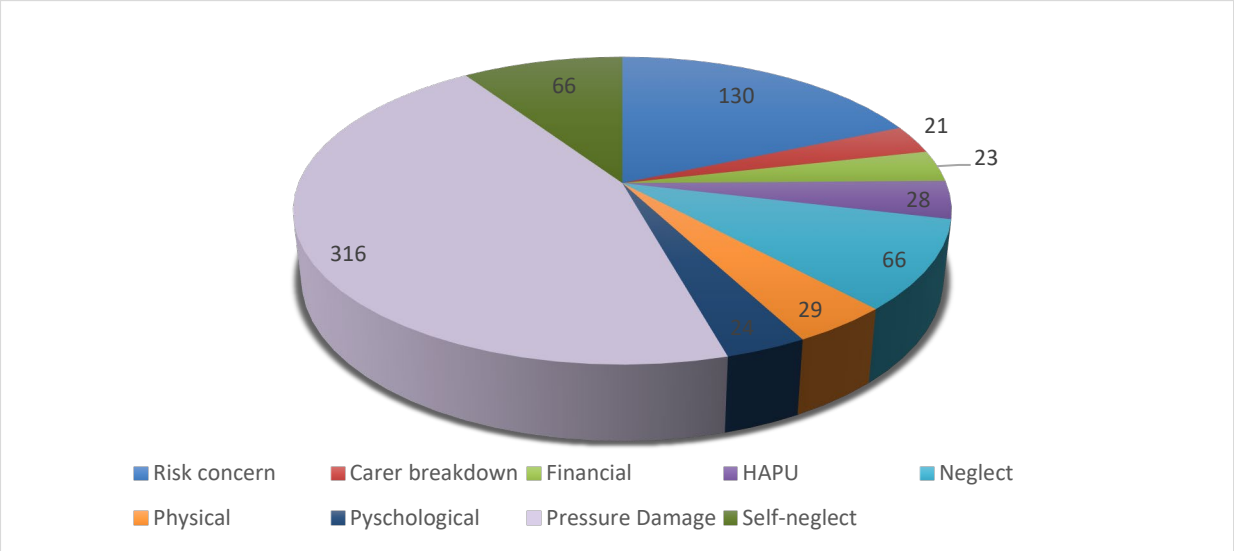
6.1 Adults

6.2 The adult's team collates data regarding safeguarding referrals and safeguarding concerns raised within the Trust. The data is extrapolated from completed datix's and allows the team to identify areas of concern.

6.3 In 2022/2023 there has been 1034 safeguarding concerns (Table 2), including 174 for domestic abuse and 213 for sexual abuse, this is a 22% increase from 2021/22, although it must be noted that some of the domestic and sexual abuse cases are the same individual who has reported both types of abuse.

6.4 In addition, there has been 1857 applications for a DoLS authorisation, an increase of 8.4% compared to 2021/2022. This reflects the year-on-year increase in DOLS which overall has increased by 195% in the past 5 years. Each of these applications is processed and quality assured by the safeguarding administrator.

Table 2: Adult Safeguarding Concerns Concern as reported via Datix (excluding DoLS, Domestic Abuse and Sexual Abuse)



N.B. The category of 'risk concern' includes were safeguarding advise may be sought but does not require further intervention from the safeguarding team.

6.5 Data shows that 157 of the concerns raised (excluding domestic abuse and sexual abuse) required a referral to a Local Authority (LA). It is worth noting that not all referrals to the LA would have progressed to a safeguarding inquiry under S42 of the Care Act, 2014.

6.6 For adult safeguarding referrals, other than in an emergency when the LA 'duty team' will be contacted, staff complete an internal referral form which is then attached to the datix. All safeguarding concerns will be quality assured and checked by the safeguarding team prior to submission to the LA; again, this excludes emergency safeguarding concerns out of hours.

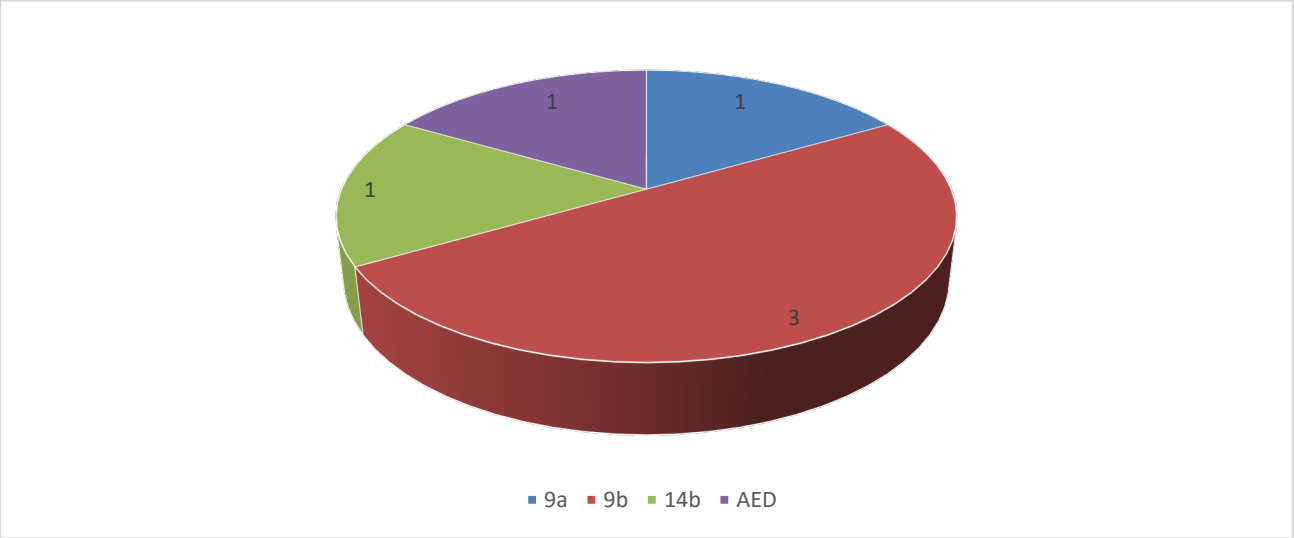
6.7 The adult team oversee two work-streams in terms of safeguarding referrals. The first relates to safeguarding alerts made by frontline staff. The second relates to safeguarding concerns raised

against the Trust. These are investigated by the Local Authority under Section 42 of The Care Act 2014.

6.8 All S42s against the Trust are sent from the Local Authority Safeguarding Team to the Trust's adult safeguarding team, who oversee the investigation and liaise with the Local Authority regarding the outcomes. In 2022/2023 there has been 6, S42 concerns raised against the Trust. This demonstrates a 70% decrease from the previous year in the number of S42's received. This is possibly due to the Memorandum of Understanding that is in place with Sefton Local Authority. This results in the safeguarding team and the Local Authority safeguarding team meeting regularly to ascertain the best course of action for when a safeguarding concern is raised, as not all concerns raised meet the criteria for a S42. With the addition of the safeguarding team providing relevant and timely information the LA are no longer required to undertake a S42 enquiry.

6.9 The themes from the S42s remain relatively consistent and are mostly in relation to concerns raised during the discharge process. All concerns raised against the Trust enter the 'harm-free' care process and are presented at the weekly 'harm-free' care meeting, to provide oversight of the investigation, learning and subsequent actions.

Table 3: Adult Safeguarding Concerns against the Trust (S42)



6.10 Making Safeguarding Personal

Where adults have capacity 'Making Safeguarding Personal' (MSP) allows them to express the outcomes they would want, and to uphold their right to refuse a referral, (where there is no concern regarding the wider public interest, or risk of serious harm to themselves). In accordance with the principal of MSP there were 47 individuals who had capacity to refuse intervention, and a referral was not made. This is an 81% increase from 2021/2022.

6.11 Children and Young People

In 2022/2023 the children's team were involved with 1208 referrals including Children's Social Care (CSC), early help, information sharing and courtesy calls (Table 4). The themes identified in the referrals are detailed in Table 5.

Following a referral and after meeting the criteria for a 'children and family assessment' the child is identified as:

- that the child is not 'In Need'. In this case, Children's Services will take no further action other than, where appropriate, to provide information and advice in accordance with the local Common Assessment Framework.
- that the child is 'In Need', but it has been determined that the child is not suffering, or considered likely to suffer, significant harm. In this case, Children's Services will determine the support which will be provided and draw up a 'Child in Need' plan accordingly.
- that the child is 'In Need' and that there are concerns that the child is suffering, or considered likely to suffer, significant harm. In which case, Children's Services will initiate a Strategy Discussion to determine whether a Section 47 investigation is necessary; and consider whether any immediate protective action is also required.

6.12 CSC do not routinely share the outcomes of referrals; however, this has improved as the team actively chase these outcomes, therefore for 2022/2023 it not known exactly how many of the Trust's referrals proceeded to a 'child in need' and or S47. For the outcomes that have been received 64 proceeded to a children and family assessment (CAF), and 21 referrals resulted in a S47 order. In this year, the Trust undertook 17 child protection medicals, which can be used as part of a S47 investigation. It is worth noting the safeguarding team will the receive the initial outcome but will not know the end outcome of the child and family assessment or S47.

6.13 The team provide 100% attendance at meetings where it is relevant and appropriate for the Trust to be represented. This year the team have provided representation for at least 288 meeting, which is a 48.5% increase from the previous year. These meetings have included but not limited to:

- 100 Strategy meetings
- 32 Child Protection Conferences
- 19 Child in Need meeting
- 40 Core Groups meetings
- 51 Discharge meetings
- 12 Professionals meeting and 9 Planning meetings

<u>Table 4:</u> Safeguarding Referrals (including early help), Information Sharing, Courtesy Calls to Children's Social Care

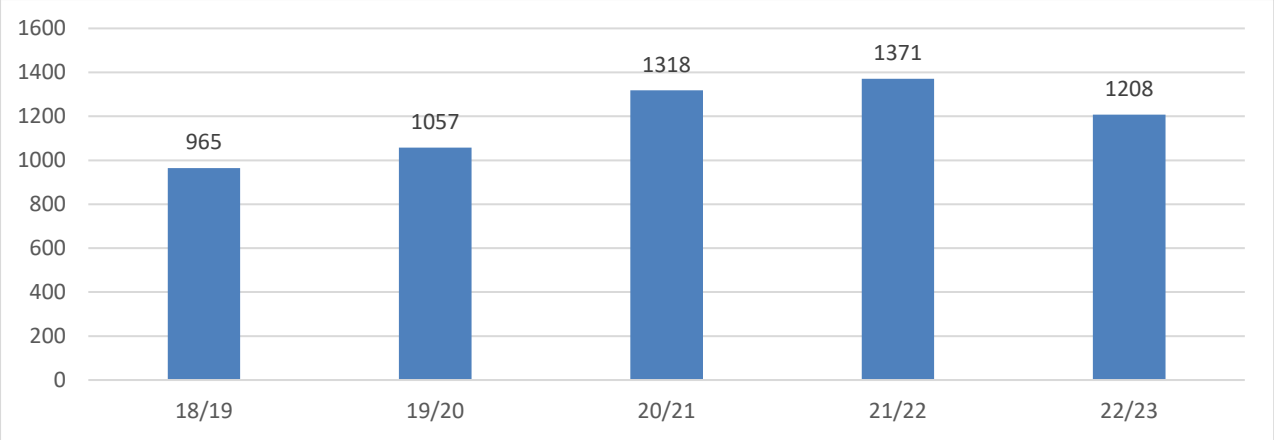
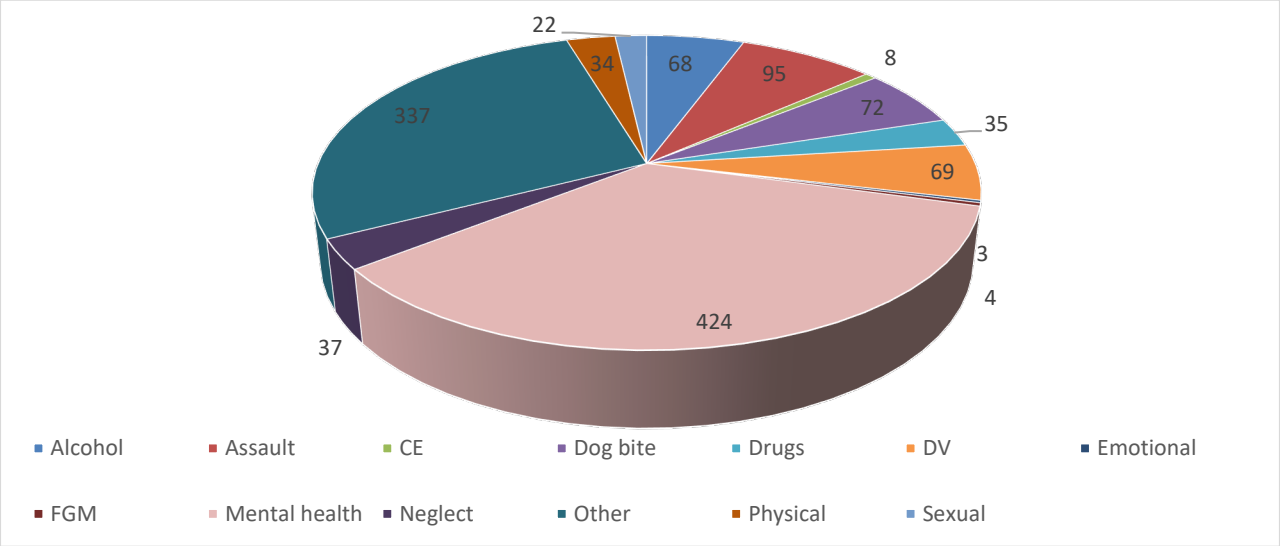


Table 5: Referral Theme by Primary Reason where this is recorded



N.B. The category of 'other' is mostly information sharing and other examples include: additional support needs, CSC are already involved, asylum seekers, early help, CSC currently involved, medical information required.

6.14 This year the themes have remained consistent with no significant increase or decrease in any one area that would require a deeper understanding.

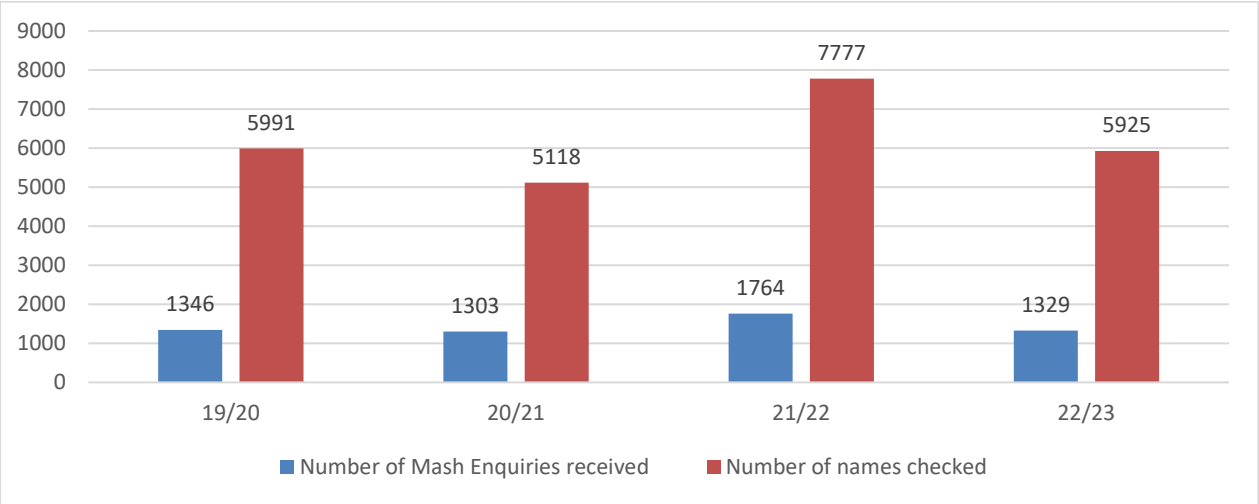
6.15 The children's team have undertaken focused improvement work with AED by presenting weekly short training sessions with staff to discuss the use of the under 18 AED CAS card, the safeguarding process and safeguarding referrals.

6.16 The children's team is required to provide an extensive amount of safeguarding information to external agencies, (Table 6). To deliver this information in a timely manner, the team has a 'duty 1' and 'duty 2,' with one duty responding to internal operational concerns, and the other duty responding to external requests for information. The team has been commended for their responsive and timely return of this information.

6.17 A single request for information can involve searching the clinical records of several patients, as the search can include a child, their siblings, their parents, grandparents and other members of the extended family. Recognising the impact of this, the MASH team had previously streamlined their process by only requesting information for relevant individuals, and by asking

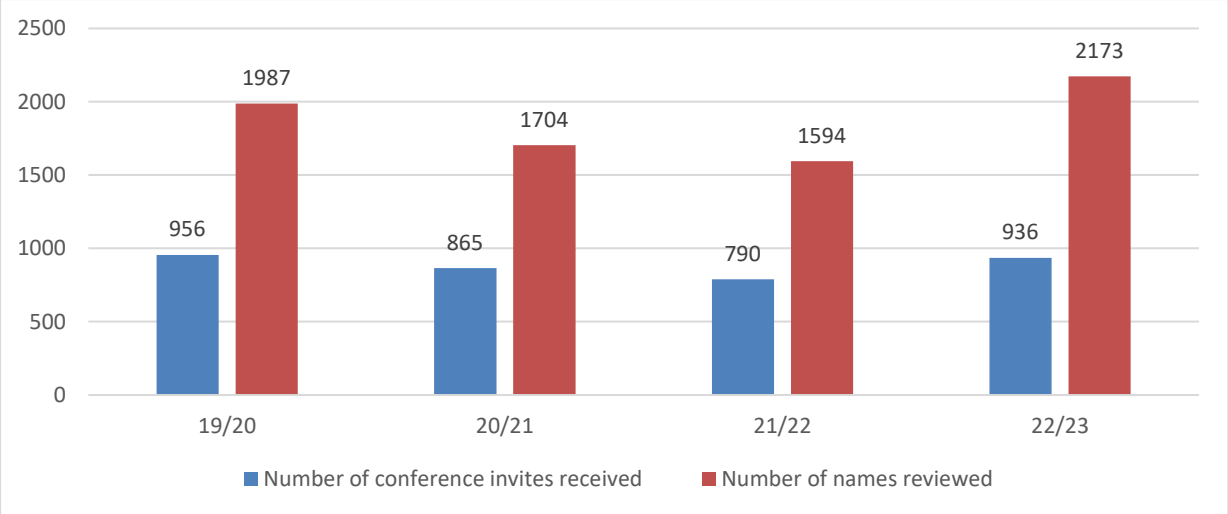
for information only dating back 2 years, (this is reflected in table 6). As an extra assurance the safeguarding practitioners will use their professional judgement, as to whether to disclose information dating back further than 2 years.

Table 6: Multi-agency Safeguarding Hub Requests for information.



6.18 This year the children's team have received invites to over 936 case conferences, (Table 7), resulting in over 2173 children's clinical records being reviewed, this is a 36% increase on the number of clinical records reviewed compared to 2021/2022. It is also worth noting the number of records checked is much higher as this figure does not include the parents' records and significant others records that are also searched.

Table 7: Case Conference Invites and Requests for Information



7.0 CHILD DEATH OVERVIEW PANEL (CDOP)

7.1 The Named Midwife and Named Nurse Children are CDOP Panel Members. The Trust meets its requirements in relation to the Local Safeguarding Children's Board child death processes, for

both Sefton and Lancashire. During this year, the Trust has received 45 child death notifications. This is a 29.7% decrease from the previous year.

7.2 Of these children, 11 were known to the Trust. In accordance with the CDOP process, all requests for further information were returned within timeframe, whether the child was known or unknown.

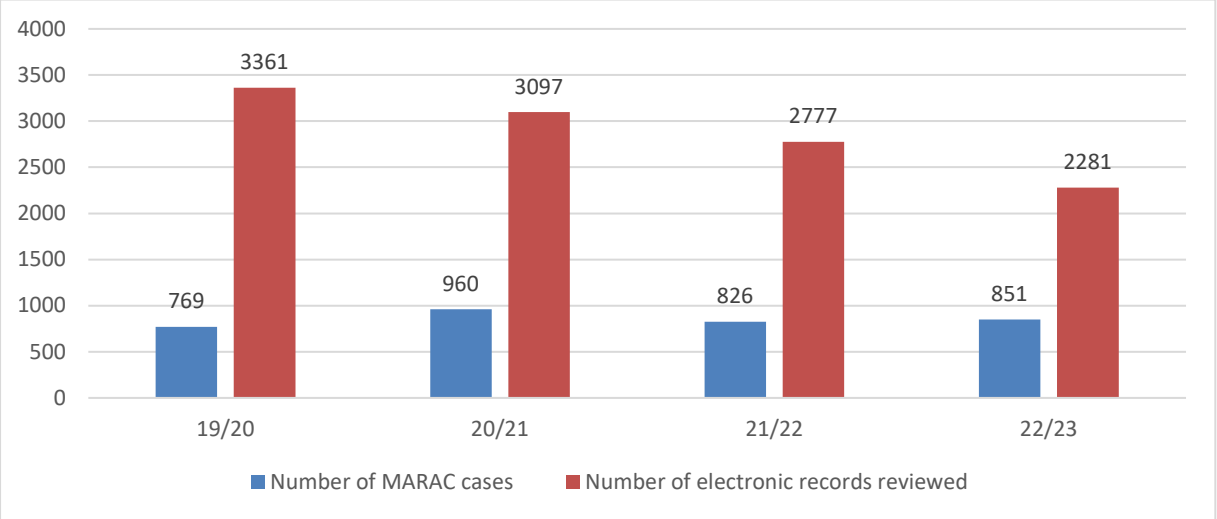
8.0 DOMESTIC ABUSE and SEXUAL ABUSE

8.1 There is recognition that domestic abuse (DA) covers a range of behaviors, and relationships, and domestic abuse is recognised under The Care Act 2014 with its own category. In 2020 there were 2.3 million adults aged between 16-74 who experienced domestic abuse (ONS, 2020). The Domestic Abuse Act 2021 came into force following the Domestic Abuse Bill being agreed by the House of Commons and the House of Lords 2022. The Domestic Abuse Act is the first act to provide a legal definition of 'Domestic Abuse'. The Act allows for wider recognition in relation to domestic abuse related crimes as well as recognition to victims, survivors, and perpetrators. It emphasises that Domestic Abuse is not just physical violence, but it can also be emotional, controlling, coercive and economic abuse. Following the publication of the Act, the team updated the Domestic Abuse Policy accordingly.

8.2 The Trust had 97% attendance (35 out of 36 attended) at the MARAC meetings in this year for Lancashire and Sefton. For the one MARAC meeting not attended relevant information was provided prior to the meeting to support decision making. The Trust continues to achieve100% compliance with adding the relevant alerts to the patient's clinical records within the 7-day timeframe, and there is a process in place to remove the flag if in 12 months no further incidents regarding the individual are referred to MARAC.

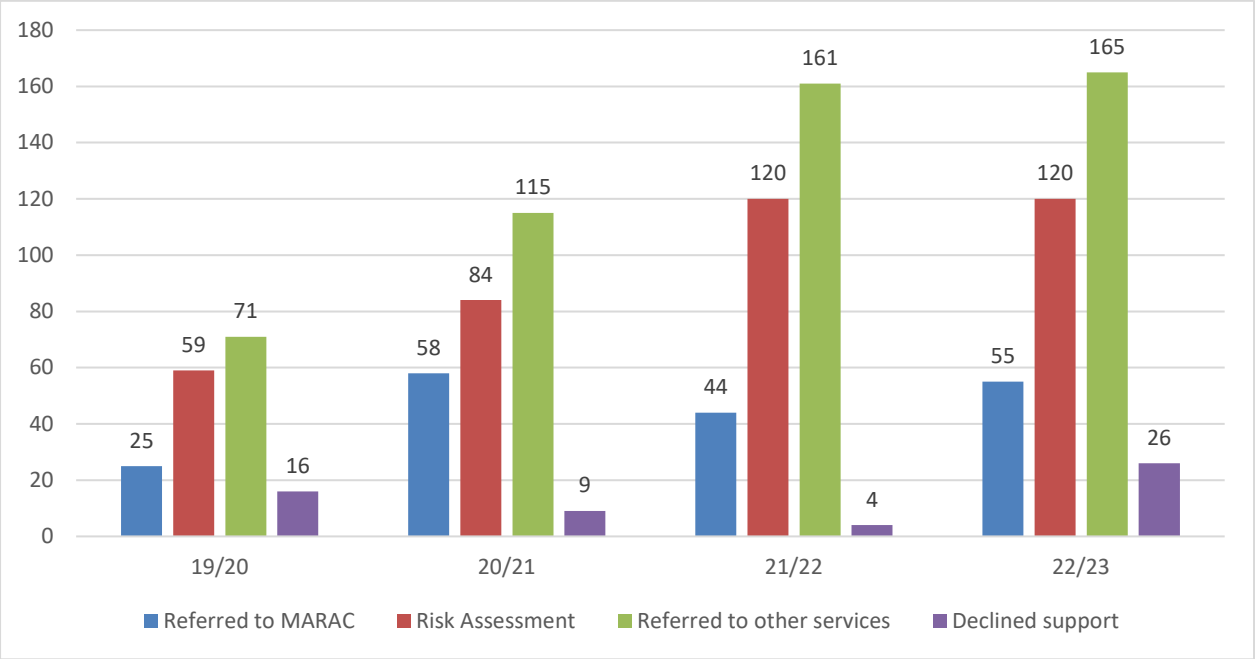
8.3 In 2022/2023 there were 851 MARAC cases, representing a 3% increase compared to the previous year. This resulted in 2281 electronic patient records being reviewed, (Table 8), as each case requires the patient's and their significant others electronic patient record to be searched, in order that relevant and proportionate information is shared during the MARAC meeting.

Table 8: **MARAC requests for information**



8.4 In incidents and or disclosure of actual or suspected domestic abuse, staff use the domestic abuse risk assessment to determine the most appropriate referral, (Table 9). This year the number of risk assessments completed has remained consistent. The referral to MARAC is undertaken by the safeguarding team, following a review of the datix and the risk assessment, and after the engagement of the person disclosing the abuse, and this year has seen a 25% increase to MARAC, indicating an increase in the number of 'high risk' cases being disclosure.

Table 9: **Risk assessments and referrals to MARAC**

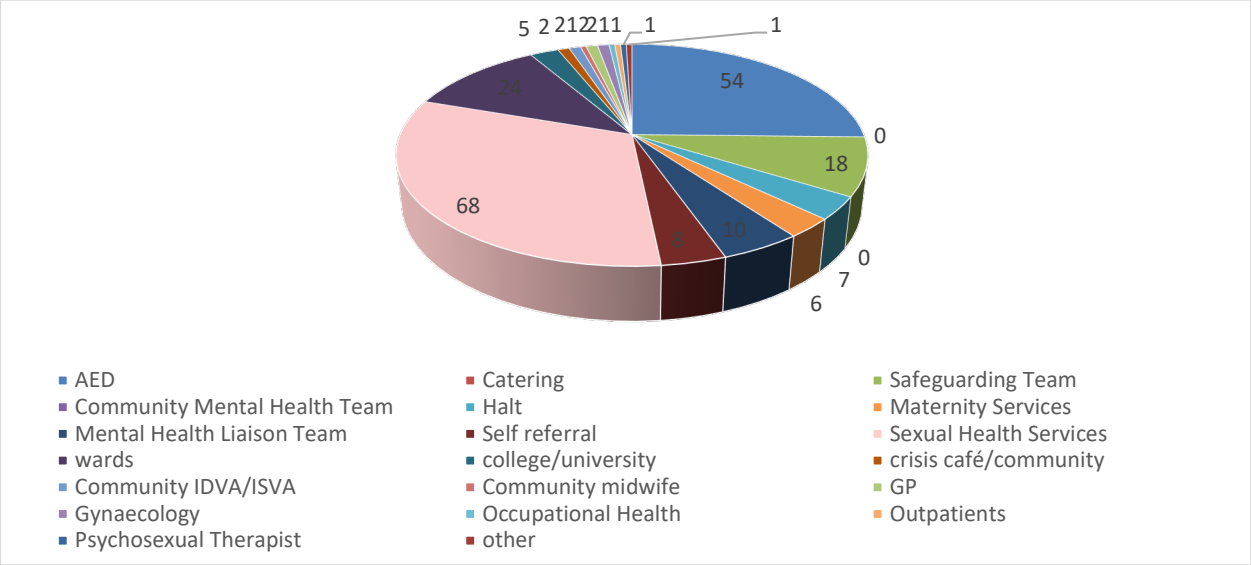


8.5 The safeguarding Team further provides support to staff who are the victim of domestic abuse.

8.6 **Health Independent Sexual Violence Adviser (ISVA)**

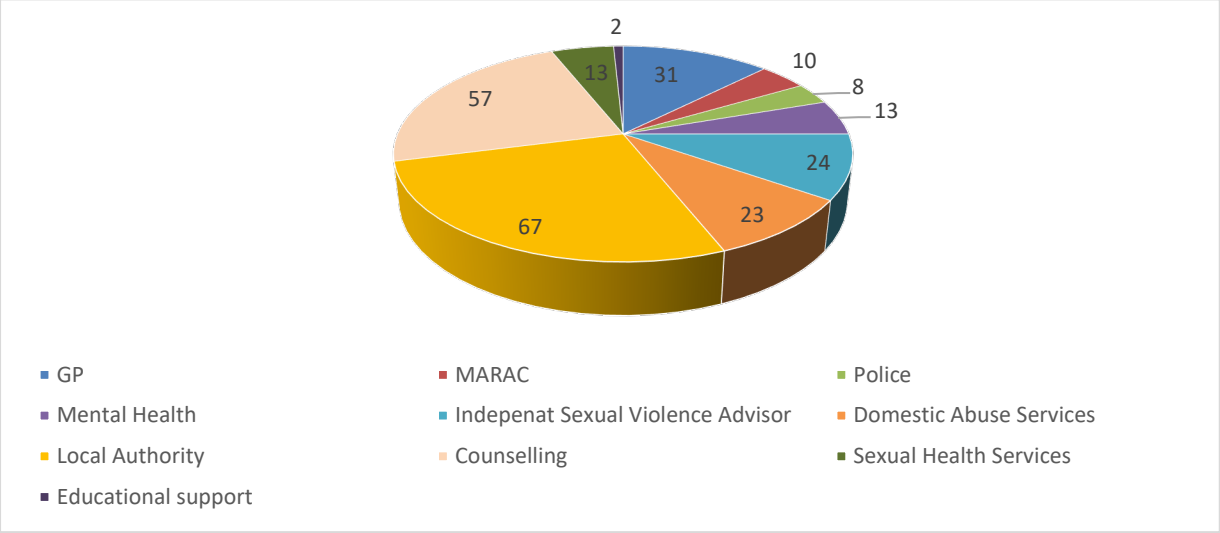
8.7 The Health Independent Sexual Violence Adviser (ISVA) is based within the safeguarding team (although employed by Blackpool Teaching Hospital). The role provides specialised support to victims of sexual abuse, male or female, aged 16 years and above, who have recently or in the past been subjected to any form of sexual abuse. In this year there have been 213 referrals made from a range of sources, (Table 10).

Table 10: HISVA Referral Source



8.8 Between April 2022 to March 2023 the percentage of patients not open to any Sexual Abuse Services prior to HISVA engagement was 80%, and the percentage of patients who had experienced recent sexual abuse (in last 10 days) was 26%, with 71% experiencing non-recent sexual abuse.

Table 11: Referrals to Support Services



9.0 DOMESTIC HOMICIDE REVIEWS (DHR's)

9.1 During 2022/2023 the Trust has been involved in 5 DHR's, which includes providing extensive chronologies (one dating back 25 years); undertaking individual management reports (IMR); providing Trust representation for all panel meetings.

9.2 The DHR's produce a final published report that the panel members approve, and the recommendations for each agency are included in report. To date the yet unpublished recommendations for the Trust include the provision of and Independent Domestic Violence Advisor (IDVA), ensuring routine enquiry at key moments, and staff undertaking professional curiosity.

10.0 SERIOUS CASE REVIEWS (SCR) and CHILD SAFEGUARDING PRACTICE REVIEWS (CSPRs)

10.1 The Named Nurse for Children's Safeguarding attends the Lancashire Safeguarding Practice Review Business Meeting, and the Sefton CSPR Group as requested. The Assistant Director of Safeguarding and the Named Nurses attend and support both SAR and CSPR panel reviews for both Lancashire and Sefton, as requested.

10.2 This year the children's Safeguarding Practitioner has supported the panel for 3 CSPRs, and the Trust has been directly involved with the two of the children. Appropriate learning has been shared internally and actions for sexual health services, from one of the CSPRs, have been completed.

10.3 This year the Trust has not been required to provide information for any rapid reviews for a CSPR.

10.4 Members of the safeguarding team and clinical staff have attended practitioner learning events in relation to local learning reviews. Actions from these reviews have been followed up and learning shared as appropriate. The safeguarding team has applied any learning ensuring this is included in level 3 children's training, and processes and policies updated, as required.

10.5 Learning from further CSPRs will be shared via the LSCB/CSAPs and the Learning and Development Subgroups, where the Trust provides representation.

10.6 SAR referrals are submitted to the LSAB, who triage and decide if to undertake a local panel to complete the SAR. The Trust has not been required to provide information to support any SARs in 2022/2023.

10.7 The safeguarding team review all learning from Lancashire and Sefton SARs and CSPRs, and as a result will adapt processes and policies, documentation, training and share information to relevant staff.

11.0 MENTAL CAPACITY ACT and DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

11.1 The Mental Capacity Act 2005 (MCA) is an integral piece of legislation used by healthcare professionals.

11.2 In 2009, DoLS was bolted onto the MCA 2005 to create a procedure enshrined in law to deprive people, who are assessed as lacking capacity, of their liberty (in their best interest). In 2014, the case 'Cheshire West' created the acid test to enable practitioners to define whether a

person is deprived of liberty. Under the acid test, any patient over the age of 18, who lacks capacity to consent to their arrangements (i.e. admissions to hospital), who is subject to continuous and effective supervision and control and is not free to leave, is defined as 'deprived of liberty,' and therefore a DoLS is required to safeguard their human rights. The impact for an acute Trust is that all patients who lack capacity and are in the acute hospital setting as an in-patient, require a DoLS authorisation.

11.3 This poses a challenge not only to S&O as an acute Trust but has also placed a heavy burden on the Supervisory Body (Lancashire and Sefton's County Council), who are required to complete Best Interest Assessments and authorise a considerable number of DoLS in the community, as well as the hospital setting. As a result, after 14 days patients are deprived of their liberty under the principal of best interests.

11.4 This is detailed in the Trust risk register which refers to patients who are placed under an urgent 14-day DoLS authorisation, which expires before the Supervisory Body has been able to complete a best interest assessment.

11.5 This year has seen the implementation of the DOLS portal where staff complete the DOLS authorisation electronically. Prior to completing the DOLS authorisation staff are required to electronically record the patients 2-stage capacity assessment. Throughout the document there are mandated fields ensuring accurate completion of the authorisation. The portal has streamlined the process for staff as they are no longer required to complete a datix, as the authorisation is automatically emailed to the safeguarding team. On receiving the completed DOLS authorisation the Safeguarding Administrator will directly email to the relevant Local Authority.

11.6 The portal and the DOLS proforma in Careflow has enabled colleagues in BI to develop a report that has replaced the DOLS database. This has provided a detailed report of all patients currently with a DOLS authorisation in place and when this expires. The BI report has improved the ease of access to data relating to DOLS.

11.7 The safeguarding team still have a robust system for monitoring the DoLS process: all DOLS authorisations are checked and quality assured; if required the authorisation is adjusted before submission to the Supervisory Body. Ward staff are required to review and record daily the restrictive practices in place to ensure these are the least restrictive and proportionate.

11.8 The team sends an email regularly to the Supervisory Body, advising of patients who no longer require a DoLS, and the patients who are awaiting a Best Interest Assessment. When the team is aware they further escalate to the Supervisory Body, any patient who needs an urgent Best Interest Assessment for example, they strongly object to being in hospital, they are subject to a high level of restrictive practice, or they have been an inpatient for significant period.

11.9 This year has seen an 8.4% increase in the number of referrals for a DoLS authorisation to 1857, (Table 12).

- 1081 Sefton / 739 West Lancashire / 29 Other

11.10 Those that are not authorised by the Supervisory Body are due to the patient being discharged before the assessment is undertaken; patients regaining capacity; patients who have

deceased; the urgent authorisation lapses due to no assessment being undertaken by the Supervisory Body, (Table 13).

Table 12: Deprivation of Liberty Safeguards Applications

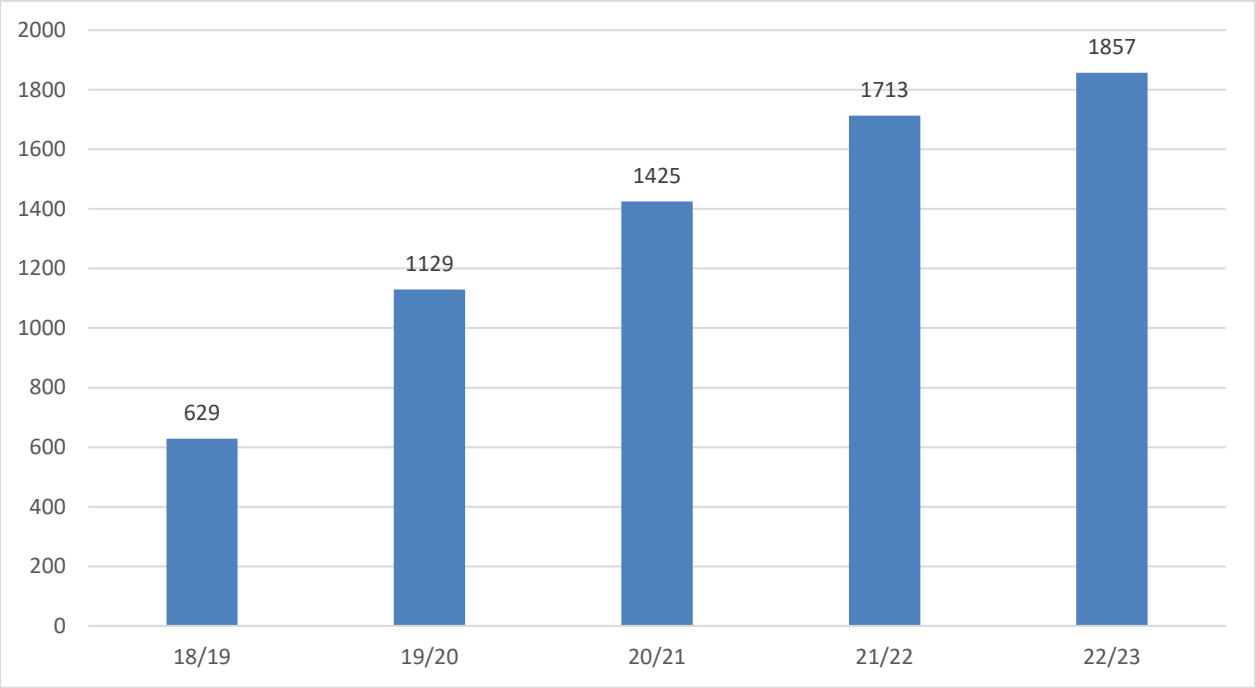
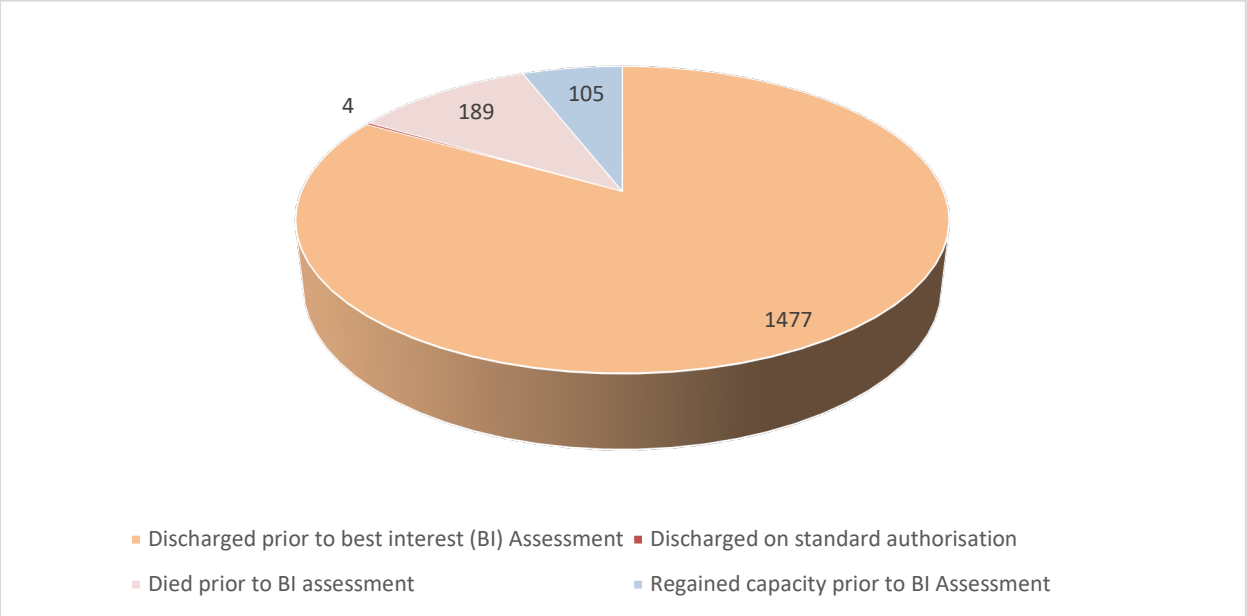


Table 13: Outcomes of DoLS Applications



11.11 Liberty Protection Safeguards (LPS)

11.12 In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards, (although the term is not used in the Bill itself). The target date for implementation was spring 2020, later revised to October 2020, and due to the pandemic October 2023.

11.13 The LPS will have significant implications for acute NHS Trusts, as the authorisation of the LPS will be the responsibility of the hospital and not the LA, as in the current arrangements.

11.14 In March 2022 the Code of Practice was released for a 16-week public consultation. The Assistant Director of Safeguarding provided both a Trust response and collaborated with partners to develop the responses for Lancashire and Cheshire and Mersey.

11.15. Since the draft Code of Practice, the Government has released a statement that LPS will not be implemented in the time of the current government. As a result, LPS working groups have been stood down until further time frames are provided by the next Government.

12.0 LEARNING DISABILITY

12.1 The Royal College of Nursing (RCN) 'Connecting for Change Report' (2016 and 2021), recommend 'Every acute hospital should employ at least one Learning Disability Liaison Nurse, and by 2020/21 all acute hospitals should have 24-hour Learning Disability Liaison Nurse cover.'

12.2 People with learning disabilities may experience multiple co-morbidities and chronic health problems. In the Confidential Inquiry (Heslop et al, 2013), 17% of the sample had four or more health conditions. Due to their experiences of both acute and chronic illness, people who are learning disabled have an increased attendance and admittance to acute general hospitals, and the demand from people with learning disabilities, their families and carers on specialist and general health service is expected to increase significantly in the future (Gates, 2011, as cited in Phillip, L. 2018).

12.3 The Learning Disability and Autism Practitioner (LDAP) became a substantive post in July 2022. Since commencing the post has demonstrated extensive value in relation to patient and care experience and providing staff support. In this time the current post-holder has shown the value of developing relationships with the patient's family, and or carers, and maintaining daily/weekly communications with the family. This has resulted in freeing the time of the ward-based nurses in conversations that can often be emotional and lengthy, and requiring a deeper level of experience and understanding of the needs of a patient with a learning disability and or autism.

12.4 The LDAP has provided an extensive amount of support to ward staff; supporting ward-based care; the provision of reasonable adjustments; facilitating a timelier discharge; providing ad-hoc learning disability and autism awareness sessions. They have established strong communications with community-based learning disability services, ensuring a collaborative approach to meeting the patient's care needs.

12.5 The LDAP has:

- Increased the number of patients with an LD alert by 17.4% to 635 compared to the 2022 benchmark, and by 207% compared to 2021 benchmark.
- Increased the number of patients with an autism alert by 416% from 12 to 50.
- Secured funding for the 'Autism Bus Reality Experience' to be provided at the Trust for a further 6 occasions during 2022/23, with 144 staff attending to date.
- Recruitment of one LD volunteer who has supported an array of events.
- Joint working with 'Live to Learn Musical Theatre Choir' to perform several musical performances at the hospital to enhance communication and integration of people with Learning Disabilities and Autism.
- Launch of the LD and autism champions, 10 staff trained to date.
- Revised the LD and autism policy.
- Teaching staff the use of Makaton.
- Developed new processes to monitor waiting times of those with a LD and or autism.
- Developed processes to provide LD and autism expertise to complaints and incidents involving those with a LD and or autism.
- Delivered face to face training to over 300 staff, using the Cheshire and Mersey LD and Autism training package.
- Supported the LD awareness week campaign – raising awareness of LD and Autism through daily posts and information boards, working collaboratively with the LD volunteer and Sefton Community LD Team.
- Represented the Trust at Sefton Parents and Carers Forum, which was attended by clients, parents and carers of children and young people with special educational needs.
- Developed and introduced social stories.

12.6 The LDAP supports the Learning from lives and deaths – People with a learning disability and autistic people **(LeDeR)** agenda. The LDAP ensures the Trust reports, within the required timeframe, the deaths of those with a learning disability and or autism. The LDAP liaises with the LeDer reviewer to provide the required information and following the review feedbacks recommendations into the Trust Mortality Operational Group. The LDAP provides representation at both Lancashire and Sefton LeDeR steering groups, ensuring the Trust is sited on improvements required to improve the lives, and prevent unavoidable deaths of those with a learning disability and or autism. The Assistant Director Safeguarding provides Trust representation at the LEDER review panel meetings for Sefton.

12.7 This year the Trust submitted 15 LEDER notifications

12.8 The annual NHS E/I submission learning disability and autism benchmark was completed and submitted in March, within the required timeframe, and the Trust are awaiting the results.

12.9 The LDAP represents the Trust at the SEND Improvement Programme Meeting and the SEND Champion meetings and has established links with the SEND Leads in both Lancashire and Sefton. In anticipation of SEND CQC inspection the Trust completed the SEND self-assessment to Sefton Place.

13.0 PREVENT

13.1 Prevent is part of the Government's counter terrorism strategy, and as the name suggests it is the part of the strategy designed to identify people who may be vulnerable to radicalisation, before they commit any crime. It therefore operates in the pre-criminal stage and essentially requires professional groups, particularly in the public sector, to be aware of the signs that an individual may be being radicalised, and then to refer such concerns onto the proper authorities

to make the necessary interventions. Local Authorities, Health, Education and the Police amongst others form the CHANNEL Panel, which considers every case referred, and determines which professionals should be engaged to intervene in addressing the individual's needs. The Named Nurse Adult is the only health representation at the Sefton CHANNEL Panel Group.

13.2 There remain 2 tiers of training aligned to staff role. All new staff receive a Prevent awareness leaflet in their welcome pack, and this is also available on the Trust intranet. For the e-learning level 3 and 5 PREVENT training, a trajectory was developed and submitted to Sefton Place, as compliance was <90%, the compliance was achieved in Q4 ahead of trajectory.

Table 15: Prevent Training Compliance

Overall Trust Compliance	Q1	Q2	Q3	Q4
PREVENT Level 1 and 2	95.2	95.1	93.8	93.7
PREVENT Level 3 and 5	88.8	89.1	89.2	90.6

13.3 The Trust has made no PREVENT referrals this year.

14.0 MANAGING ALLEGATIONS

14.1 There has been 30 reports that led to consideration for evoking the allegation policy. This is a 36% increase from the previous year, which may in part due to greater compliance with the policy.

14.2 In all cases the CBUs have taken responsibility for responding to the allegation raised and undertaken the required strategy meetings for an informed decision making in managing the allegation.

15.0 SAFEGUARDING AUDITS

15.1 The safeguarding team have undertaken a number of audits this year including:

Quality of child protection medicals
Paediatric Accident and Emergency Documentation Audit
Use of the under 18 AED card
Completion of safeguarding documentation for children attending the Paediatric Department and identified as being at risk of deliberate self-harm
Paediatric Safeguarding Audit - triangulating completed documentation against referrals and other information
The quality of children's social care referrals from Paediatrics, Maternity and adult AED referrals
Antenatal Home assessment visits including numbers of referrals
The completion of MCA and DoLS documentation - full site audit
The quality of adult safeguarding referrals
Completion of safeguarding documentation in AED for those attending with mental health and indicators of domestic abuse
SOCASS MCA & DoLs Audit- all Adult Wards
SOCASS Safeguarding Knowledge- All in-patient and outpatient areas

15.2 Quality of adult referrals audit.

This audit offered significant assurance. It was apparent that staff are not always providing details of the dependants. This is mitigated as the referral to the online Local Authority portal is completed by the safeguarding team who will undertake an advanced search to identify dependants and provide this information. The internal referral form has been adapted to support staff in completing this information.

15. 3Quality of Children's referrals audit.
This audit offered significant assurance. Again, further assurance is provided as the safeguarding team quality assure all referrals and if required provided additional information to the Local Authority.

15.4 Completion of MCA and DOLS documentation whole site.
The audit offered significant assurance that patients lacking capacity have a completed 2-stage capacity assessment, and an urgent DoLS authorisation completed. Regarding the completion of the daily restrictive practice review, although it has not achieved significant assurance this seen a 109% increase compared to the result in 2021.

15.5 Child Protection Medical Audit
The assurance level is significant for this audit. This is a clear improvement on the original audit and indicates that the recommendations and additional training and discussions of the importance of the process has been beneficial.

15.6 MCA knowledge transfer audit.
This is audited as part of the Trust Southport and Ormskirk Clinical Assessment and Accreditation Scheme SOCAAS. The knowledge audit is demonstrating staff have an underpinning knowledge of MCA and safeguarding.

15.7 Paediatric Accident and Emergency (PAED) Documentation Audit
The audit provided full assurance for the safeguarding questions considered in the audit, with all questions achieving 90% - 100%

15.8 Antenatal home visits
This audit relates to the undertaking one home visit during the ante-natal period. From the cases reviewed 59% had a home visit undertaken. The audit will be repeated as it was felt that not all staff would be aware that the ante-natal home visits have recommenced post pandemic.

15.9 AED Documentation compliance audits
These two audits are essentially documentation audits, to demonstrate if staff are completing the safeguarding question set on their documentation. The audits offered limited assurance that staff are completing the safeguarding documentation. To offer some reassurance the team reviewed another 10 cases where referrals had been made to the safeguarding team. In all but one (90%) staff had made a referral to the safeguarding team in the absence of completing the safeguarding documentation. The Safeguarding concerns raised were in fact documented elsewhere in the AED documentation. This would indicate that staff are considering safeguarding in the absence of completing the safeguarding questions. This could be seen as a positive and considered that staff are not requiring the prompts of the safeguarding questions to consider safeguarding, although this would need to be demonstrated further.

15.10 Completion of safeguarding documentation for children attending the Paediatric Department and identified as being at risk of deliberate self-harm

This audit offered significant assurance; however, further improvements have been noted regarding the risk assessment documentation, and this is included in the work plan.

15.11 <18 CAS Card use

This audit is now undertaken on a regular basis by the CBU, and compliance has increased to 70%.

16.0 COMMISSIONING STANDARDS

16.1 The Trust submits a quarterly update to Sefton Place as part of the KPI submission. The requirement has been for an updated commissioning standards action plan to be submitted each quarter, to demonstrate progress against the action plan developed against the previous self-assessment. All actions in the commissioning standards were achieved in Q4 2021/2022. The Trust awaits the publication of the revised commissioning standards which will be standardised across Cheshire and Mersey.

Comm Standards Action plan

17.0 RISK REGISTER

17.1 There are 2 risks relating to safeguarding in 2022/23:

17.2 DoLS- Lancashire Local Authority is not undertaking Best Interest Assessments; therefore, the Trust may be depriving patients of their liberty without the necessary legislation in place. This has been escalated via the Lancashire Safeguarding Board, and the Local Authority has a process for prioritising their waiting list. This has been mitigated as detailed in section11.

17.3 The Trust currently does not have a clinical photography team; as a result, photographs provided by the Trust for the purpose of child protection and criminal investigation processes and wound or pressure ulcer management do not represent the injury/harm/wound/pressure ulcer accurately. The Assistant Director of Safeguarding and colleagues from STHK presented a business case to the Executive Team. Expanding the service to Southport and Ormskirk is recognised as a cost pressure and will be considered under the new organisation.

18.0 THE SAFEGUARDING TEAM's WORK PLAN 2023/2024

- We will align safeguarding processes and practice across the new organisation with STHK and develop ways of working across the teams.
- We will ensure the safeguarding team undertake Trauma Informed Training, incorporating the principals into their practice.
- We will develop and embed the role of the HIDVA and increase staff awareness in relation to domestic abuse and the potential opportunity for support during health appointments and attendances.
- We will ensure the Trust is compliant with the requirements of the Domestic Abuse Act (2021).
- We will ensure the Trust is compliant with the Serious Violence Duty (2022)
- We will ensure compliance with the NICE Guidance 'Integrated health and social care for people experiencing homelessness,' (2022)
- We will ensure the Trust is meeting its statutory responsibilities of the SEND agenda.

- We will develop an internal process for identifying patients who are homeless or at risk of homelessness to ensure the trust is fulfilling its “Duty to Refer” requirements.
- We will implement the Oliver McGowan e-learning for all staff.
- We will review the continued provision of Personal Safety Training engaging with colleagues at STHK to ensure this is across all sites.
- We will collaborate with the Sefton MASH Team to streamline information sharing.
- We will provide partner support to the Sefton Children’s Social Care Improvement plan.
- We will support Lancashire’s review and implementation of new MARAC process.
- We will become a member of the Pre-Birth Protocol task and finish group in Sefton, supporting the ‘Building Attachment and Bonds Service’ (BABS).
- We will work with the BI Team to streamline the process for identifying and following up patients with LD and or autism who have missed an appointment.
- We will undertake a review of the S42 Memorandum of Understanding with Sefton Local Authority.
- We will increase staff awareness of advocacy and other services such as IMCAs.
- We will undertake a review of the mental capacity training to improve compliance.
- We will provide tools to support staff to complete 2 stage capacity assessments.
- We will develop a suite of pathways to support clinical staff in safeguarding decision making and referrals
- We will revise the mental health risk assessments used in Paediatric departments.
- We will continue to improve the completion of the safeguarding documentation and assessment in AED.
- We will continue to ensure the development of a network of safeguarding ambassadors.
- We will seek to maintain training compliance ensuring compliance to the intercollegiate documents.
- We will work with IT colleagues to develop and implement digital streamlined process.
- We will review the ways of working of the team and make improvements that will support the safeguarding agenda.

19.0 CONCLUSION

19.1 Significant progress has been made in the journey towards safeguarding being embedded in to practice and considered everyone’s business. The team work operationally within the Trust and engage extensively with external partners, given the nature of safeguarding being a multi-agency and multi-professional practice.

19.2 The Safeguarding team oversee and monitor key areas to ensure appropriate referrals and actions are made to safeguard the un-born, children, young people and adults at risk of abuse. This has been enhanced by the additional roles of the LDAP, the HIDVAs and the HISVA. The safeguarding team will continue to improve and simplify processes, embed training into practice, ensuring quality referrals are made, and enable staff to use their time with patients effectively to identify and manage safeguarding concerns.

20.0 RECOMMENDATIONS

20.1 The Committee is asked to recognise the achievements made by the Safeguarding Team this year outlined in the report and agree the work plan for the year ahead.

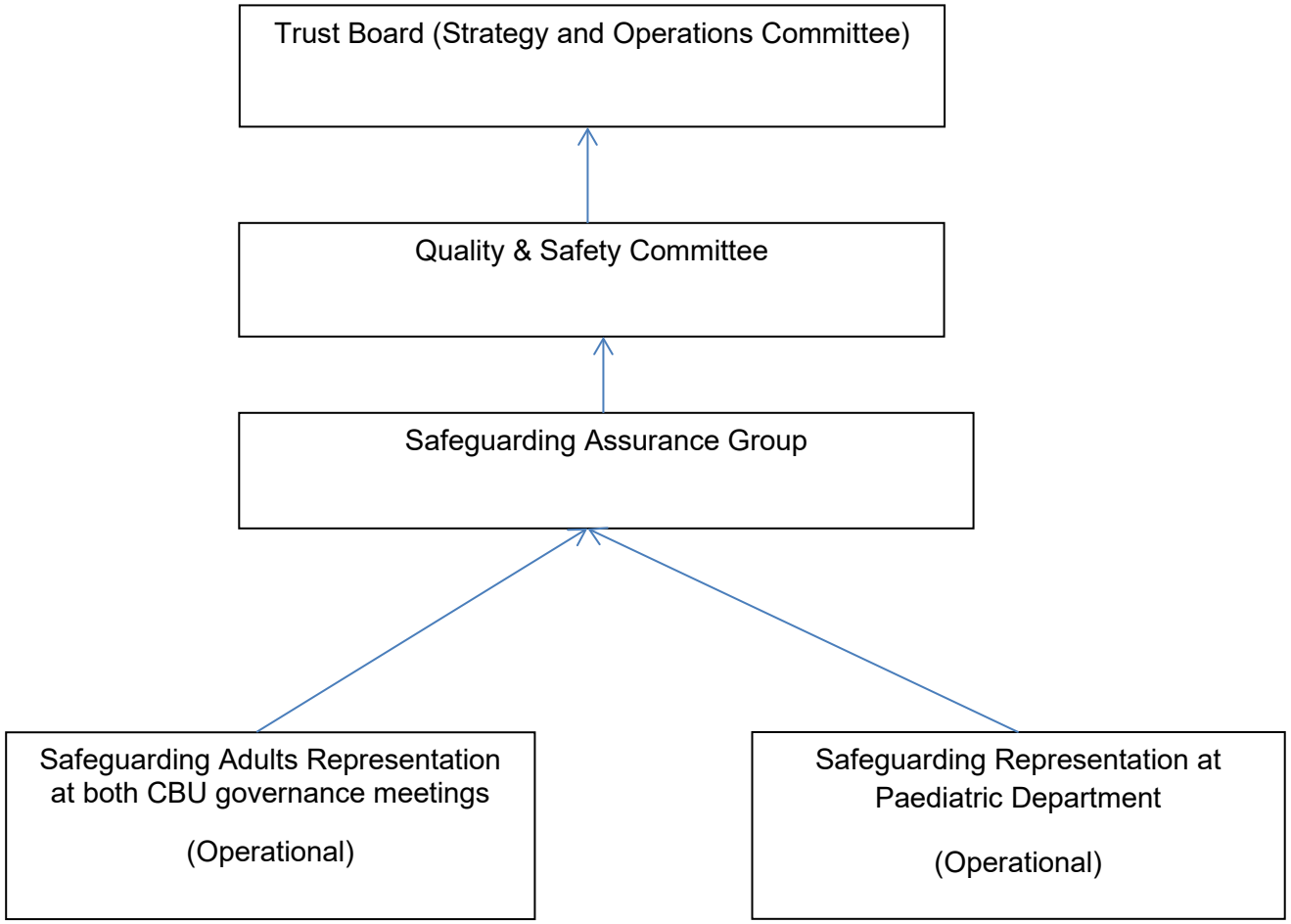
21.0 CASE STUDIES

21.1 The 5 case studies below provide examples of the role of the safeguarding team and value in safeguarding the un-born children, young people and adults at risk of abuse. In all names have been changed.

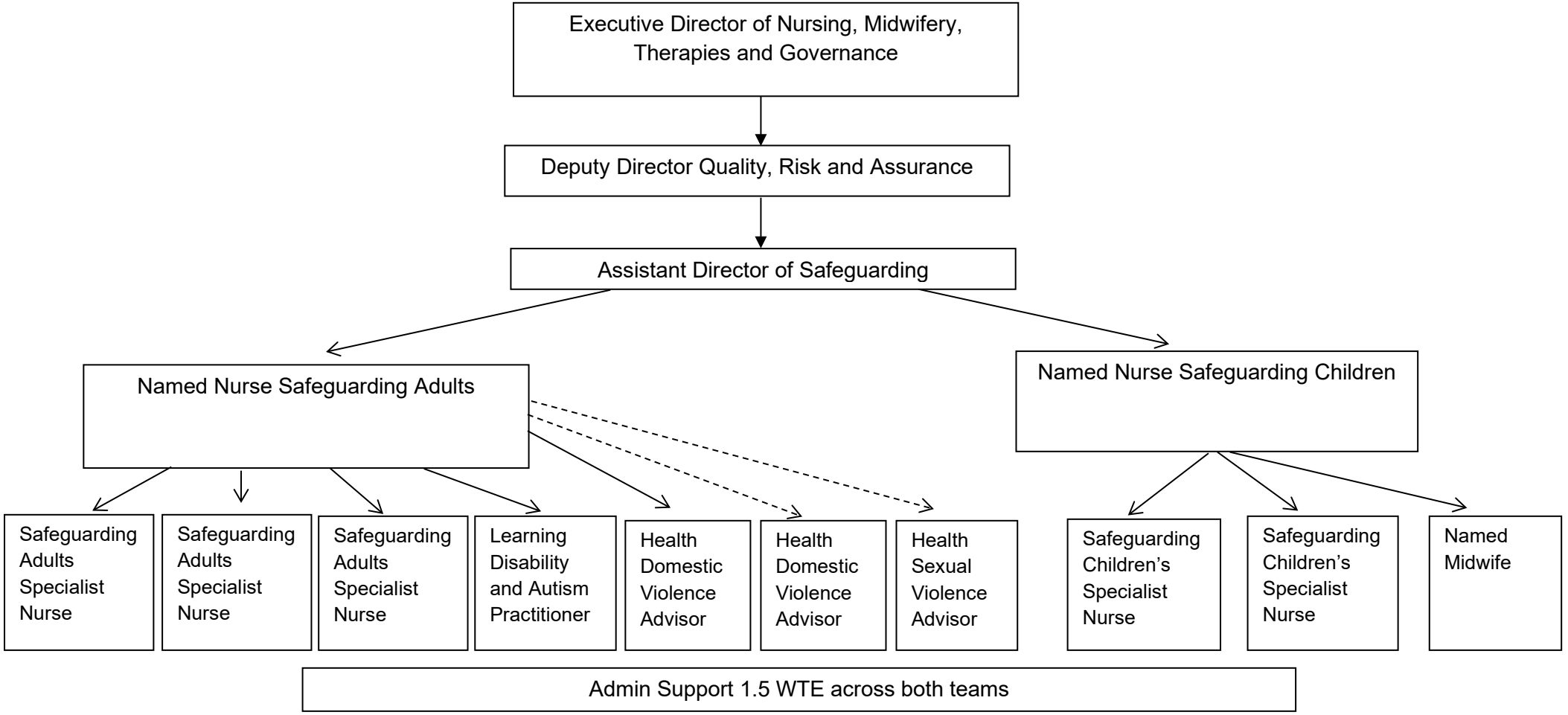
21.2 Given the sensitive and emotional content of the case studies and protecting confidentiality, the case studies have been removed for meetings with external and public membership.

21. 3 The case studies related to the disclosures of domestic abuse, sexual abuse and financial abuse by both female and male adults and children.

Appendix 1: Governance Arrangements



Appendix 2: Southport and Ormskirk Trust Safeguarding Structure



Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	**25 October 2023**
Agenda Item	**MWL TB23/052 (15.1)**			
Report Title	Workforce Race Equality Standard 2022/23			
Executive Lead	Anne-Marie Stretch, Director of Human Resources			
Presenting Officer	Anne-Marie Stretch, Director of Human Resources			
Action Required	X	**To Approve**		**To Note**

Purpose

This report provides an overview and analysis of the Trust's Workforce Race Equality Standard (WRES) for 2023. The data was submitted to NHSE on the 31 May 2023 (WRES).

This report provides an overview and analysis of the legacy St Helens & Knowsley Teaching Hospital NHS Trust's Workforce Race Equality Standard (WRES) data for 2022/2023. Where data is available, comparison data is provided for Southport & Ormskirk NHS Trust, and NHS national averages were available.

Executive Summary

Summary: The following is an overview of the WRES Highlights for 2022/23

Workforce data metrics:

- An increase in the proportion of total BME staff to 13%; Non-Clinical staff to 2.5%; Clinical Non-Medical staff to 13.1%; and Clinical Medical & Dental staff to 45.3%
- An increase in BME staff in non–clinical bands 2-8b. There are no BME declared staff on Bands 8c, 8d, 9 or VSM.
- An increase in BME staff in clinical non-medical bands 2 to 6, 8a. There are no BME staff declared on Bands 8b, 8d, 9 or VSM.
- BME applicants are 2 times less likely to be appointed from shortlisting compared to White applicants.
- BME staff less likely to enter disciplinary process than White staff.
- No ethnicity gap on accessing non-mandatory training or CPD

Staff survey data:

- 29.1% BME staff report experiencing harassment, bullying or abuse from patients (30.3% nationally) compared to 25.9% of White staff.
- 8.6% BME staff report experiencing harassment, bullying or abuse from managers (11.6% nationally) compared to 7.4% of White staff.
- 22.6% BME staff report experiencing harassment, bullying or abuse from colleagues (22.6% nationally) compared to 13.7% of White staff.
- 48.3% BME staff states they don't believe the Trust provides equal opportunities for career progression or promotion (47.1% nationally), compared to 65.5% of White staff.
- 22.2% BME staff states they have experienced discrimination from a manager or colleague (16.1% nationally), compared to 3.9% of White staff.

Financial Implications
None
Quality and/or Equality Impact
This report is a regulatory requirement under the NHS Contract. It forms part of the Trust's work to promote race equality in line with the Equality Act 2010.
Recommendations
The Trust Board is asked to note and approve the report for publication and to approve the summary actions.

Strategic Objectives	
	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Workforce Race Equality Standard Report
Data Summary

April 2022 – March 2023

1. Executive Summary

This report provides the Trust Board with the Workforce Race Equality Standard (WRES) data for St Helens & Knowsley Teaching Hospitals NHS Trust only; for the period 2022-2023 in line with the NHS Standard Contract requirements to publish the WRES indicators.

Comparison data is provided for Southport & Ormskirk Hospitals NHS Trust, and national averaged where applicable, and available.

2. Introduction

NHS England 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 Black and Minority Ethnic (BME) staff in the NHS and places an onus on NHS organisations to develop and implement actions to bring about continuous improvements. The main purpose of the WRES is:

- to help NHS organisations 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 BME staff,
- to improve BME representation at the Board level of the organisation.

Indicators 1 and 9 refer to the **31st March 2023** snap short date; Indicators 2-4 refer to the financial year **1st April 2022 to 31st March 2023**; and indicators 5-8 refer to the **November 2022** staff survey.

The 9 WRES indicators are:

1. **Staff Population**: Percentage of White and BME staff who are Non-Clinical, Clinical Non-Medical, and Clinical Medical by Agender for Change (AfC) pay bands or grade codes.
2. **Recruitment & Selection**: Relative likelihood of staff being appointed from shortlisting across all posts.
3. **Disciplinary**: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. **Training**: Relative likelihood of staff accessing non-mandatory training and Continuing Professional Development (CPD).
5. **Harassment 1**: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months
6. **Harassment 2:** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

7. **Discrimination 1**: Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
8. **Discrimination 2**: In the last 12 months have you personally experienced discrimination at work from any of the following, a manager/team leader or other colleagues
9. **Board Representation**: Percentage difference between the organisations' Board membership and its overall workforce disaggregated: By voting membership of the Board; By executive membership of the Board

2.1. Scope

The following data principles are applied to the WRES data:

- Data relates to the total substantive workforce on the relevant snapshot date with the exception of Indicator 1 which disaggregates the data by Non-Clinical, Clinical Non-Medical and Clinical-Medical, and by Pay Band.
- Medical staff are included; however a new Medical WRES data set is to be published by NHSE in 2023/24 which will capture additional questions.
- Bank staff are not included; however a new Bank WRES data set is to be published by NHSE in 2023/24 which will capture additional questions.
- WRES data is only reported on the broad ethnicity categories of Black and Minority Ethnic (BME), White, and Unknown.

The WRES submission does not provide an in-depth analysis of the different demographics of the NHS workforce or the different source population and talent pipelines that make up the career groups. For example, nationally the medical and dental workforce is significantly overrepresented by BME individuals which will skew staff population data incorporating these job groups. This can inflate BME population figures when comparing to the local population, and job groups which are more likely to recruit locally

3. Workforce WRES Data

3.1. Staff Profile Workforce Overview

In the snapshot date of 31st March 2023, St Helens and Knowsley Teaching Hospitals NHS Trust employed 6965 staff which consisted of:

- 13.0% Black and Minority Ethnic staff (BME)
- 85.61% White staff
- 1.42% Not Stated/ unspecified / prefer not to answer.

3.2. Indicator 1: Non-Clinical and Clinical Workforce

Indicator 1 is a review of the staff population by Non-Clinical Workforce by AfC pay bands; Clinical Workforce not Medical by AfC pay bands; and Clinical Workforce Medical and Dental.

Table 1: Staff Headcount

Staff Headcount March 2023	White	BME	Unk	STHK %BME	S&O %BME	NW %BME	Acute %BME	National %BME
Total	5963	903	99	13.0%	11.6%	17.1%	28.9%	26.4%
Non-Clinical AfC Workforce	1844	47	21	2.5%	3.6%	-	-	-
Clinical AfC Workforce	3812	583	56	13.1%	11.1%	-	-	-
Medical and Dental Workforce	307	273	22	45.4%	45.9%	-	-	-

From March 2022 to March 2023, there was an increase in the number and proportion of BME staff

- The total workforce from 756 (11.3%) to 903 (13.0%).
- Non-Clinical staff from 38 (2.1%) to 47 (2.5%)
- Clinical Non-Medical roles from 458 (10.7%) to 583 (13.1%)
- Clinical Medical & Dental roles from 260 (45.1%) to 273 (45.3%)

Indicator 1a) Non-Clinical workforce

- The total number of BME Non-Clinical staff increased from 38 to 47, with an increase in the number and proportion of BME staff on bands 2 to 8b.
- There were no declared BME staff on Bands 8c, 8d, 9 or VSM.

Table 2: Staff Headcount Non-Clinical Workforce

STHK	2021-2022		2022-2023	
	% White	% BME	% White	% BME
Band 1	100%	-	87.0%	-
Band 2	97.2%	1.9%	97.3%	2.1%
Band 3	96.7%	2.5%	96.2%	3.1%
Band 4	98.6%	0.8%	98.5%	1.0%
Band 5	94.1%	4.6%	93.9%	4.9%
Band 6	96.5%	1.1%	97.7%	2.3%
Band 7	96.5%	3.5%	94.1%	4.9%
Band 8A	95.8%	2.1%	93.9%	4.1%
Band 8B	97.6%	2.4%	95.7%	4.3%
Band 8C	100%	-	100%	-
Band 8D	90.0%	10.0%	100%	-
Band 9	100%	-	100%	-
VSM	85.7%	14.3%	100%	-
Average	97.1%	2.1%	96.4%	2.5%

Indicator 1b) Clinical workforce: Non-Medical

- The total number of BME Clinical Non Medical staff increased from 458 (10.7%) to 583 (13.1%), with an increase in the number and proportion of BME staff on bands 2 to 6, 8a.

- There were no declared BME staff on Bands 8b, 8d, 9 or VSM.

Table 3: Staff Headcount Clinical Non-Medical Workforce

STHK	2021-2022		2022-2023	
	% White	% BME	% White	% BME
Band 1	100%	-	100%	-
Band 2	95.1%	3.8%	94.6%	4.7%
Band 3	96.4%	2.5%	93.5%	5.1%
Band 4	91.1%	8.3%	91.6%	7.8%
Band 5	73.3%	24.4%	67.3%	30.4%
Band 6	91.8%	6.6%	91.1%	7.7%
Band 7	92.7%	6.2%	93.4%	5.7%
Band 8A	93.4%	6.0%	92.1%	7.9%
Band 8B	100%	-	100%	-
Band 8C	92.3%	7.7%	91.7%	8.3%
Band 8D	100%	-	100%	-
Band 9	100%	-	100%	-
VSM	100%	-	100%	-
Average	87.9%	10.7%	85.6	13.1%

Indicator 1c) Clinical workforce: Medical & Dental

- The total number of BME Clinical Medical & Dental staff has increased from 260 (45.1%) to 273 (45.3%) and the total number of White staff has increased from 302 to 307. There was also an increase in the number of unknown ethnicities recorded from 14 to 22, mainly in Trainee Grades.
- The main increase of BME staff was for Trainee Grades (74 to 91), whereas the main increase for White staff was Consultants (169 to 178) whereas the number of BME consultants remained the same.

Table 4: Staff Headcount Clinical Medical & Dental Workforce

STHK	2021-2022		2022-2023	
	% White	% BME	% White	% BME
Consultants	55.8%	41.9%	57.1%	40.7%
Consultants also Senior medical manager	100%	0.0%	100%	0.0%
Non-consultant	26.3%	71.3%	26.0%	70.1%
Trainees	54.8%	42.3%	47.7%	46.1%
Other	88.2%	11.8%	93.3%	6.7%
Average	52.4%	45.1%	51.0%	45.4%

Medical data does not include Lead Employer staff, including Lead Employer doctors who are on placement within the Trust.

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

Indicator 2 is an assessment of the Trusts recruitment and selection practices, and whether BME applicants are as likely as White applicants to be successfully shortlisted and appointed.

This indicator is assessed at “whole organisation” level and does not disaggregate the recruitment trends by job group or department where BME individual may be more or less likely to form part of the talent pool e.g., BME people are overrepresented in the medical and dental profession.

Table 5: Relative likelihood of appointment from shortlisting

STHK	White	BME	Unknown
2022-2023	26.04%	12.88%	70.45%

Table 6: Relative likelihood of White staff being appointed from shortlisting compared to BME staff

STHK	
2022-2023	2.02

A value <1 means that BME applicants are more likely to be appointed, and value >1 means they are less likely to be appointed. For example a value of "2.0" would indicate that White candidates were twice as likely as BME candidates to be appointed from shortlisting, whilst a value of "0.5" would indicate that White candidates were half as likely as BME candidates to be appointed from shortlisting.

- White applicants who are shortlisted are more likely to be offered a post compared to BME applicants.
- The relative likelihood of white applicant being appointed compared to BME staff stands at x2.02 times that a BME applicant.

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

Indicator 3 is an assessment of whether BME staff are more likely to face formal disciplinaries compared to White staff. There are relatively few formal disciplinaries each year, with 71 in 2021/2022, and 130 in 2022/2023.

In 2022/2023 the relative likelihood measure for this indicator was 0.67, meaning that White staff were more likely than BME staff to enter formal disciplinary processes. This was a reduction from a likelihood of 1 in 2021/2022 which meant there was an equal likelihood.

Table 7: Likelihood of staff entering the formal disciplinary process

YES	STHK White	STHK BME	STHK Unk	S&O White	S&O BME	S&O Unk
2021-2022	1.06%	1.06%	1.11%	0.13%	0.00%	0.17%

2022-2023	1.98%	1.33%	0.00%	0.16	0.25%	0.35%

Table 8: Relative likelihood of BME staff entering the formal disciplinary process compared to White staff

	STHK	S&O
2021-2022	1.00	0.00
2022-2023	0.67	1.55

A value <1 means that BME staff are less likely to enter formal disciplinary processes, and value >1 means they are more likely to enter formal disciplinary processes. For example a value of "2.0" would indicate that BME staff were twice as likely as White staff to enter a formal disciplinary process, whilst a value of "0.5" would indicate that BME staff were half as likely as White staff to enter a formal disciplinary process.

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

Indicator 4 is an assessment of whether BME staff have the same access to non-mandatory training and development as White staff.

Non-mandatory training refers to any learning, education, training or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement or mandated by the organisation. All training and development recorded on ESR that is not classed as mandatory training has been included in this data.

For 2022/2023:

- 100% of White staff and 99.89% of BME staff had accessed non-mandatory training and CPD
- The relative likelihood measure for this indicator was 1.00, meaning there was no difference in the relative likelihood of white and BME staff accessing non-mandatory training and CPD in the reporting period.

Table 9: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.

	STHK	S&O
2021-2022	1.03	0.97
2022-2023	1.00	0.96

4. Staff Survey Questions

The NHS Staff Survey was completed by 2691 staff, this equates to a 34% response rate. The average combined percentage for combined acute and community trusts in England is 44%

4.1. Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months (Staff Survey)

Table 10:

	STHK All	STHK White	STHK BME	S&O All	S&O White	S&O BME	National BME
2021-2022	25.9%	25.5%	29.7%	28.3%	26.1%	28.8%	29.3%

2022-2023	26.2%	25.9%	29.1%	29.4%	27.9%	32.3%	30.3%

- 0.29 point increase in the proportion of staff reporting experiencing bullying and harassment
- 0.36 point increase in the proportion of White staff reporting experiencing bullying and harassment
- 0.54 point decrease in the proportion of BME staff reporting experiencing bullying and harassment

4.2. Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (Staff Survey)

Table 11:

Manager	**STHK All**	**STHK White**	**STHK BME**	**S&O All**	**S&O White**	**S&O BME**	**National BME**
2021-2022	10.3%	10.2%	11.1%	13.4%	TBC	14.5%	12.0%
2022-2023	7.5%	7.4%	8.6%	14.0%	TBC	13.2%	11.6%

- 2.80 point decrease in the proportion of staff reporting experiencing bullying and harassment
- 2.87 point decrease in the proportion of White staff reporting experiencing bullying and harassment
- 2.47 point decrease in the proportion of BME staff reporting experiencing bullying and harassment

Table 12:

Colleague	**STHK All**	**STHK White**	**STHK BME**	**S&O All**	**S&O White**	**S&O BME**	**National BME**
2021-2022	15.0%	14.2%	22.6%	21.1%	TBC	25.8%	21.9%
2022-2023	14.7%	13.7%	22.6%	22.7%	TBC	31.3%	22.6%

- 0.29 point decrease in the proportion of staff reporting experiencing bullying and harassment
- 0.44 point decrease in the proportion of White staff reporting experiencing bullying and harassment
- 0.22 point increase in the proportion of BME staff reporting experiencing bullying and harassment

4.3. Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (Staff Survey)

This staff survey question asks; *"Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?"* with the options to answer; Yes, No or Don't Know.

Table 13:

YES	**STHK**	**STHK**	**STHK**	**S&O**	**S&O**	**S&O**	**National**

	All	White	BME	All	White	BME	BME
2021-2022	62.5%	64.5%	48.3%	50.3%	50.9%	48.5%	45.4%
2022-2023	63.6%	65.5%	48.3%	49.5%	50.7%	43.0%	47.1%

- 1.06 point increase in the proportion of staff reporting Yes
- 1.01 point decrease in the proportion of White staff reporting Yes
- 0.00 point change in the proportion of BME staff reporting Yes
- 1.01 point increase in the difference between White v BME in 2021/22 (16.24 points) to 2022/23 (17.25 points)

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

Table 14:

YES	STHK All	STHK White	STHK BME	S&O All	S&O White	S&O BME	National BME
2021-2022	6.7%	5.8%	17.1%	8.5%	6.2%	25.4%	16.5%
2022-2023	5.1%	3.9%	22.2%	8.7%	6.0%	22.2%	16.1%

- 1.63 point decrease in the proportion of staff reporting Yes
- 1.89 point decrease in the proportion of White staff reporting Yes
- 5.08 point increase in the proportion of BME staff reporting Yes
- 6.97 point increase in the difference between White v BME in 2021/22 (11.39 points) to 2022/23 (18.36 points)

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

Table 15: Board Membership

		2021-2022			2022-2023		
		% White	% BME	% Unknown	% White	% BME	% Unknown
STHK	Board Member	93.8%	6.3%	0.0%	93.8%	6.3%	0.0%
	Workforce	87.3%	11.3%	1.3%	85.6%	13.0%	1.4%
	Difference	6.4	-5.1	1.3	8.1	-6.7	1.4
S&O	Board Member	94.5%	0.6%	0.0%	78.6%	0.0%	21.4%
	Workforce	72.1%	9.1%	18.8%	71.9%	11.6%	16.5%
	Difference	22.4	-3.6	18.8	6.8	-11.6	4.9

The Trust has 1 BME member of the Board out of 16 or 6.3%. This compares to 13.2% nationally (2022).

	% White	% BME	% Unk	% White	% BME	% Unk
2022-2023	66.7%	11.1%	22%	-	-	-

5. Conclusion

Overall, the WRES indicators show the following:

- An increase in the proportion of total BME staff to 13%; Non-Clinical staff to 2.5%; Clinical Non-Medical staff to 13.1%; and Clinical Medical & Dental staff to 45.3%
- An increase in BME staff in non–clinical bands 2-8b. There are no BME declared staff on Bands 8c, 8d, 9 or VSM.
- An increase in BME staff in clinical non-medical bands 2 to 6, 8a. There are no BME staff declared on Bands 8b, 8d, 9 or VSM.
- BME applicants are 2 times less likely to be appointed from shortlisting compared to White applicants.
- BME staff less likely to enter disciplinary process than White staff.
- No ethnicity gap on accessing non-mandatory training or CPD
- 29.1% BME staff report experiencing harassment, bullying or abuse from patients (30.3% nationally) compared to 25.9% of White staff.
- 8.6% BME staff report experiencing harassment, bullying or abuse from managers (11.6% nationally) compared to 7.4% of White staff.
- 22.6% BME staff report experiencing harassment, bullying or abuse from colleagues (22.6% nationally) compared to 13.7% of White staff.
- 48.3% BME staff states they don’t believe the Trust provides equal opportunities for career progression or promotion (47.1% nationally), compared to 65.5% of White staff.
- 22.2% BME staff states they have experienced discrimination from a manager or colleague (16.1% nationally), compared to 3.9% of White staff.

6. Summary Action Plan

To address the issues identified within the WRES data analysis, the Trust is committed to delivering the following summary actions:

Table 16: Action Plan

Area of Activity	Main Action	Success Measures	Deadline
Underrepresentation of BME staff	To develop a Reverse / Reciprocal Mentoring programme or offer	Programme options identified and approved	To implement in 2024/2025
	To develop Leadership Development programmes or offer for BAME staff	Programme options identified	June 2024
To ensure Managers are equipped to identify and address racism in the workplace and champion inclusive culture	EDI Training programme for line managers and decision makers launched and delivered	50 staff completed each course	March 2024
Bullying and harassment and support staff who experience incidents	To develop and launch a bullying and harassment reporting tool using DATIX	• System live and in use. • 50 cases in Yr1 • Reduction in reported Harassment from colleagues / managers	• December 2023 • October 2024
Anti-Racist culture to address all WRES indicators	Join Northwest Anti-Racism Framework and adopt Anti-Racist activities.	Bronze Level achieved	2024/2025
Career Development	To develop resources and training offer for BME nursing staff, to support progression	• Guidance published • Career Workshops delivered. • Improved Staff Survey results	• Ongoing • February 2024 • October 2024
Apprenticeships	To become an Apprenticeship Diversity Champion	Membership completed	October 2023
Cultural Awareness	To develop, publish and promote cultural awareness resources for managers and international staff.	• Guidance published. • Improved Staff Survey results	• Ongoing • October 2024
Support for International Staff	• To appoint an International Accommodation Officer • To develop processes and resources to support living/integration of international staff	• Post in place • Resources developed. • Improved experience	• August 2023 • Ongoing • June 2024
Awareness Raising and Allyship	• To run a Anti-Racist Ally campaign • To run a Show Racism the Red Card Campaign • To mark Black History Month	• 100 staff signed up • 50 staff participate • Programme completed	• March 2024 • October 2023 • October 2023
Physical Violence	• Implement the new “Violence Prevention & Reduction Strategy	• Decrease % BME staff reporting physical violence from Patients (Q13a) to 13%	• Ongoing • December 2023 • December 2023

Area of Activity	Main Action	Success Measures	Deadline
	• Ensure all ward/patient facing staff are aware of the "Management of incidents of unacceptable behaviour by patients et al Policy". • Launch a "Red Carded" style campaign to promote patient awareness of unacceptable behaviour policy	• Decrease % BME staff reporting discrimination from Patients (Q16a) to 15%	
Promotion of EDI Support	EDI Clinical Quality Specialist to visit all Trust Wards to promote EDI / Anti-Bullying / Training etc	• 100% Wards visited. • Improvements in staff survey results	June 2024.
Ethnicity Pay Gap	• To calculate the Ethnicity Pay Gap from 2023 onwards • Where relevant to identify actions that contribute to the reduction of identified ethnicity pay gaps	• Analysis completed	March 2024.
Consultant Recruitment	To complete a data deep dive to understand the causes of the apparent race disparity in the recruitment process.	Completed	March 2024

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**	**Date**	**25 October 2023**
Agenda Item	**MWL TB23/052 (15.2)**		
Report Title	Workforce Disability Equality Standard Report (WDES) 2022/23		
Executive Lead	Anne-Marie Stretch, Director of Human Resources		
Presenting Officer	Anne-Marie Stretch, Director of Human Resources		
Action Required	X **To Approve**		**To Note**

Purpose

This report provides an overview and analysis of the legacy St Helens & Knowsley Teaching Hospital NHS Trust's Workforce Disability Equality Standard (WDES) data for 2022/2023. Where available, comparison data is provided for Southport & Ormskirk NHS Trust, and NHS national averages.

Executive Summary

The following is an overview of the WDES Highlights for 2022/23 for STHK:

Workforce data metrics:

- An increase in the proportion of total disabled staff reported to 4.3%; non-Clinical staff to 5.3%; Clinical Non-Medical staff to 4.3%; and Clinical Medical & Dental staff to 1.5%
- An increase in disabled staff in non–clinical bands 2-8a/8d. There are no know disabled staff reported in Bands 8c, 9 or VSM.
- An increase in disabled staff reported in clinical non-medical bands 2-8a. There are no known disabled staff reported in Bands 8b, 8c, 9 and VSM
- Disabled applicants were less likely to be appointed than non-disabled applicants.
- Disabled staff are more likely than non-disabled staff to go through the formal capability process, however this is not statistically significant.

Staff survey data:

- 33.6% Disabled staff report experiencing harassment, bullying or abuse from patients (32.2% nationally) compared to 23.6% of non-disabled staff.
- 12% Disabled staff report experiencing harassment, bullying or abuse from managers (16.1% nationally) compared to 6% of non-disabled staff.
- 22.3% Disabled staff report experiencing harassment, bullying or abuse from colleagues (24.8% nationally) compared to 12.1% of non-disabled staff.
- 58.9% Disabled staff state they believe the Trust provides equal opportunities for career progression or promotion (52.1% nationally), compared to 65.4% of non-disabled staff.
- 26.2% Disabled staff state they have felt pressure to come to work (27.7% nationally) compared to 17.9% of non-disabled staff.
- 34.4% of Disabled staff state that they feel the Trust values their work (35.0% nationally), compared to 46.8% of non-disabled staff.
- 70.9% of Disabled staff state that they have been provided with adequate adjustments (73.4% nationally).

Benchmarking:
The Trust is below the national averages for a number of indicators with the exception of the staff survey results for Harassment by Managers (44th), Career Opportunities (37th), and Staff Engagement (30th).

Financial Implications

None

Quality and/or Equality Impact

This report supports the Trusts duties under the Equality Act 2010 and the NHS contract. The attached action plan has been developed to address gaps identified within this data set, as well as the advancing the Trusts anti-discrimination and reasonable adjustment duties under the Equality Act 2010 and Disability Confident Scheme.
Recommendations
The Trust Board is asked to note and approve the Workforce Disability Equality Standard Report (WDES) and to approve the WDES Action Plan.

Strategic Objectives	
	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Workforce Disability Equality Standard Report
Data Summary

April 2022 – March 2023

1. Executive Summary

This report provides an overview of the Workforce Disability Equality Standard (WDES) data return for 2022/2023 for St Helens & Knowsley Teaching Hospitals NHS Trust (STHK), in line with the requirement to annually report the 10 WDES indicators as part of the NHS Standard Contract.

Comparison data is provided for Southport & Ormskirk Hospitals NHS Trust, and national averages where applicable.

2. Introduction

NHS England introduced the Workforce Disability Equality Standard (WDES) in 2019. The WDES exists to highlight any differences between the experiences and treatment of disabled staff and non-disabled staff in the NHS and places an onus on NHS organisations to develop and implement actions to bring about continuous improvements. The main purpose of the WDES is:

- to help NHS organisations to review performance on disability equality, based on the ten WDES indicators
- to produce action plans to close any gaps in workplace experience between disabled and non-disabled staff
- to improve the disabled representation at the Board level of the organisation.

Indicators 1 and 10 refer to the **31st March 2023** snapshot date; Indicators 2-3, 9 refer to the financial year **1st April 2022 to 31st March 2023**; and indicators 4-8 refer to the **November 2022** staff survey.

The 10 WDES indicators are:

1. **Staff Population**: Percentage of Disabled/Non-Disabled staff who are Non-Clinical, Clinical Non-Medical, and Clinical Medical by Agender for Change (AfC) pay bands or grade codes.
2. **Recruitment & Selection**: Relative likelihood of staff being appointed from shortlisting across all posts.
3. **Capability**: Relative likelihood of staff entering the formal capability process, as measured by entry into a capability process.
4. **Harassment**: Percentage of staff experiencing harassment, bullying or abuse from patients et al, managers, colleagues
5. **Discrimination**: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion
6. **Presenteeism**: Percentage of staff stating that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties

7. **Being values**: Percentage of staff reporting that they are satisfied with the extent to which their organisation values their work.
8. **Reasonable Adjustments**: Percentage of staff reporting that reasonable adjustments have been provided.
9. **Disabled staff voice**: activities to engage disabled staff and facilitate staff voice
10. **Board**: Proportion of disabled staff on the Trust Board.

2.1. Scope

The following data principles are applied to the WDES data:

- Data relates to the total substantive workforce on the relevant snapshot date, with the exception of Indicator 1 which disaggregates the data by Non-Clinical, Clinical Non-Medical and Clinical-Medical, and by Pay Band.
- Bank staff are not included.
- Lead Employer doctors are not included
- WDES data is only reported on the broad disability; Yes, or No categories.

The WDES submission does not provide an in-depth analysis of the different demographics of the NHS workforce or the different source population and talent pipelines that make up the career groups.

3. WDES Indicators

3.1. Staff Profile Workforce Overview

In the snapshot date of March 2023, St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) employed 6965 staff which consisted of:

- 4.3% Known Disability
- 85.79% No Known Disability
- 9.88% Not Stated/ unspecified / prefer not to answer.

Overall, the Trust has increased the proportion of known disabled staff from 3.1% (2022) to 4.3% (2023). The Trust is below the national average of 4.9% although the gap has reduced.

Table 1: 5 year trend and benchmarking

	2019	2020	2021	2022	2023
STHK	3.2%	2.8%	3.0%	3.1%	4.3%
S&O	8.5%	2.7%	3.1%	3.3%	4.3%
National	3.2%	3.6%	3.9%	4.3%	4.9%

3.2. Indicator 1: Workforce Staff Data

Indicator 1 is a review of the staff population by Non-Clinical Workforce by Agenda for Change (AfC) pay bands; Clinical Workforce not Medical by AfC pay bands; and Clinical Workforce Medical and Dental.

From March 2022 to March 2023, there was an increase in the number and proportion of known disabled staff as follows:

- The total workforce from 207 (3.1%) to 301 (4.3%).
- Non-Clinical staff from 71 (3.9%) to 102 (5.3%)
- Clinical Non-Medical roles from 129 (3.0%) to 190 (4.3%)
- Clinical Medical & Dental roles from 7 (1.3%) to 9 (1.5%)

Despite the increase for non-clinical AfC and clnical AfC staff, STHK remains below the national average for all staff groups,The gaps has increased for Clinical Medical and Dental.

Table 2: % Disabled by Staff Pay Group

Staff Headcount March 2023	STHK Disabled	S&O Disabled	National Disabled
Total Workforce	4.3%	4.3%	4.9%
Non-Clinical AfC Workforce	5.3%	4.8%	5.8%
Clinical AfC Workforce	4.3%	4.4%	5.0%
Medical and Dental Workforce	1.5%	1.4%	2.2%

Indicator 1a) Non-Clinical workforce

- The total number of STHK Disabled Non-Clinical staff increased from 71 to 102, with an increase in the number and proportion of Disabled staff on bands 2 to 8a, and 8d.
- There were no known disabled staff on Bands 8b, 9 or VSM.

Table 3: % Disabled Non-Clinical Workforce

	2021-2022		2022-2023	
	% Disabled	% No Known Disability	% Disabled	% No Known Disability
Band 1-4	4.2	95.8	5.7	94.3

	2021-2022		2022-2023	
	% Disabled	% No Known Disability	% Disabled	% No Known Disability
Band 5-7	2.1	97.9	3.7	96.3
Band 8a/8b	4.4	95.6	4.1	95.9
Band 8c-VSM	7.9	92.1	7.9	92.1
Average	3.9	96.1	5.3	94.7

Indicator 1b) Clinical workforce: Non-Medical

- The total number of STHK Disabled Clinical Non-Medical staff increased from 129 (3%) to 190 (4.3%), with an increase in the number and proportion of disabled staff on bands 2-8a.
- There were no known disabled staff on Bands 8b, 8c, 9 and VSM.

Table 4: % Disabled Clinical Non-Medical Workforce

	2021-2022		2022-2023	
	% Disabled	% No Known Disability	% Disabled	% No Known Disability
Band 1-4	2.0	98.0	4.0	96.0
Band 5-7	3.7	96.3	4.5	95.5
Band 8a/8b	1.8	98.2	2.9	97.1
Band 8c-VSM	5.0	95.0	5.6	94.4
Average	3.0	97.0	4.3	95.7

Indicator 1c) Clinical workforce: Medical & Dental

The proportion of STHK Clinical Medical & Dental staff who have disclosed a disability is low, at only 7 (1.3%) in 2022, and increasing slightly to 9 (1.5%) in 2023.

Table 5: % Disabled Clinical Medical & Dental Workforce

	2021-2022		2022-2023	
	% Disabled	% No Known Disability	% Disabled	% No Known Disability
Consultants	0.3	99.7	1.0	99.0
Non-consultant	3.8	96.3	2.6	97.4
Trainees	1.7	98.3	2.0	98.0
Average	1.3	98.7	1.5	98.5

Medical data does not include Lead Employer staff, including Lead Employer doctors who are on placement within the Trust.

3.3. Indicator 2: Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Indicator 2 is an assessment of the Trusts recruitment and selection practices, and whether disabled applicants are as likely as non-Disabled applicants to be successfully shortlisted and appointed.

This indicator is assessed at "whole organisation" level and does not disaggregate the recruitment trends by job group or department. The methodology used for the 2022/2023 data is not directly comparable to the previous year, therefore like-for-like comparison is not possible. The previous years data is provided for information.

Table 6: Relative likelihood of Disabled staff being appointed from shortlisting compared to non-disabled staff

	STHK	S&O	National
2021-2022	1.2	1.1	1.1
2022-2023	1.4	TBC	1.0

A figure below 1.00 indicate that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting/ S&O data has been removed for quality checking.

- Disabled applicants who are shortlisted are less likely to be offered a post compared to non-Disabled applicants.

3.4. Indicator 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.

Indicator 3 is an assessment of whether disabled staff are more likely to be subject to formal capability processes compared to non-disabled staff for non-health related reasons, based on a 2-year average (2021/22 + 2022/23).

1 out of 300 Disabled staff entered formal Capability proceedings (0.33% of the Disabled workforce) compared to 4 out of 5,965 Non-disabled staff (0.07% of the Non-disabled workforce). This results in a likelihood ration of 4.97, a decrease from 9.96 the previous year. .

Table 7: Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff

	STHK	S&O	National Average
2020/21 + 2021/22	9.96	0.00	-
2021/22 + 2022/23	4.97	0.00	2.17

A figure above 1.00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.

3.5. Indicator 4a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients/service users, their relatives or other members of the public

The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months was higher for Disabled staff (33.6%) than for Non-disabled staff (23.6%).

However, the proportion of disabled staff reporting this decreased by 1.92 points compared to an increase in the proportion of non-disabled staff.

Table 8: Harassment by Patients et al

	STHK All	STHK Disabled	STHK No Disability	S&O Disabled	S&O No Disability	National Disabled
2021	25.90	35.55	22.62	35.18	24.17	33.0
2022	26.19	33.63	23.63	33.88	26.79	32.2

3.6. Indicator 4b) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers (Staff Survey)

The percentage of staff experiencing harassment, bullying or abuse from line managers in last 12 months was significantly higher for Disabled staff (12.0%) than for Non-disabled staff (6.0%).

However, the proportion of disabled staff reporting this decreased by 6.17 points compared to a 1.78 point decrease for non-disabled staff.

Table 9: Harassment by Managers

	STHK All	STHK Disabled	STHK No Disability	S&O Disabled	S&O No Disability	National Disabled
2021	10.33	18.12	7.48	18.39	11.34	16.97
2022	7.53	11.95	5.95	17.43	12.33	16.10

3.7. Indicator 4c) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Colleagues (Staff Survey)

The percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months was higher for Disabled staff (22.3%) than for Non-disabled staff (12.1%).

However, the proportion of disabled staff reporting this decreased by 0.46 points.

Table 10: Harassment by Colleagues

	STHK All	STHK Disabled	STHK No Disability	S&O Disabled	S&O No Disability	National Disabled
2021	14.98	22.76	12.36	29.57	16.87	25.00
2022	14.69	22.30	12.13	27.16	21.45	24.77

3.8. Indicator 4d) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it (Staff Survey)

The percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it was similar for Disabled staff (54.6%) and for Non-disabled staff (51.2%).

However, the proportion of disabled staff reporting this increased by 3.23 points compared to a 1.88 point increase for non-disabled staff.

Table 11: Reporting Harassment

	STHK All	STHK Disabled	STHK No Disability	S&O Disabled	S&O No Disability	National Disabled
2021	50.1	51.38	49.36	51.11	42.58	49.86
2022	52.2	54.61	51.24	46.43	44.93	51.30

3.9. Indicator 5: Percentage of Disabled staff compared to non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion. (Staff Survey)

The percentage of staff who believe that the Trust provides equal opportunities for career progression or promotion was lower for Disabled staff (58.9%) than for Non-disabled staff (65.4%).

However, the proportion of disabled staff reporting this increased by 4.42 points.

Table 12: Career Opportunities

"Yes"	STHK All	STHK Disabled	STHK No Disability	S&O Disabled	S&O No Disability	National Disabled
2021	65.52	54.50	65.45	42.95	52.64	51.30
2022	63.58	58.92	65.35	41.56	51.87	52.10

3.10. Indicator 6: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (presenteeism)(Staff Survey)

The percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (presenteeism) was significantly higher for Disabled staff (26.2%) than for Non-disabled staff (17.9%).

However, the proportion of disabled staff reporting this decreased by 8.27 points compared to a 4.28 decrease for non-disabled staff.

Table 13: Presenteeism

	STHK All	STHK Disabled	STHK No Disability	S&O Disabled	S&O No Disability	National Disabled
2021	26.39	34.50	22.15	34.12	21.04	29.93
2022	20.75	26.23	17.87	26.86	20.36	27.70

3.11. Indicator 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 (Staff Survey)

The percentage of staff satisfied with the extent to which their organisation values their work was lower for Disabled staff (34.8%) than for Non-disabled staff (47.4%).

However the proportion of disabled staff reporting this decreased by 2.01 points compared to a 0.88 decrease for non-disabled staff.

Table 14: Feeling Valued

	STHK All	STHK Disabled	STHK No Disability	S&O Disabled	S&O No Disability	National Disabled
2021	45.4	36.80	48.32	30.03	40.51	35.08
2022	44.1	34.79	47.44	27.69	40.67	35.02

3.12. Indicator 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. (Staff Survey)

The proportion of disabled staff reporting this increased by 1.93 points.

Table 15: Reasonable Adjustments

	STHK Disabled	S&O Disabled	National Disabled
2021	68.97	74.46	72.23
2022	70.90	72.26	73.40

3.13. Indicator 9a: The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation

The score for the staff engagement theme is derived from the nine questions (Q2a, Q2b, Q2c, Q3c, Q3d, Q3f, Q23a, Q23c and Q23d), grouped into three themes: motivation; involvement; and advocacy.

Disabled staff (6.9) have a lower score than that for Non-disabled staff (7.3).

Table 16: Staff Engagement

	STHK Disabled	STHK No Disability	S&O Disabled	National Disabled
2021	6.76	7.26	6.24	6.47
2022	6.88	7.33	6.13	6.43

3.14. Indicator 9b: Has your Organisation taken action to facilitate the voices of Disabled staff in your organisation to be heard (yes or no)?

Indicator 9b is an open question asking how the Trust engaged disabled staff. The Trust reported doing the following:

- The Trust supports the Building Abilities Network staff network, which is open to disabled staff and allies.
- The network is represented on a number of groups including a regular Staff Network Chair meeting with the Equality, Diversity & Inclusion Team; membership of the Equality, Diversity & Inclusion Steering Group; the Equality, Diversity & Inclusion Strategic Advisory Group; and the People Council.
- The network has been actively consulted on a number of projects including the WDES Innovation Fund Project to review the Reasonable Adjustments Policy, and to develop a new Reasonable Adjustments Passport; the development of the ED&I Operational Plan and Action Plan for 2022-2025; all business tabled at the ED&I Steering Group and ED&I Advisory Group; and the development of an annual calendar of events, and events/comms to support the aims of the staff network.

3.15. Indicator 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated

At March 2023, the difference between Disabled representation on the board and in the workforce was +1.9%..

Table 17: Trust Board

	STHK Disabled	S&O Disabled	National Disabled
2021	0.00	0.00	4.58
2022	6.25	7.14	5.70

4. Conclusion

Overall the proportion of known disabled staff at the Trust continues to improve, including a reduction in the gap between the national average, with the area with the smallest disclosure rate being Medical and Dental staff.

Disabled staff overall are less satisfied that non-disabled staff in the staff survey responses, though several improvements have been made in staff responses.

Key challenges remain to support disabled staff in the workplace and ensure that they have equal access to opportunities and experience equal levels of satisfaction to non-disable staff.

5. Action Plan

To address the issues identified within the WDES data analysis, a single action plan for Mersey & West Lancashire Teaching Hospital NHS Trust (MWL) has been developed, as follows:

Area of Activity	Main Action	Success Measures	Deadline
To streamline the reasonable adjustment request process	• Update the equality monitoring data protection statements and disclosure processes • To create an online RA request form and embed in onboarding processes • To create disability guidance documents for employees and managers	• Increase in number of known disabled staff in ESR to 5.5% • 50 disability advance cases in year 1 provided by EDI Team	March 2024
To ensure that all applicants, staff and managers, have clear processes to follow to request and agree reasonable adjustment; and standard processes to implement agreed adjustments.	• To map disability disclosure processes for different type of employee/worker (Employer, Bank, Apprentice, International batch recruitment etc) • To create processes / process diagrams / guidance for staff / manager / HR on the various reasonable adjustment processes.	• Each employee life cycle / stage mapped out, agreements in place. • Standard Operating Procedures agreed and guidance published • Increase in number of known disabled staff in ESR to 5.5%	July 2024 Dec 2024
To implement a central disability reasonable adjustment advise service by the EDI Team	• To implement an advice function by the EDI Team to disabled staff, managers, HRBP's, and OH. • To make staff aware of this service via internal comms, website, guidance, and training.	• Increase in number of known disabled staff in ESR to 5.5% • 50 disability advance cases in year 1 provided by EDI Team • Staff Survey score improvements by disabled staff	March 2024 October 2024
To rollout disability reasonable adjustment policy, passport and EDI advice service to Southport and Ormskirk Hospitals following merger	• To update S&O webpages with RA/EDI Team information • To extend disability training to S&O managers • To roll out disability comms to S&O • Deliver new disability training sessions for S&O	• Increase in number of known disabled staff in ESR • Complete • Complete • To deliver 10 training sessions to S&O	Aug 2023 July 2023 Ongoing Dec 2024
Proportion of known disabled board members	To work with corporate services to review the completion of EDI Monitoring Data of the Board and whether ESR has been updated recently	Complete	March 2024
Awareness of types of disability and common reasonable adjustments	To create and publish guidance documents on common disabilities and reasonable adjustments. Topics to include Dyslexia, ADHD, Autism, VI, HI, Physical impairment.	Complete	Dec 2023

Area of Activity	Main Action	Success Measures	Deadline
To support partners to become disability confident	To offer information, advice and guidance on becoming disability confident to partner organisations who have not yet started their disability confident journey/would like to progress	X4 relationships completed	Dec 2024
To engage with the DWP/Job Centre and local disability groups to promote jobs and careers at MWL.	• Investigate Step into NHS programme with DWP • To work with "Supported Employment Services" at St Helens Council (and similar initiatives in Sefton/Knowsley/Liverpool City Region) to promote career opportunities and development relationships	Complete Relationships formalised	Dec 2024
To promote apprenticeships, volunteering and work experience to disabled people	• To join the Apprenticeship Diversity Champions Network • To promote opportunities through networks	• Membership completed • Increased in disabled apprentices, volunteers, work experiences participants	Mar 2025
Reasonable Adjustment Policy and Passport	• To review policy after year 1, and usability of passport • Improve processes	• Reviews complete • Increase in number of known disabled staff in ESR to 5.5%	Mar 2024
Increase the use of Disability Leave in Employee Online/eRoster/ESR	• Include Disability Leave in Managers Training • Provide guidance for staff and line managers on when to use disability leave. • To review eRoster/ESR to determine whether the category of disability leave is clear in the system	X10 staff recorded as using disability leave	May 2024
Estates information	• To work with estates to identify and make readily available information on the accessibility of the Trusts buildings for patients, visitors and staff • To draft a proposal to increase the number of changing places toilets at the Trust	• Information collated and publicly provided • Changing Places strategy agreed	Dec 2024
Funding and Procurement of RA	• To work with Finance and IT to review the procurement, buying and catalogue processes for RA purchases. • To review funding arrangement for RA, in particular A2W recharge	• Recommendations for improvement identified and implements. • Decrease in wait time for RA purchases	July 2024