Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 29 May 2024
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	**Employee of the Month (May 2024)** *Purpose: To **note** the Employee of the Month presentations for May 2024*	Film	Chair *(10 mins)*
10.10	2.	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.25	3.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**TB24/036 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 24 April 2024*	Report	
	6.	**TB24/037 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				
10.35	7.	**TB24/038 Integrated Performance Report** 7.1. Quality Indicators 7.2. Operational Indicators 7.3. Workforce Indicators 7.4. Financial Indicators	Report	L Barnes R Cooper obo L Neary AM Stretch G Lawrence *(30 mins)*

		*Purpose: To **note** the Integrated Performance Report for assurance*		
Committee Assurance Report				
11.05	8.	**TB24/039 Committee Assurance Reports** 8.1. Executive Committee 8.2. Quality Committee 8.3. Strategic People Committee 8.4. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports for assurance*	Report	A Marr G Brown L Knight S Connor *(30 mins)*
Other Board Reports				
11.35	9.	**TB24/040 Aggregated Incidents, Complaints and Claims Report** *Purpose: To **note** the Aggregated Incidents, Complaints and Claims Report for assurance*	Report	L Barnes *(15 mins)*
11.50	10.	**TB24/041 Quality Account** *Purpose: To **approve** the Quality Account*	Report	L Barnes *(15 mins)*
12.05	11.	**TB24/042 Board and Committee Effectiveness Review** *Purpose: To **approve** the updated Terms of Reference following the annual effectiveness review*	Report	N Bunce *(10 mins)*
12.15	12.	**TB24/043 Review of Trust Board Objectives for 2023/24** *Purpose: To **note** the Review of the Trust Board Objectives for 2023/24*	Report	A Marr *(15 mins)*
Concluding Business				
12.30	13.	**Effectiveness of Meeting**	Report	Chair *(5 mins)*
12.35	14.	**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 26 June 2024 at 09:30		**12.45 close**
15 minutes lunch break				

Chair: Richard Fraser

itle of Meeting	Trust Board			Date	29 May 2024
Agenda Item	TB24/000				
Report Title	Patient Story				
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance				
Presenting Officer	Yvonne Mahambrey, Quality Matron, Patient Experience				
Action Required		To Approve	X	To Note	

Purpose

To receive the Patient Story

Executive Summary

After previous positive birth experiences Ashley chose to have her fourth baby, Cassius, with Ormskirk Maternity Services. She shared her journey through her pregnancy from antenatal care to her postnatal experience and highlighted the following:

- The continuity of care provided by the Sapphire team in the community.
- Feeling reassured when asking questions about her birth plan during her antenatal period and it not being presumed that she knew 'everything' as an older mother due to her previous births.
- Due to her previous 'fast' deliveries Ashley felt fully informed and supported in the shared decision making with her consultant to opt for an induction at 38 weeks.
- The induction did not go to plan and Cassius was born via Caesarean section. Ashley described that she was fully informed of the plan, and this enabled her not to feel guilty about having a c-section after previous natural deliveries.
- Unfortunately, the sex of the baby was announced by the anaesthetist when it was planned to be announced by Ashley's husband. This has been highlighted to the theatre team and bi-monthly meetings are now held between theatre and the maternity department where patient experience concerns can be raised.
- When asked to 'sum' up her experience in a few words Ashley described her experience as relaxed, validated and being in control.

Ashley's maternity journey demonstrated the following elements of care which supported a safe and positive experience:

- Shared decision making.
- Information sharing and communication.
- Consistency of care.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Patient Story.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care

X	**SO2** 5 Star Patient Care - Safety
	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
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Minutes of the Trust Board Meeting
Held at Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 24 April 2024
(Approved at the Trust Board on Wednesday 29 May 2024)

Name	Initials	Title
Richard Fraser	RF	Chair
Ann Marr	AM	Chief Executive Officer
Geoffrey Appleton	GA	Non-Executive Director & Deputy Chair
Lynne Barnes	LB	Acting Director of Nursing, Midwifery & Governance
Gill Brown	GB	Non-Executive Director
Nicola Bunce	NB	Director of Corporate Services
Ian Clayton	IC	Non-Executive Director (via MS Teams)
Steve Connor	SC	Non-Executive Director
Rob Cooper	RC	Managing Director
Malcolm Gandy	MG	Director of Informatics
Paul Growney	PG	Associate Non-Executive Director
Lisa Knight	LK	Non-Executive Director
Gareth Lawrence	GL	Director of Finance and Information
Lesley Neary	LN	Chief Operating Officer
Hazel Scott	HS	University Non-Executive Director
Rani Thind	RT	Associate Non-Executive Director
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Adesuwa (Ade) Garrick		Consultant Eye Surgeon Southport and Ormskirk Hospitals (observer) (via Teams)
Carole Spencer	CS	Associate Non-Executive Director Designate (observer) (via 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
Anne-Marie Stretch	AMS	Deputy Chief Executive Officer & Director of Human Resources

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for April 2024 was Dr Maria Konstantopoulou, Consultant and Clinical Director of Dermatology at Ormskirk Hospital, and the

	Board watched the film of LN reading the citation and presenting the award to Maria. **RESOLVED:** The Board **noted** Employee of the Month film for April 2024 and congratulated the winner.
2.	**Chair's Welcome and Note of Apologies**
	2.1. RF welcomed all to the meeting and in particular welcomed LB who was attending her first Board meeting in her role as Acting Director of Nursing, Midwifery and Governance and MG who was attending his first Board meeting as Director of Informatics. RF wished LB and MG all the best for their new roles. Additionally, RF welcomed AG and CS who were attending the meeting as observers. 2.2. RF wished SR a speedy recovery following her recent surgery. 2.3. RF acknowledged the following awards and recognition that the Trust had recently received: 2.3.1. Team MWL was officially awarded the National Preceptorship for Nursing Quality Mark. 2.3.2. Sue Ashton, Dispensing Assistant, Southport Hospital, was awarded Highly Commended in the 'Against All Odds' category at Preston College's 'Exceptional Employer and Apprenticeship' Awards 2024. MWL won the 'Large Employer' category beating more than 750 other employers who work alongside Preston College. 2.3.3. Joyce Williams, Volunteer, Whiston Hospital, was awarded a Good Citizenship Award in 'recognition of her outstanding contribution towards enriching the lives of the residents of Rainhill' and was presented with a plaque to mark the occasion by Councillor Graham Barker, Chair of the Parish Council. Apologies for absence were **noted** as detailed above
3.	**Declaration of Interests**
	3.1. There were no declarations of interests in relation to the agenda items.
4.	**TB24/028 Minutes of the previous meeting**
	4.1. The meeting reviewed the minutes of the meeting held on 27 March 2024 and approved them as a correct and accurate record of proceedings subject to the following amendments: 4.1.1. Date of meeting to be amended to *27* March 2024. *4.1.2.* 8.3.1.1 to be amended to read '*AM observed that the ratio of incidents on each site appeared to be proportionate to the number of cots but agreed that*

	the Quality Committee should receive assurance that the planned actions were having the intended impact.' **RESOLVED:** The Board **approved** the minutes from the meeting held on 27 March 2024 subject to the amendments detailed above
5.	**TB24/029 Action Log and Matters Arising**
	5.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 5.2. The following actions were closed: 5.2.1. Agenda Ref 6 (MWL TB23/043 Integrated Performance Report, 6.2 Operational Indicators) - the action plans were reviewed at Executive Committee on 11 April and presented at the Finance and Performance Committee on 18 April 2024. 5.2.2. Agenda Ref 9 (MWL TB24/008 Corporate Risk Register) – MG to provide an update under Agenda Ref 8 (TB24/032 Corporate Risk Register). 5.2.3. Agenda Ref 6 (MWL TB14/024 Integrated Performance Report, 6.2 Operational Indicators) - the report was presented to the Executive Committee and Quality Committee in March 2024 and the Quality Committee requested further analysis. **RESOLVED:** The Board **approved** the action log.
Performance Reports	
6.	**TB24/030 Integrated Performance Reports**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for March 2024 was presented.
6.1.	**Quality Indicators**
	6.1.1. LB presented the Quality Indicators and advised that the Care Quality Commission (CQC) rating for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) remained as Outstanding. There had been five CQC inspections over the preceding four months and LB noted that three of the inspection reports had been received and had not changed the overall Trust rating. 6.1.2. LB highlighted the following: 6.1.2.1. There had been no never events reported in March 2024 6.1.2.2. Nurse Safer Staffing was at 95.5% and this included staffing for the winter escalation areas that remained open. 6.1.2.3. Pressure Ulcers – the latest validated data was for December 2023 and five category 2 or above pressure ulcers with lapses in care had been recorded.

	The learning reviews, mainly about heel protection, had been completed and improvement actions were in place. 6.1.2.4. Three patient falls resulting in moderate or above harm had been recorded in February 2024. It was noted that two had resulted in moderate harm (one at S&O sites and one at STHK sites) and one had resulted in severe harm (STHK sites). LB noted the main learning from the falls reviews was for timely risk assessments and re-assessment of patients if their condition changed and commented that this had also been highlighted in a recent MIAA audit report. 6.1.2.5. The Escherichia coli (E.coli) tolerance target had been breached with 22 cases reported in March and 171 for the year, against the NHSE tolerance of 121. LB noted that the Infection Prevention and Control (IPC) report for Q3 reported at Quality Committee had included a deep dive into the interventions in place to reduce cases of E coli. Investigations had found most cases were associated with urinary and hepatobiliary infections and the focus on improving hydration would help reduce the incidence of these infections. 6.1.2.6. There has been 12 cases of Clostridium difficile (C.diff) reported in month and 114 for the year against the NHSE assigned tolerance of 85. The impact of improvement actions would be reported to the Quality Committee in May 2024. Investigations most commonly showed delays in testing and the isolation of patients with diarrhoea. 6.1.2.7. 47.1% of complaints had been responded to within 60 days, which was a deterioration from February, but a number of actions were in place to improve performance and deliver the target of 90%. 6.1.2.8. The inpatient Friends and Family Test (FFT) recommendation rate in March was 93.8% against the target of 90%. LB reported that in Maternity the response rates for the FFT remained low and noted the work that was being undertaken to try and understand the reasons for this. The response rates remained consistent for inpatients, outpatients, antenatal and birth, and the Emergency Department (ED). 6.1.3. HSMR to December 2023 was 84.1. PW advised that he would provide an update on Hospital Standardised Mortality Ratio (HSMR) as part of agenda item 10 (TB24/034 Learning from Deaths Quarterly Report).
6.2.	**Operational Indicators**
	6.2.1. LN presented the operational indicators and advised that all the operational metrics had been reviewed and discussed in detail at the Finance and Performance (F&P) Committee. 6.2.2. LN highlighted the following: 6.2.2.1. Urgent Care performance remained pressured, and 4-hour (all types) performance in March 2024 was 72.6% (72.1% in February 2024) and all types mapped performance 77.6% against the target of 76%. 6.2.2.2. The Super Multi Agency Discharge Event (MADE) that ran across Cheshire and Merseyside (C&M) at the end of March had supported the reduction in the number of patients who did not meet the criteria to reside (NC2R),

	increased the number of discharges and reduced bed occupancy levels which had resulted in an improved patient flow in Accident and Emergency (A&E) performance over the Easter bank holiday weekend. There had been a review of several internal processes as well as protecting elective and patient flow resources by not bedding down Urgent and Emergency Care (UEC) patients in certain areas. 6.2.2.3. Bed occupancy for all general and acute (G&A) beds was 98% and for medical beds had been 106% in March and the Non-Criteria to Reside patients were 19.1% of all inpatients. 6.2.2.4. The Trust had achieved the target of zero 78-week waiting list breaches by the end of March 2024 despite several complicated orthopaedic patients. 6.2.2.5. The Trust was also on track to achieve the target of zero 65-week waiting list breaches by the end of August 2024 instead of the national deadline of September 2024. There were weekly meetings to review the trajectories at speciality level to identify and monitor any hotspots, which currently included plastics and orthopaedics. LN noted that the new theatres would be opening in the summer which would create more capacity and combined with maximising capacity at Ormskirk Hospital theatres and the recruiting of the additional consultants into posts approved by the Board, additional capacity was being created to achieve the reduction in waiting lists. 6.2.2.6. The Trust had seen an improvement in the overall diagnostics 6-week performance from 66.4% in September 2023 to 87.8% in March 2024. There had been a significant reduction in the endoscopy and non-obstetric ultrasound waiting lists which had contributed to this improvement. DEXA scans remained challenged due to the need for additional capacity combined with an increase in referrals. 6.2.2.7. The Trust was in the top 10% of the country for the 62-day cancer pathway in February 2024 at 74.7%. The Trust had been set a target of 83% for 2024/25 (compared to a national target of 70%) by the Integrated Care Board (ICB) and was the only acute Trust in Cheshire and Merseyside to have been set this target. LN noted that the Trust still aimed to achieve the previous national ambition of 85%. 6.2.2.8. STHK sites achieved the target of 75% for the 28-day faster diagnosis pathway and there had been an improvement to 70% for S&O sites. The improvement action plans and trajectories for each tumour specific pathway had been presented at the last Finance and Performance Committee, to provide assurance on the actions being taken. 6.2.3. RT reflected on the improvement in the 6-week diagnostics performance and asked if the capacity could be maintained without the use of bank staff. LN commented that capacity and demand had been modelled and it was felt that once the backlog had been cleared there would be sufficient capacity for the predicted growth with the plans the Trust already had in place. 6.2.4. RT commented that non-obstetric ultrasound was not included on the Corporate Risk Register (CRR) and asked if additional capacity was planned or if the Trust would continue to outsource this. LN responded that outsourcing had been used to overcome the backlog, but once again there

was sufficient internal capacity to cope with the predicted levels of growth once a steady state was achieved. LN suggested the capacity and demand modelling for each diagnostic modality be presented at the Finance and Performance Committee to provide assurance.

ACTION:
LN to present the diagnostic capacity and demand model to the Finance and Performance Committee.

6.2.5. NB reflected on the positive short-term impact of the Super MADE event and asked what would need to change to maintain improved flow going forward. LN responded that the Super MADE event had made a significant difference for Whiston Hospital where there had been support from the PLACE Directors and additional Local Authority staff on site from system partners to support the event, however, these improvements had not been experienced to the same extent at the Southport site where there had been significantly less support from Sefton Place. The Trust had also reviewed its internal processes and data validation and made decisions to stop using areas essential for patient flow as escalation areas, which had also led to better flow, but left more patients being cared for in ED.

6.2.6. AM reflected on the financial cost of capacity issues as well as the human cost to patients and staff and asked if it would not be more economically beneficial for the system to maintain the level of interventions and support seen during the Super MADE event. AM felt it was important to communicate the lessons learnt, savings delivered and improvements for patients achieved, to the ICB.

6.2.7. RC commented that, following the Super MADE event, a piece of work to review the outcomes and successes had been commissioned by the ICB and a list of recommendations would be created. RC also noted that this supported the work already being undertaken by the Trust to establish an Urgent and Emergency Care support structure around the MWL footprint. The original focus had been on the mid Mersey region (legacy STHK footprint); however, it was recognised that a standardised approach was needed for the footprint covered by MWL. RC commented that the local authorities could not deliver the levels of support seen during the Super MADE week on a consistent basis because of the financial implications. However, there was a growing acknowledgment that as a system more funding was being spent on premium cost services and the standing up of escalation capacity than was needed and this resource could be spent more efficiently and effectively.

6.2.8. GA commented that the longer an older person remained in hospital the more care would be required when the patient was discharged, so there should be a financial incentive for Local Authorities for stopping delayed discharges.

	6.2.9. PW agreed that if the Trust declared Opal 4 or above, events with similar actions to the Super MADE event were implemented and there was a short-term improvement, however, if these were applied consistently there would not be an overall increase in costs.
6.3.	**Workforce Indicators**
	6.3.1. RC, on behalf of AMS, presented the Workforce Indicators and highlighted the following: 6.3.1.1. The MWL appraisal compliance rate was 82% against a target of 85% (1.2% decrease on the previous month). Compliance for the legacy S&O sites declined in month from 75.6% to 69.8% and these sites would be transitioning to the new MWL appraisal paperwork which would make the process more streamlined. 6.3.1.2. The core mandatory training compliance was above target at 86.7% against a target of 85%. 6.3.1.3. In month sickness remained above target at 5.7% (a reduction of 0.6%) against a target of 5%. Anxiety, stress, and depression remained the main reasons for sickness. Work was ongoing with the Human Resources (HR) Business Partners to manage this. 6.3.2. RF commented on the adoption of the new MWL paperwork for appraisals and asked if there had been any resistance to this change. RC responded that to date the majority of staff had reacted positively to the new paperwork which embedded the discussion of their wellbeing and was easier to complete and record. LK noted that the new paperwork led to better quality appraisal conversations and other actions had been taken to make the recording of appraisals on the Electronic Staff Records (ESR) easier, which staff welcomed. LB agreed, reporting that she had found the new format easier to use. 6.3.3. HS asked if the reasons for staff sickness were known and if the wellbeing section in the appraisals covered this. RC responded that, whilst there was a confidential aspect of an appraisal, if there was a concern about health and wellbeing or a staff member identified an issue, the appraiser was empowered to refer this to the appropriate resources. RC added that regular reminders of the support available via the Health, Work and Well Being (HWWB) service were regularly included in Trust Brief Live. 6.3.4. GA suggested that the Workforce Committee undertake a deep dive into the long- and short-term absence by department to obtain a better understanding of the reasons for this as well as the cost to the organisation. LK confirmed that this was reported on a regular basis to the Strategic People Committee, and she would include more detail in the Committee Assurance report to Board when this report was next presented.
6.4.	**Financial Indicators**

	6.4.1. GL presented the Financial Indicators and highlighted the following: 6.4.1.1. The MWL financial plan for 2023/24 was to achieve a surplus of £5.6m (£2m deficit for legacy S&O and £7.6m surplus for legacy STHK) . The plan also included the delivery of the CQUIN programme, £31.8m recurrent Cost Improvement Programme (CIP), £7.0m non-recurrent CIP as well as the delivery of the 2023/24 activity plan. 6.4.1.2. GL noted that the figures reported were provisional as the final accounts for the year ended 31 March 2024 were being complied and a final report would be shared once the accounts had been audited. 6.4.1.3. At Month 12 the financial outturn reduced to a £0.6m surplus for the 2023/24 financial year. The deterioration of the forecast outturn was due to two key elements: • Failure to deliver CQUIN targets, confirmed by the ICB. • Discrepancies in the Electronic Recovery Fund (ERF) allocation/payments for Q4. The deterioration was discussed with the ICB and NHSE. 6.4.1.4. The Trust's combined 2023/24 CIP target was £41.6m which included £7.0m non-recurrent CIP. The Trust had achieved the CIP target for 2023/24. 6.4.1.5. Capital expenditure for the year was £61.8m which was an increase of £44m compared to the preceding financial year. The 2023/24 capital plan had been delivered. 6.4.2. GA and MG reflected on the delivery of CIP which was an exceptional achievement and congratulated everyone involved. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
7.	**TB24/031 Committee Assurance Reports**
7.1.	**Executive Committee**
	7.1.1. AM presented the Executive Committee Assurance report covering the meetings held in March 2024. AM highlighted the following: 7.1.1.1. MIAA had undertaken spot checks on four wards across all sites in November 2023 and the audit had received limited assurance. The Committee had discussed the assurances provided from the regular tendable audits, the ward accreditation process, and the Quality Ward Rounds (QWR) and it had been agreed that a refresh of the nursing standards was required. 7.1.2. RT asked whether the three systems would be reviewed to determine what assurance each system had provided and whether the action plans would include all the issues. NB commented that the ward accreditation system should combine all elements. AM commented that previously ward dashboards had enabled the areas of focus for each ward to be highlighted

and the equivalent for MWL was needed based on a common set of standards and quality metrics.

7.1.3. LB reported that she had presented the audit to the senior nursing team and now there were quality and safety walkabouts every Wednesday afternoon. The MIAA process was also being repeated across every MWL ward. The team were also revising and standardising the Quality Ward Round (QWR) format and developing a new MWL ward accreditation scheme, which would be reviewed and agreed via the Executive Committee. LB that there had been a very high volume of audits, but the main priority needed to be a focus on the basics and to ensure the same standard was achieved across all MWL sites.

7.1.4. GB felt that there needed to be an increased focus on C.Diff and Methicillin-Resistant Staphylococcus Aureus (MSRA) as learning from investigations did not seem to have become embedded. GB felt this was a role for the Patient Safety Council. AM agreed that the Quality Committee should receive assurance that the systems for monitoring performance and resolving any issues were effective.

7.1.5. AM continued with the report and advised that:

7.1.5.1. The Committee had reviewed the Nurse Staffing Establishment Review and recognised that the wards were busy with additional beds due to escalation levels and poorly patients. The final report had been approved at the March Board.

7.1.5.2. The Committee had a demonstration of the E-Vitals system which was used to record patient observations and it had been interesting to see how technology had transformed the working life of nurses and Health Care Assistants (HCA).

7.1.5.3. The Cancer Tumour Site Improvement Plans had been reviewed and scrutinised particularly in relation to lower GI performance.

7.1.5.4. The Committee had discussed HSMR rates and PW had provided an update on the progress in reviewing the backlog of notes to be coded at the legacy S&O sites. The Committee had noted that the action plan to improve the recruitment and retention of clinical coders had been presented at the Strategic People Committee.

7.1.5.5. A review of temporary and locum medical staff had been requested and each Clinical Division asked to present plans for reducing reliance on locum staff, however, it was recognised that several of the fragile services at the S&O sites would have had to close to referrals without the support of locum medical staff.

7.1.6. RT commented on the cancer performance and noted that previously it had always been the complex pathways involving several trusts that had been outliers, with the cancer network leading on resolving the issues, and asked if any further progress had been made to improve these pathways. AM responded that several of the cancer pathways were complicated with a small number of patients, for example head and neck, which was part of the Ear,

	Nose and Throat (ENT) pathway. There had also been an increase in the two-week gynaecological cancer referrals which also involved the tertiary unit, and there had not yet been a significant change in the position. AM noted that it was easier to improve a pathway if the Trust was responsible for all steps, for example lower GI. 7.1.7. IC recalled there had been a plan to recruit five additional consultants to support the C&M head and neck pathway and asked if this had happened. AM responded that there had not been any success in recruiting to these posts, and PW advised that the posts had been advertised but there had been no suitable candidates to appoint. The possibility of joint appointments had also been investigated but this was a national shortage speciality, so even specialist centres with large services were having difficulty in recruiting. The remainder of the report was **noted.**
7.2.	**Audit Committee**
	7.2.1. IC presented the Audit Committee Assurance Report for the meeting held on 17 April 2024 and advised that the meeting consisted of two parts, the first related to legacy S&O and the second related to MWL and as a consequence of the three-month delay to the transaction date it was necessary for legacy S&O to present a set of accounts for the first quarter of 2023/24. 7.2.2. IC informed the Board that Grant Thornton (GT), had been appointed as the MWL external auditors, and had advised the Audit Committee that they would not be able to meet the nationally set timetable for completion of the 2023/24 audit. GT therefore did not present a detailed workplan at the meeting. 7.2.3. IC highlighted the following from the report: 7.2.3.1. The Committee had approved the draft internal audit plan for 2024/25 and IC reminded the Board that this was risk based picking up areas identified as part of the transaction process. 7.2.3.2. In relation to the 2023/24 internal audit programme a review of Safeguarding for MWL had received substantial assurance, whilst the review of the MWL risk management process had received high assurance. 7.2.3.3. The Trust had received ten substantial assurance, six high assurance, two moderate assurance and one limited assurance reviews in 2023/24. The limited assurance review related to the Quality Spot Checks. 7.2.3.4. The two moderate assurance reviews (E-Discharge and Information Asset Register) had agreed management actions that were being addressed. The remainder of the report was **noted.**
7.3.	**Quality Committee**
	7.3.1. GB presented the Quality Committee Assurance Report for the meeting held on 18 April 2024.

	7.3.2. There was one outstanding action relating to Neonatal Medication Errors that would be presented at the May meeting and include benchmarking information. 7.3.3. The Committee had received the following reports: <u>Committee Performance Report</u> 7.3.3.1. The number of patient falls had reduced for the second month. 7.3.3.2. There had been an improvement in the position for resolved Complaints as well as a reduction in the number of first stage complaints received. However, there had been a fall in the percentage of complaints resolved within 60 days, and the Committee had asked for further assurance on the actions being taken to address this. 7.3.3.3. There had been an increase in the proportion of pregnant women who smoked being referred to the Stop Smoking Services following their initial anti-natal appointment. A concern had been raised that the funding for the Smoking Cessation Assistants had not yet been formalised by commissioners beyond 2024/25. 7.3.3.4. The Committee had noted a 10% difference in induction rates between the two maternity units and had requested further information be included in the next quarterly Maternity Update to the Quality Committee. 7.3.3.5. The Committee had noted the higher reported HSMR rates for the S&O sites and requested more information when the Medical Director had completed his investigation. <u>Clinical Effectiveness Council (CEC)</u> 7.3.3.6. An increase in mortality in ED had been reported for January 2024 and PW had requested that a deep dive be undertaken, and feedback would be provided via CEC to the Quality Committee. <u>Mandatory Training Compliance Report</u> 7.3.3.7. The report had included an update on the 24-month project to review mandatory and compulsory skills training for MWL. The Committee had noted several compulsory skills subjects where compliance remained below 70% but had been assured by the monthly scrutiny and review at the Executive Committee to oversee improvement. <u>The Patient Safety Council Report</u> 7.3.3.8. The Patient Safety Council had escalated an alert in relation to specialist paediatric pharmacist cover at both Whiston and Ormskirk Hospitals. The new MWL Chief Pharmacist was reviewing the arrangements. 7.3.3.9. A risk had been identified in relation to the increase in C.diff, due to the vacancy for an Anti-Microbial Prescribing Pharmacist as the substantive postholder was seconded to another position. <u>The Safeguarding Quarterly Report</u> 7.3.3.10. The report showed good performance and improved training compliance. It was noted there was a vacancy for a Learning Disability Specialist

	Practitioner at the S&O site but there was an interim plan in place which included support from the Team at Whiston. Infection, Prevention and Control (IPC) Report 7.3.3.11. The Quality Committee had received the IPC report and noted that the MRSA and C.diff improvement plans were also due to be presented to the Committee in May. 7.3.3.12. Compliance with IPC and Aseptic Non-Touch Technique (ANTT) training remained below the target compliance level. 7.3.3.13. There had been a reduction in the number of E-coli infections, following the delivery of improvement actions. 7.3.3.14. The IPC team staffing was under review and a business case was being produced. Fluid Balance Recording Report 7.3.3.15. There had been a small improvement in the Fluid Balance Recording and the Committee was assured that the further improvement work being undertaken following the quality spot check audit would result in further improvement. Patient Experience Council 7.3.3.16. The Council had acknowledged the work of the 371 volunteers in the Trust, as well as the work of the Chaplaincy service to improve patient experience. 7.3.4. RF supported the value of the volunteers to the Trust and their commitment to supporting our patients. 7.3.5. RF asked if the Committee had been concerned that the Trust was an outlier in relation to neonatal medication errors. RT reflected that the reported errors had all been near misses or low harm but wanted to be assured that there was on going learning and additional training provided if this was indicated. GB felt that the inclusion of the benchmarking information in the next medication errors report by the Chief Pharmacist would show if the Trust was an outlier. The remainder of the report was **noted**.
7.4.	**Strategic People Committee**
	7.4.1. LK presented the Strategic People Committee Assurance report and highlighted the following: 7.4.1.1. An update following the deep dive into the Health and Well Being (HWB) Did Not Attend (DNA) performance rates had been considered. It was noted that the DNA rate was 13% against a target of 10% and benchmarking across C&M and nationally ranged from 15 to 20% with an average DNA rate of 17 to 19%. Pre-employment checks, vaccinations, and blood tests as well as return to work checks remained the main reasons for DNAs and work was being undertaken with the operational managers to address this.

	7.4.1.2. An update on the People Plan delivery had been received and the challenge of combining the two organisations was noted. The remainder of the report was **noted**.
7.5.	**Finance and Performance Committee**
	7.5.1. SC presented the Committee Assurance report and noted that the Committee had reviewed the CPR and monthly finance report, but the key points had already been discussed in previous reports. Other points to highlight were: 7.5.1.1. All C&M Trusts had received a request from the ICB for enhanced vacancy controls in light of the current financial challenges. 7.5.1.2. The Committee had reviewed the workplan for 2024/25 which would be circulated for final approval. 7.5.1.3. The Committee had received the revised draft plan for 2024/25 which included non-recurrent benefits of £9.6m including an additional £9m CIP. The challenges within the plan and the mitigations had been discussed. 7.5.1.4. The Committee received the Month 12 CIP update and noted that the targets for 2023/24 had been achieved in full. Additionally, it was noted that circa £40m of CIP schemes had already been identified for 2024/25 and work had started to deliver these. 7.5.1.5. The Clinical Support Services (CSS) and Community Division presented their CIP delivery in 2023/24 and plans for 2024/25. 7.5.1.6. The Cancer site access target improvement plan had been presented, which detailed the actions being undertaken. There was a focus on the creating of capacity to reduce waiting lists by utilising facilities across MWL. 7.5.1.7. The Committee received the assurance reports from the Procurement Council, CIP Council, Capital Planning Council, Estates and Facilities Management Council and the IM&T Council. 7.5.2. SC advised that the Committee recommended the revised 2024/25 financial plan to Board for approval subject to further guidance around the treatment of PFI in the accounts. The remainder of the report was **noted**. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
8.	**TB24/032 Corporate Risk Register**
	8.1. NB presented the quarterly Corporate Risk Register (CRR) report which provided an overview of the risks that had been escalated to the MWL CRR and noted that work was ongoing to align the processes across MWL. The new Risk Management Framework (RMF) had been formally launched on 01 April to coincide with the formation of the new Clinical Divisions and work was progressing to review and align risks as well as reporting protocols where

	services had changed reporting arrangements. The Trust would continue to operate two risk management recording systems until the new MWL system for risk, incident, complaints, and claims reporting was implemented later in the year. 8.2. NB noted that the report provided a snapshot of the risk register on 02 April 2024 and reflected all risks reported and reviewed during March 2024. 8.3. NB advised that the total number of risks on the MWL risk register was 1,055 (211 at the legacy S&O sites and 844 at the legacy STHK sites) of which 44 had been escalated to the CRR (nine at the legacy S&O sites and 35 at the legacy STHK sites). 8.4. NB highlighted the following: 8.4.1. Appendix 1 reflected a good turnover of risks. 8.4.2. There were several overdue risks at the time of reporting mainly due to missed review dates over the Easter bank holidays, however, the Risk Management Council had noted an improvement in this position at its meeting on 09 April. 8.4.3. Work had started on creating a risk profile for each Clinical Division which would include removing duplicates and ensuring consistent risk scoring. 8.5. NB provided an update on the Cyber Security risk (action 9) and noted that the Informatics team had advised that they were in the process of aligning informatics risks and had already closed several duplicate risks. They had proposed creating separate cyber security and IT infrastructure risks and would review the scoring of these in the context of the combined resources of MWL. IC thanked NB for the update and asked whether other trusts had this as a separate risk. MG advised that there was a varied approach to the treatment of these risks by different organisations, but his previous organisation had distinct cyber security and IT infrastructure risks due to the complexity and the magnitude of risk if the Trust was impacted. MG stated that this would also be his preference for MWL, and he would discuss this with his team. **RESOLVED:** The Board **noted** the Corporate Risk Register Report.
9.	**TB24/033 Board Assurance Framework**
	9.1. NB presented the quarterly review of the Board Assurance Framework (BAF) and the proposed amendments being recommended. 9.2. NB noted that there was one overdue (red) action which related to the 92% bed occupancy target for 2023/24 which had been a system action to deliver. 9.3. NB highlighted the proposed changes to the risk scores:

	9.3.1. Risk 3 (Sustained failure to maintain operational performance/deliver contracts) to be decreased to 16 which reflected the new financial year and the plans to achieve the activity and access performance targets for 2024/25. 9.4. IC reflected that Risk 2 (Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners) had not included narrative about extending of planning beyond one year and suggested that the constraints and difficulties be acknowledged in the next review. **RESOLVED:** The Board **approved** the decreased risk score and changes to the Board Assurance Framework
10.	**TB24/034 Learning from Deaths Quarterly Report (Quarter 3 2023/24)**
	10.1. PW presented the Learning from Deaths Quarterly report and noted that, whilst this was the first combined report for MWL, there was still a difference in processes for reviewing deaths between the legacy organisations which was being aligned . 10.2. PW highlighted the following: <u>Whiston and St Helens Hospitals:</u> 10.2.1. 40 Structured Judgement Reviews (SJRs) had been requested of which 22 had been completed to date. From the 22 completed SJRs, 13 were graded as green, three green with learning, five green with positive feedback and one as amber. There had been no SJRs graded as red. 10.2.2. The SJR rated as amber had been referred for investigation via the Patient Safety Incident Response Framework (PSIRF) process and the outcome would be presented at the Mortality Surveillance Group. <u>Southport and Ormskirk Hospitals</u> 10.2.3. All inpatient deaths in Q3 had been reviewed by the Medical Examiners Office and 13 SJRs had been requested. From the SJRs it had been concluded that none of the deaths were avoidable (equivalent to the STHK green rating) and three had identified learning points for the clinical teams (green with learning) which included recognition of patients reaching end of life and nutrition. 10.3. PW advised that the HSMR for August 2023 had been elevated at 122 for the legacy S&O sites and this had been investigated. It was identified that there had been a drop in the number of patients that had been coded as receiving specialist palliative care or being diagnosed with septicaemia which would raise the expected HSMR. PW assured the Board that the crude mortality rate remained unchanged throughout this period. Work was ongoing with the Clinical Coding and Palliative Care teams to ensure that all patients were accurately coded especially those who had received Specialist Palliative Care or had a life limiting diagnosis.

	10.4. PW advised that the most up to date figures were for December 2023 and the in-month figures were 84.9 for legacy STHK sites (YTD 91) and 81.4 for legacy S&O sites (YTD 98). This resulted in a YTD HSMR for MWL of 93 which was within target. 10.5. PW noted that the S&O SJRs had highlighted the association between long length of stay in the ED and poor patient experience and outcomes and work was ongoing to reduce the long ED waits. 10.6. There had been an increase in Structured Medication Reviews (SMR) for several diagnostic groups including chest infections and Pneumonia and PW noted that these had been previously reviewed by the Mortality Operational Group and no avoidable deaths had been identified, however, an additional sample would be reviewed to ensure that there were no ongoing concerns. 10.7. PW advised that the learning from quarter three included the conclusion of the coroner's inquest into a maternal death due to complications of a major haemorrhage at Ormskirk Hospital. There had been significant learning following the death and several immediate and long-term actions had been implemented. The actions included the implementation of a second emergency Caesarean section theatre list as well as a clinically led process for planning elective caesarean sections based upon the identification of clinical urgency. PW advised that the Lancashire coroner had commented that the changes that had been implemented would save lives. 10.8. RT commented on the five green with positive feedback completed SJRs and reflected on the importance of providing positive feedback to the trainees. PW agreed with RT's comment and added that compassionate leadership was important. 10.9. GB reflected on the association between long length of stay in the ED and poor patient experience and outcomes in the Southport ED and asked if this had been highlighted to Sefton PLACE. LN confirmed that this had been raised at the Urgent Care Board for Sefton. **RESOLVED:** The Board **noted** the Learning from Deaths Quarterly Report
11.	**TB24/035 Laboratory Information Managements System (LIMS) Full Business Case**
	11.1. MG presented the Laboratory Information Managements System (LIMS) Full Business Case which outlined the proposal for a shared LIMs across all C&M trusts providing laboratory services to enhance the efficiency and information sharing. 11.2. MG noted that one of the ambitions of the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) was to unify acute and

	specialist providers to improve health services at scale and one of the initiatives was the Diagnostics Programme whose core aim was to procure and implement a LIMS system to support the transformation of Pathology services across the network. 11.3. MG advised that the current pathology systems across C&M were very dated and limited the system's ability to meet the NHSE requirement of a mature pathology network by March 2025. The new LIMS solution would enable the improved connectivity and integration of the diagnostic workforce which was crucial for patient safety and efficient services. 11.4. MG advised that there had been a robust procurement exercise and evaluation process involving all the acute providers in the C&M region and Magentus had been selected as the preferred supplier. 11.5. Once the full business case (FBC) had been approved by all partners there would be a full programme of work to implement the new system. 11.6. MG advised that he would be the Executive Lead for the implementation programme and act as programme Chief Information Officer (CIO) because MWL would hold and manage the LIMS contract on behalf of all the trusts. 11.7. MG advised that the pathology systems at STHK sites were over 30 years old and had many limitations which impacted services, and replacing this system was an imperative. There were of course also risks to implementing a new system, but these would be managed by the programme board, which would report to CMAST. MG noted that an expression of interest request had gone out for a LIMS Programme Director. 11.8. MG noted that the FBC had been reviewed by the Executive Committee and was fully supported. 11.9. IC asked for clarity on the financial impact, with his understanding being that for the first three years the Trust would invest £100,000 per year to cover the risk without any returns, but from year 4 would start to receive a return on the investment and by year 6 the Trust would break even. GL confirmed that this was correct. 11.10. MG noted that the FBC was being presented to all Trust Boards in the C&M region for approval during April 2024 and the final paper would be presented at the CMAST Board in May 2024. AM commented, that as this was a CMAST project, the FBC needed to be approved by the five boards of the partner trusts. Additionally, ICB approval would be required for any new investment given the current financial situation. The new system would facilitate the development of pathology hubs across the region and MWL would be one of the three hubs in C&M, and these would be more efficient.

	RESOLVED: The Board **approved** the Laboratory Information Managements System (LIMS) Full Business Case
Concluding Business	
12.	**Effectiveness of Meeting**
	12.1. In response to RF's question about the effectiveness of the meeting LB commented that she had felt trusted and valued as a member of the meeting and that the Trust's new values of being open and kind as well as fair challenge had been clearly demonstrated. MG agreed with LB's comment and added that he had felt welcomed as a new member of the Board. 12.2. RF commented that one of the strengths of the Board was the Executive Directors could challenge each other as comfortably as the NEDs and this was important to maintain an effective and united Board.
13.	**Any Other Business**
	13.1. RF reflected on the recent Start of the Year Conference which was one of the best events that he had attended and congratulated the Assistant Director of Communications and her team. 13.2. PG advised that he would be taking part in the Miles for Memories charity event in support of the new MWL Hospital Charity, raising funds for the care of the elderly. The three-man team would be walking 26 miles from Ormskirk Hospital to Whiston Hospital carrying a log. AM suggested that PG contact the Communications team for assistance in raising awareness of the event. 13.3. IC noted that there had not been an option to attend the Start of the Year Conference remotely and asked if the event had been recorded. AM advised that the recording would be available on the intranet. The being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.02. The next Board meeting would be held on **Wednesday 29 May 2024 at 10.00**

Meeting Attendance 2024/25												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser (Chair)	✓											
Ann Marr	✓											
Anne-Marie Stretch	A											
Geoffrey Appleton	✓											
Lynne Barnes	✓											
Gill Brown	✓											
Nicola Bunce	✓											
Ian Clayton	✓											
Steve Connor	✓											
Rob Cooper	✓											
Paul Growney	✓											
Malcolm Gandy	✓											
Lisa Knight	✓											
Gareth Lawrence	✓											
Lesley Neary	✓											
Sue Redfern	A											
Hazel Scott	✓											
Rani Thind	✓											
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 24 May 2024

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
12	31/01/2024	**MWL TB24/010 Learning from Deaths Quarterly Report** 12.1 STHK sites	The Board requested a summary of the themes, learning and actions plans from the Quarterly Learning from Deaths Report be brought together in to an annual report each year. PW agreed to do this for July and NB to update the Board workplan to include this. Update (April 2024) Board workplan updated	PW	Jul-24		
6	28/02/2024	**MWL TB14/024 Integrated Performance Report** 6.1 Quality Indicators	Review of the reasons for the reduction in FFT scores and actions being taken to address this. Update (May 2024) Data collection methods have been reviewed and some additional options being implemented including paper base. Volunteer available in one area to support. Information provided to women regarding the 4 touch points due to repetitive nature of the survey. FFT not to be used in isolation to monitor patient experience. MNVP and feedback from compliments and complaints also to be reported. This is being monitored at local governance, Patient Experience Council and Quality Committee on a regular basis.	~~SR~~ LB	May-24		Closed

6	24/04/2024	**TB14/030 Integrated Performance Report** 6.2 Operational Indicators	RT commented that non-obstetric ultrasound was not included on the Corporate Risk Register (CRR) and asked if additional capacity was planned or if the Trust would continue to outsource this. LN responded that outsourcing had been used to overcome the backlog, but once again there was sufficient internal capacity to cope with the predicted levels of growth once a steady state was achieved. LN suggested the capacity and demand modelling for each diagnostic modality be presented at the Finance and Performance Committee to provide assurance	LN	Jun-24		**Delegated to Finance & Performance Committee**

Completed Actions

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
6	25/10/2023	**MWL TB23/043 Integrated Performance Report** 6.2 Operational Indicators	Executive Committee would to review the cancer two-week referral target performance and potential improvements.	LN	Apr-24	24/04/2024 - The action plans were reviewed at Executive Committee on 11 April and will be presented at the Finance & Performance Committee on 18 April.	**Closed**
9	31/01/2024	**MWL TB24/008 Corporate Risk Register**	CW to review if there should be a seperate CRR cyber security risk	~~CW~~ MG	Apr-24	24/04/2024 - NB advised that the creation of a separate risk for Cyber Security was being reviewed. MG advised that he would prefer separate risks for IT Infrastruture and Cyber Security.	**Closed**
6	28/02/2024	**MWL TB14/024 Integrated Performance Report** 6.1 Quality Indicators	A thematic review of all falls with moderate or higher levels of harm should be completed with a focus on risk factors and presneted at the Quality Committee	~~SR~~ LB	Apr-24	24/04/2024 - Report was presented to the Executive Committee and Quality Committee in March 2024 and Quality Committee requested further anlaysis.	**Closed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	29 May 2024
Agenda Item	**TB24/038**			
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 performance 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

NHS
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	Dec-23	84.1	100	93.0	Best 30%
FFT - Inpatients % Recommended	Apr-24	94.7%	90.0%	94.7%	Worst 50%
Nurse Fill Rates	Apr-24	99.1%	90.0%	99.1%	
C.difficile	Apr-24	10		10	
E.coli	Apr-24	14		14	
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-23	0.16	0.00	0.10	
Falls ≥ moderate harm per 1000 bed days	Mar-24	0.13	0.00	0.18	
Stillbirths (intrapartum)	Apr-24	0	0	0	
Neonatal Deaths	Apr-24	1	0	1	
Never Events	Apr-24	0	0	0	
Complaints Responded In 60 Days	Apr-24	73.5%	80.0%	73.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Mar-24	75.3%	75.0%	70.0%	Worst 40%
Cancer 62 Days	Mar-24	82.1%	85.0%	78.4%	Best 10%
% Ambulance Handovers within 30 minutes	Apr-24	56.1%	95.0%	56.1%	
A&E Standard (Mapped)	Apr-24	75.0%	78.0%	75.0%	Best 50%
Average NEL LoS (excl Well Babies)	Apr-24	4.1	4.0	4.1	Best 30%
% of Patients With No Criteria to Reside	Apr-24	21.5%	10.0%	21.5%	
Discharges Before Noon	Apr-24	17.7%	20.0%	17.7%	
G&A Bed Occupancy	Apr-24	97.8%	92.0%	97.8%	Worst 40%
Patients Whose Operation Was Cancelled	Apr-24	0.8%	0.8%	0.8%	
RTT % less than 18 weeks	Apr-24	61.9%	92.0%	61.9%	Best 30%
RTT 65+	Apr-24	553	0	553	Worst 40%
% of E-discharge Summaries Sent Within 24 Hours	Apr-24	84.1%	90.0%	84.1%	
OP Letters to GP Within 7 Days	Mar-24	40.5%	90.0%	44.8%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Apr-24	79.2%	85.0%	79.2%	
Mandatory Training	Apr-24	87.5%	85.0%	87.5%	
Sickness: All Staff Sickness Rate	Apr-24	5.5%	5.0%	5.5%	
Staffing: Turnover rate	Apr-24	0.8%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Apr-24		1,400	1,000	
Cash Balances - Days to Cover Operating Expenses	Apr-24	2.5	10		
Reported Surplus/Deficit (000's)	Apr-24		-4,875	-4,875	

Board Summary - Quality

Quality

Never Events - There were no never events in April.

Pressure Ulcers - The latest validated month is December 2023. There were 5 category 2 or above pressure ulcers with lapse in care in December (all category 2's). Learning reviews have been completed and improvement actions in place. The TVN team are continuing to align pathways and processes for pressure ulcer prevention across the MWL organisation.

Patient Falls - There were 5 falls resulting in moderate or above harm in March (2 S&O, 3 StHK). All falls with harm have been reviewed and Trust-wide falls actions are in place.The Trust is progressing learning from the recent MIAA Quality Spot Check audit, relating to falls and pressure ulcer risk assessments.

MRSA - no cases were reported in April. Achieving zero MRSA BSI is a Trust Objective for 2024/25, with ongoing delivery of the Peripheral Intravenous Vascular Cannula Improvement Plan.

C.Diff - All cases have been reviewed by the IPC Team and IPLR's are requested of the clinical team.A CDI Improvement Plan has been developed, incorporating the key elements of environmental cleanliness, appropriate antimicrobial prescribing and staff awareness and training.

E coli - The E coli Improvement Plan remains on track, and the Trust is also collaborating on an ICB-led North Mersey IPC/AMR action plan, with a focus on reducing E coli BSIs and hydration.

Neonatal Deaths - 1 neonatal death reported in April.

HSMR - Latest data available up to and including Dec-23. YTD the Trust HSMR remains low at 93.0, with both sites below 100 (STHK site 91.0 and S&O 98.0). The YTD S&O HSMR has increased from 22-23. The factors driving the rise in HSMR have been reviewed and this appears to be driven by a fall in palliative care coding and a drop in patients recorded as having septicaemia. Action has been taken to ensure that patients are coded as accurately as possible to ensure an accurate HSMR. The Trust continues to monitor and investigate any alerting diagnosis groups. Crude mortality remains unchanged. The SHMI remains within expected levels.

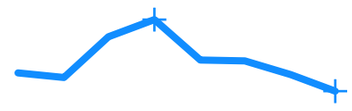
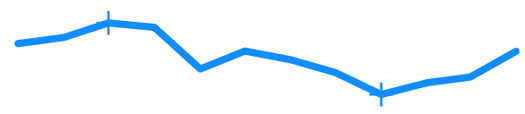
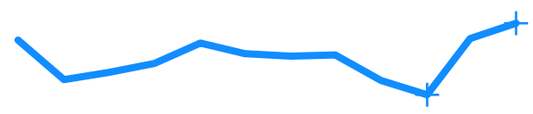
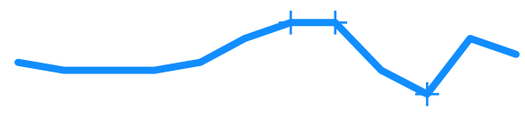
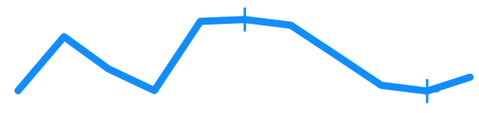
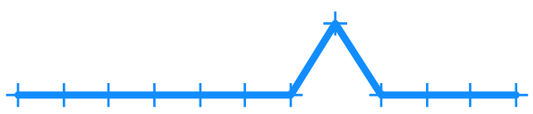
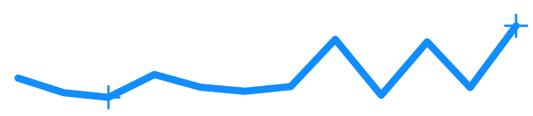
Friends & Family Test – FFT response rates remain fairly consistent, with ongoing work to improve rates within maternity services. The recommendation rates for April 2024 were above target for inpatients, ED, outpatients and all maternity areas.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Dec-23	84.1	100	92.2	Best 30%	
FFT - Inpatients % Recommended	Apr-24	94.7%	90.0%	94.7%	Worst 50%	
Nurse Fill Rates	Apr-24	99.1%	90.0%	99.1%		
C.difficile	Apr-24	10		10		
E.coli	Apr-24	14		14		
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-23	0.16	0.00	0.10		
Falls ≥ moderate harm per 1000 bed days	Mar-24	0.13	0.00	0.19		
Stillbirths (intrapartum)	Apr-24	0	0	0		
Neonatal Deaths	Apr-24	1	0	1		
Never Events	Apr-24	0	0	0		
Complaints Responded In 60 Days	Apr-24	73.5%	80.0%	73.5%		

Board Summary - Operations

Operations

Urgent Care/Bed Pressures
4-Hour performance decreased in April with the Trust (mapped) achieving 75%. This compares with national performance 74.4% and providers across Cheshire & Merseyside averaging 72.1%.
The Trust continue to utilise all escalation capacity across both sites and progress with improvement plans. C&M ICB have established a UEC Recovery programme with a focussed programme for Mid Mersey covering MWL and all system partners. Three key workstreams have been established, admission avoidance, acute length of stay and acute discharge.

Elective
The Trust had 2,551 52-week waiters at the end of April (162 S&O and 2,389 StHK) and no 78 week waiters. The Trust are on track with achieving zero 65 week waiters by the end of September 2024.
The 52-week position is an increase of 15 from March. 18 Week performance in April for MWL was 61.9%, S&O 67.6% and StHK 59.8%. National performance (latest month March) was 57.2% and C&M regional performance was 56%.
The trust continues to risk stratify patients to ensure that our focus remains on those who are most clinically urgent (P2) and who have waited the longest.

Diagnostics
The Trust has seen an improvement in the overall diagnostics 6 week performance. From 66.4% in September 2024 to 89% in April 2024. The 3 key modalities that were under performing were endoscopy, non-obstetric ultrasound and DEXA scans. Significant improvement has been seen in endoscopy and non-obstetric ultrasound with improvements expected in DEXA scans in May 2024 with additional capacity coming on line.

Cancer
MWL treated more patients on a 62-day cancer pathway across Cheshire and Mersey and more patients within 62 days. The cancer teams across both legacy Trusts have been brought together with 1 PTL being run for each tumour site. Tumour site specific improvement plans have been developed to set out the key actions being taken to achieve the 28 day and 62 day standards for 2024/25. These were presented to the committee in April 2024.

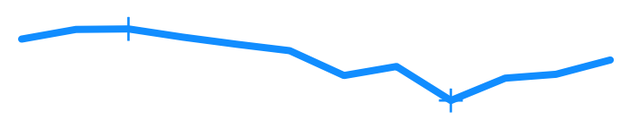
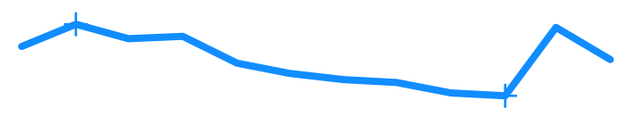
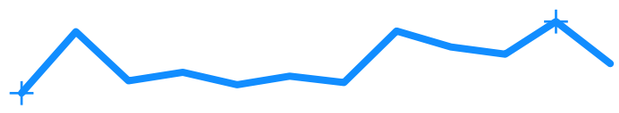
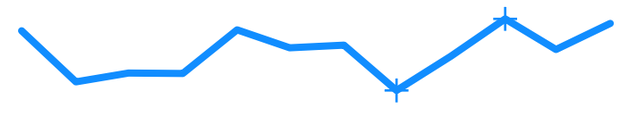
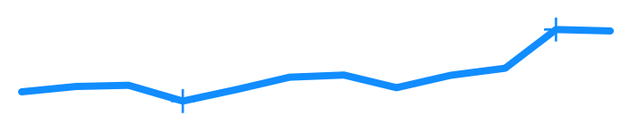
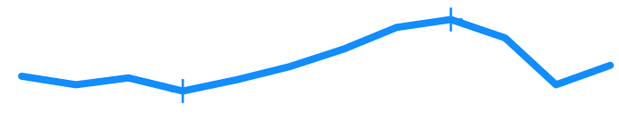
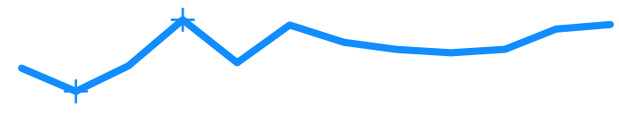
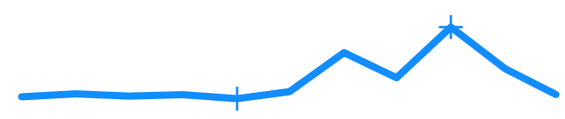
Letters
Challenges continue with the production of letters following an outpatient appointment. However, urgent letters are being produced within 48 hours of appointment and routine within 10 days, which is line with internal targets. An interim solution has started to be rolled out and will continue across Q1 2024/25.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Mar-24	75.3%	75.0%	70.2%	Worst 40%	
Cancer 62 Days	Mar-24	82.1%	85.0%	78.6%	Best 10%	
% Ambulance Handovers within 30 minutes	Apr-24	56.1%	95.0%	56.1%		
A&E Standard (Mapped)	Apr-24	75.0%	78.0%	75.0%	Best 50%	
Average NEL LoS (excl Well Babies)	Apr-24	4.1	4.0	4.1	Best 30%	
% of Patients With No Criteria to Reside	Apr-24	21.5%	10.0%	21.5%		
Discharges Before Noon	Apr-24	17.7%	20.0%	17.7%		
G&A Bed Occupancy	Apr-24	97.8%	92.0%	97.8%	Worst 40%	
Patients Whose Operation Was Cancelled	Apr-24	0.8%	0.8%	0.8%		
RTT % less than 18 weeks	Apr-24	61.9%	92.0%	61.9%	Best 30%	
RTT 65+	Apr-24	553	0	553	Worst 40%	
% of E-discharge Summaries Sent Within 24 Hours	Apr-24	84.1%	90.0%	84.1%		
OP Letters to GP Within 7 Days	Mar-24	40.5%	90.0%	45.3%		

Board Summary - Workforce

Workforce

Mandatory Training - The Trust continues to exceed its mandatory target at 87.5% against a target of 85%.

Appraisals - The Trust has not achieved the appraisal target, achieving 79.2% against a target of 85%, a 3% decrease on the previous month. The lower compliance on the legacy S&O sites has positively improved in month (from 69.8% to 72.8%) with there being a reduction in compliance across legacy STHK sites (82.3%).

Sickness - In-month sickness remains above target, at 5.4% against the 5% target. This is a further 0.3% in month reduction. 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 on 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.
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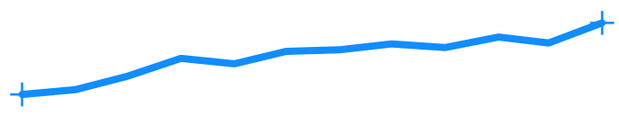
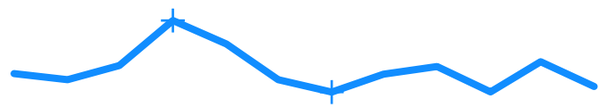
• Facilitating early engagement of all employees who are absent due to musculoskeletal problems.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Apr-24	79.2%	85.0%	79.2%		
Mandatory Training	Apr-24	87.5%	85.0%	87.5%		
Sickness: All Staff Sickness Rate	Apr-24	5.5%	5.0%	5.5%		
Staffing: Turnover rate	Apr-24	0.8%	1.1%	0.8%		

Board Summary - Finance

Finance

The final approved MWL financial plan for 24/25 gives a deficit of £33.8m, which assumes:

- Payment of £12m funds in line with transaction business case
- Delivery of £36.2m recurrent CIP
- Delivery of £9m non-recurrent CIP
- Delivery of the 24/25 activity plan, in order to achieve planned levels of income including ERF/API variable funding
- Contract agreements in line with planned values

Surplus/Deficit – At Month 1, the Trust is reporting a year to date deficit of £4.9m in line with plan. This position includes underperformance against the activity plan of £1.3m which is currently mitigated by non recurrent underspends elsewhere in the position.

CIP - The Trust's CIP target for financial year 2023/24 is £45.2m, of which £36.2m is to be delivered recurrently and £9.0m non-recurrently. As at Month 1, the Trust has successfully transacted CIP of £8.9m in year of which £8.1m is recurrent, with a further £9.4m of recurrent CIP at finalisation stage.

Cash - At the end of M1, the cash balance was £6.4m, the Trust will require cash support throughout the year and will need to provide significant assurance to recieve this. Trust will continue to monitor Lead Employer cash balances to ensure no detrimental impact to the Trust.

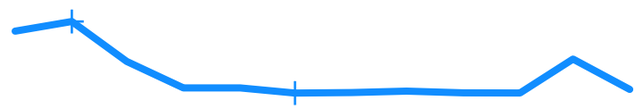
Capital - Capital expenditure for the year to date (including PFI lifecycle) totals £1m which includes the use of PDC funding (provided by Department of Health & Social Care).

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Apr-24		1,400	1,000		
Cash Balances - Days to Cover Operating Expenses	Apr-24	2.5	10			
Reported Surplus/Deficit (000's)	Apr-24		-4,875	-4,875		

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	Dec-23	81.4	100	98.0	
FFT - Inpatients % Recommended	Apr-24	93.9%	90.0%	93.9%	
Nurse Fill Rates	Apr-24	98.2%	90.0%	98.2%	
C.difficile	Apr-24	4		4	
E.coli	Apr-24	7		7	
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-23	0.07	0.00	0.06	
Falls ≥ moderate harm per 1000 bed days	Mar-24	0.15	0.00	0.11	
Stillbirths (intrapartum)	Apr-24	0	0	0	
Neonatal Deaths	Apr-24	0	0	0	
Never Events	Apr-24	0	0	0	
Complaints Responded In 60 Days	Apr-24	82.4%	80.0%	82.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Mar-24	71.6%	75.0%	69.7%	
Cancer 62 Days	Mar-24	70.2%	85.0%	63.2%	
% Ambulance Handovers within 30 minutes	Apr-24	67.6%	95.0%	67.6%	
A&E Standard (Mapped)	Apr-24				
Average NEL LoS (excl Well Babies)	Apr-24	5.3	4.0	5.3	
% of Patients With No Criteria to Reside	Apr-24	18.3%	10.0%	18.3%	
Discharges Before Noon	Apr-24	20.2%	20.0%	20.2%	
G&A Bed Occupancy	Apr-24	97.5%	92.0%	97.5%	
Patients Whose Operation Was Cancelled	Apr-24	1.0%	0.8%	1.0%	
RTT % less than 18 weeks	Apr-24	67.6%	92.0%	67.6%	
RTT 65+	Apr-24	5	0	5	
% of E-discharge Summaries Sent Within 24 Hours	Apr-24	81.8%	90.0%	81.8%	
OP Letters to GP Within 7 Days	Mar-24	62.3%	90.0%	69.7%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Apr-24	72.8%	85.0%	72.8%	
Mandatory Training	Apr-24	90.4%	85.0%	90.4%	
Sickness: All Staff Sickness Rate	Apr-24	5.9%	6.0%	5.9%	
Staffing: Turnover rate	Apr-24	0.8%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Apr-24				
Reported Surplus/Deficit (000's)	Apr-24				

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	Dec-23	84.9	100	91.0	
FFT - Inpatients % Recommended	Apr-24	95.0%	94.0%	95.0%	
Nurse Fill Rates	Apr-24	99.9%	90.0%	99.9%	
C.difficile	Apr-24	6		6	
E.coli	Apr-24	7		7	
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-23	0.22	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	Mar-24	0.12	0.00	0.22	
Stillbirths (intrapartum)	Apr-24	0	0	0	
Neonatal Deaths	Apr-24	1	0	1	
Never Events	Apr-24	0	0	0	
Complaints Responded In 60 Days	Apr-24	64.7%	80.0%	64.7%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Mar-24	77.9%	75.0%	70.2%	
Cancer 62 Days	Mar-24	86.8%	85.0%	83.8%	
% Ambulance Handovers within 30 minutes	Apr-24	50.0%	95.0%	50.0%	
A&E Standard (Mapped)	Apr-24				
Average NEL LoS (excl Well Babies)	Apr-24	3.7	4.0	3.7	
% of Patients With No Criteria to Reside	Apr-24	23.4%	10.0%	23.4%	
Discharges Before Noon	Apr-24	15.4%	20.0%	15.4%	
G&A Bed Occupancy	Apr-24	97.9%	92.0%	97.9%	
Patients Whose Operation Was Cancelled	Apr-24	0.7%	0.8%	0.7%	
RTT % less than 18 weeks	Apr-24	59.8%	92.0%	59.8%	
RTT 65+	Apr-24	548	0	548	
% of E-discharge Summaries Sent Within 24 Hours	Apr-24	84.7%	90.0%	84.7%	
OP Letters to GP Within 7 Days	Mar-24	27.4%	90.0%	30.2%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Apr-24	82.3%	85.0%	82.3%	
Mandatory Training	Apr-24	86.1%	85.0%	86.1%	
Sickness: All Staff Sickness Rate	Apr-24	5.3%	5.0%	5.3%	
Staffing: Turnover rate	Apr-24	0.7%	1.1%	0.7%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Apr-24				
Cash Balances - Days to Cover Operating Expenses	Apr-24				
Reported Surplus/Deficit (000's)	Apr-24				

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	29 May 2024
Agenda Item	**TB24/039 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in April 2024		
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 April 2024. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded.		
04 April 2024		
Nurse Safe Staffing Report - January	• The Director of Nursing, Midwifery and Governance introduced the report which provided assurance that there were safe levels of nurse staffing across the Trust. • The overall fill rate for January 2024 had been 99.5% for registered nurses and 108% for health care assistants (HCAs). • There had been an increase in HCA temporary staffing at all sites reflecting the need to cover sickness absence and supplementary care requests. A deep dive into the areas with the highest sickness absence was being undertaken. • Work continues to align the bank and agency booking controls and roster management across the trust and to develop proposals for reducing agency spend by increasing staff numbers on the bank. • In relation to nurse recruitment there remained a strong pipeline of recruitment to both RN and HCA posts, substantive and for the bank with the time to hire reduced to 31.5 days.	Assurance
Increases to the national minimum wage (NMW).	• The report set out the new NMW of £11.44 and impact for band 2 Agenda for Change (AfC) staff, where the NMW was only slightly below the national AfC hourly rate, pending the 2024/25 pay award. The paper detailed the HMRC rules for salary deductions where these would impact the	Approval

	NMW and the steps the Trust needed to take to remain compliant. • Temporary adjustments to some salary deductions were approved.	
Winter Schemes Review	• The Chief Operating Officer provided an update on the work that was being undertaken to review the impact of each of the 2023/24 winter plan schemes, in order to select the most effective for the 2024/25 winter plan. • The outcome of the review would be presented at a future committee meeting.	Assurance
Band 2 -3 Grievance	• The Director of HR/Deputy CEO reported on the latest meeting with Unison. A proposal was due to be made at the next planned meeting, which would hopefully allow a settlement to be reached.	Assurance
2024-25 Financial Plan	• The Director of Finance and Information reported that the NHS Cheshire and Merseyside (NHSC&M) ICB draft plan had been rejected by NHS England and further mitigations requested to reduce the deficit. • Recruitment freezes on all non-clinical staff were being proposed as well as a review of other types of expenditure. • The Trust continued to be part of the system wide discussions.	Assurance
11 April 2024		
Improving Fluid Balance Recording	• The Director of Nursing, Midwifery and Governance introduced the presentation which set out the actions being taken to improve fluid balance recording. • The Committee recognised the work that was being done and additional assurance measures were discussed which would be incorporated into the presentation ahead of sharing with the Quality Committee.	Assurance
St Helens Skills Academy	• The Director of Integration reported on the work with St Helens Council to create a Skills Academy with a physical presence in St Helens town centre. • As part of the programme to support the Skills Academy a recruitment event for the different NHS roles and professions had been arranged at Whiston Hospital for 20th April 2024.	Assurance
Maternity CQC Report and Action Plan	• The Director of Nursing, Midwifery and Governance presented the CQC Maternity Service reports and combined MWL action plan. • The deadlines for completion of the actions and monitoring arrangements were discussed.	Assurance

	• The reports and action plan were due to be presented to the Quality Committee on 16th April.	
Agency Spend Analysis	• The Director of Finance and Information presented the report which analysed the 2023/24 agency spend to identify areas for improvement in 2024/25. • In 2023/24 MWL had spent 3.9% of the total paybill on agency staff. The national target for 2024/25 was 3.2%. • The main area of focus was the legacy STHK sites where bank and agency spend on nursing and HCA staff had increased significantly. • The report identified the top 10 areas of increased spend and corrolated this with reported levels of vacancies, sickness absence and maternity leave. • Each division had been asked to produce a plan in relation to their highest spending areas, which would be reported in May, with the objective to stop agency HCA bookings from 1st June 2024.	Assurance
Impact Assessment – Introduction of long day shifts	• The Director of Nursing, Midwifery and Governance introduced the report which assessed the impact of the introduction of long day shifts for nursing at the legacy STHK sites, in November 2022. • The long day shifts remained popular with nursing staff and were seen as supporting work/life balance and flexible working. • The review had found there had been a small reduction in staff turnover and no increase in absence due to stress and anxiety, with a small overall decrease in sickness absence levels. • The Committee agreed with the assessment that there had been no detrimental impact and some positive outcomes. • It was noted that there were plans to align the long day shift patterns across all MWL sites during 2024/25. • Opportunities for different shift patterns were still available for those who wanted or needed to work a more traditional 7.5 hour shift.	Assurance
Cancer Tumour Pathway Improvement Plans	• The Managing Director introduced the report, which detailed the action being taken for each tumour pathway to improve performance and achieve the national access standards.	Assurance

	• Committee focused particularly on urology and lower GI where there had been particular issues in respect of capacity for diagnostics. • The improvements in dermatology and lung cancer were noted. • The plans were designed to deliver the faster diagnosis standard by 30 June 2024. • The report was being presented to the Finance and Performance Committee on 18th April.	
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the report from the RMC meeting on 9 April 2024 • There had been 1055 risks reported on the MWL risk register, including 33 new risks reported in March and 54 risks closed. • 44 risks had been escalated to the Corporate Risk Register (CRR). • Risks were now being aligned to the new Clinical Divisions. • MIAA had completed a review of the new MWL risk management process, which had received a rating of substantial assurance.	Assurance
Integrated Performance Report (IPR)	• The Director of Finance and Information presented the March IPR and Committee reviewed the metrics and the accompanying commentary.	Assurance
18 April 2024		
Draft Quality Account	• The Acting Director of Nursing, Midwifery and Governance introduced the draft 2023/24 Quality Account, which was to be published by 30 June 2024. • Acievement against the 2023/24 quality improvement priorities were reviewed in detail and the proposed quality improvement objectives for 2024/25 confirmed, following the survey of staff and stakeholders. • The draft was due to be presented to commissioners and the Quality Committee before final approval at the June Trust Board.	Assurance
Policies Update	• The Acting Director of Nursing, Midwifery and Governance presented the report. • There were 877 policies and procedural documents across MWL inherited from the legacy organisations, of which 204 were overdue for review and awaiting alignment.	Assurance

	• 63 policies had been fully harmonised including 11 of the 20 priority clinical policies identified during the transaction quality governance review. • Of the 9 outstanding, 6 were in progress and due to be approved by June, and the remaining 3 were awaiting updated national guidance but work had started to align these for MWL and a risk assessment completed on the current policies.	
Appraisal and Mandatory Training Compliance	• The Director of HR/Deputy CEO presented the compliance figures for month 12. • Mandatory training compliance had increased slightly to 82% and the report detailed the services and teams where compliance was below 70%. • Core skills manatory training compliance was at 86.7% and the report detailed services which were not achieving the 85% target level of compliance. • The report also detailed compliance against the compulsory skills training which was 82.3%. The report detailed compliance by staff group and by subject where compliance was less than 80%. • From April recovery plans would be required from directors for staff groups/teams who had not achieved the 85% target for compulsory skills training.	Assurance
Board Assurance Framework (BAF)	• The Director of Corporate Services presented the draft BAF following the Q4 review. • The Committee reviewed and agreed the proposed changes to be recommended to the Trust Board.	Assurance
Electronic Patient Record (EPR) Programme Governance	• The Director of Informatics presented proposals for the EPR programme oversight council as a time limited addition to the Trust's corporate governance arrangements, until the new EPR was implemented. • It was agreed that the council should report to the Executive Committee.	Approval
Laboratory Information System (LIMS) Full Business Case (FBC)	• The Director of Informatics presented the LIMS FBC which proposed the purchase of a single LIMS for Cheshire and Merseyside (C&M) and required the approval of all acute trusts with a current LIMs. This was scheduled for April Boards across C&M. • MWL will host the LIMS contract on behalf of CMAST and the Pathology Network.	Approval

	• The Committee endorsed the project as being a key enabler for closer integration and supported the FBC for presentation to the Trust Board.	
Implied Productivity	• The Director of Finance and Information presented a paper detailing the methodology used by NHSE to calculate implied productivity, which compared activity and costs planned for 2024/25 with 2019/20 (before COVID-19). • The calculations used PBR income and excluded maternity services and service developments since 2019/20. • The inflation used was NHS planned inflation not actual inflation. • The paper included the variables which were not allowed for in this calculation for MWL, including the growth of lead employer contracts and other hosted services, such as the collaborative staff bank and payroll, the COVID vaccination programme, and the underlying deficit inherited from S&O (£30m). • It was agreed that the analysis should be kept live to enable proactive articulation of the Trust's position in discussion with both the ICB and NHSE.	Assurance
Appraisal Process Alignment	• The Director of HR/Deputy CEO presented a report that set out the plans for aligning the Agenda for Change staff appraisal process across MWL. • The appraisal paperwork had been updated and would be launched for the 2024/25 appraisal window.	Approval
25 April 2024		
DNACPR Decision Trends	• The Acting Director of Nursing, Midwifery and Governance introduced the report. • The report had been commissioned on DNACPR decisions made during the pandemic. This followed complaints received from patients and relatives about the DNACPR decisions not being withdrawn on discharge. • The review had found there had been 49 complaints and 215 PALs concerns between April 2020 and March 2022 relating to a DNACPR decision, of whom 56 were for patients with COVID-19. • The case notes of the 56 patients had been reviewed and it was found that 32 of the patients had been discharged, of which 13 had survived	Assurance

	for 2 years and 8 of these still had DNACPRs in place (due to other conditions) and in 5 cases the DNACPR had been rescinded. • The case note review showed that the DNACPR decision and conversation with patients/relatives was well recorded in the notes, including review at discharge. • All patients were discharged with a copy of the DNACPR (purple form). • The audit provided assurance that the DNACPR process had been used correctly, but more training and support materials may be useful for both patients and relatives.	
Nurse Safe Staffing Report – February	• The Acting Director of Nursing, Midwifery and Governance introduced the report for month 11. • The RN overall fill rate was 95.9% and the HCA overall fill rate was 113.3%. • The calculations in February had not been adjusted for the increase in staffing from 12 February when the decision had been taken to open a 5th bed in each bay as part of the winter escalation. • This change had not impacted Care Hours Per Patient Per Day (CHPPD), which remained above the target level for each ward. • The systems for reporting staffing continued to be aligned and a standard report format would be in place for the April (month 1) report for 2024/25. • The recruitment pipeline remained strong with a time to hire of 34 days for RNs and 28 days for HCAs. • Plans to reduce the use of agency HCA staff were being refined as the number of staff on the bank increased.	Assurance
Regional spinal injuries unit hydrotherapy pool – Southport Hospital	• The Managing Director presented the review on behalf of the Director of Strategy and Clinical Reconfiguration, that had been undertaken following questions from the local MP, and Councillors. • The review had assessed the implications of patients other than those being cared for by the regional spinal injuries unit using the hydrotherapy facilities. • The risks and additional safeguards that would be needed if the hydrotherapy pool was open to other types of patient and groups were noted.	Assurance

	• It was agreed that a formal response would be drafted based on the report.	
Partnership Report	• The Director of Integration reported on the Place Board and how they were supporting the ICB recovery programme with the main focus on Urgent and Emergency Care improvements to increase admission avoidance schemes, reduce length of stay, and improve discharges. • Committee discussed how the executive and other trust resources could be deployed to align to and support this programme.	Assurance
Ambulance Assesmement Unit – Benefits Realisation	• The Managing Director gave a presentation detailing the impact of the new ambulance assessment unit in the Emergency Department at Whiston Hospital. • The unit had opened in early March which had coincided with the opening of the 5th bed in a bay. • Ambulance handover times had reduced and the privacy and dignity and experience of patients was significantly improved by having a dedicated area to await assessment and streaming.	Assurance
Alerts:		
None		
Decisions and Recommendations:		
New investment decisions taken by the Committee during April 2024 were: • None		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	29 May 2024
Agenda Item	**TB24/039 (8.2)**		
Committee being reported	Quality Committee		
Date of Meeting	21 May 2024		
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 16 April 24: Following a few minor clarifications the minutes were approved as a correct and accurate record of the proceedings.	Approved
Matters arising/Action Log	Noted actions aligned to agenda items on the meeting with remaining actions due at future meeting.	Assurance
Quality Committee Corporate Performance Report	**Care Quality Commission (CQC):** Trust maintains outstanding CQC status. **0** Never Events in April 24. **Pressure Ulcers: 6** Category 2 or above (with lapses in care). Themes identified within improvement plans. Proposed validation of Q4 data for next month's Committee meeting. **Patient Falls (with moderate harm or above)**: **5**. Aligned Falls Prevention and Supplementary Care Strategies across the Trust now in place. **Infection Prevention and Control:** • C Diff - **10** in April 24 • E-Coli -**14** in April 24 • MSSA – **9** in April 24 • MRSA - **0** in April 24 Awaiting national/regional 2024/25 target thresholds. **Nutrition:** All 3 Indicators below target. Remains a priority aligned to MIAA workstream. **Complaints:** Increased number of complaints received in April (**44**) noting a correlation to waiting times for appointments, admissions, and cancellations. Trust response time showing a positive trend. **Friends and Family Test (FFT):** Overall reporting positively, recognising work ongoing to improve response rates in maternity through paper/digital and volunteer role. **Maternity:** Assured on perinatal, stillbirth and maternal death rates in-month. Induction of labour rates increased - review on-going across both maternity units.	Assurance

	Hospital Standardised Mortality Ratio (HSMR): December 2023 data reporting improved position 93 YTD with coding anomalies resolved with continued monitoring.	
Quality Account	• First Quality Account as MWL - Presentation received and Quality Account document approved by the Committee. • QA to be presented to the Trust Board in June for final approval. • Key highlights: formation of the new Trust MWL, positive Staff Survey results - first survey after the transaction to MWL, positive in-patient survey results, various awards / accreditations – both for the Trust and individuals, excellent PLACE (Patient Led Assessment of the Care Environment) results. • Challenges: Work to align systems and processes from legacy organisations, 5 CQC inspections, delivery of national targets and recovery programme with on-going periods of industrial action, 6 MRSA bacteraemia with on-going improvement actions, 1 never event. • Progress against 2023-24 Quality Objectives and rational for Quality Objectives selected for 2024-25. • Feedback for amendments suggested by Committee members: addition of volunteer photos, Equality, Diversity, and Inclusion (EDI) anti racism framework, spiritual care team. • QA to be shared with stakeholders for comment and feedback.	Approved
CQC Update	• Medicine and Spinal Unit: Unannounced CQC inspection 24 January 2024 • Positive feedback following the inspection including staffing, training, protecting patients from abuse, risk assessments, policies, and procedures. • Recommendations: Ensure records are always stored securely; staffing levels for dieticians /SALTs / 7-day dietetics & SALT service; MCA training. • Action / Improvement plan developed for the CQC recommendations. This will be monitored through relevant governance structures and the CQC Assurance Group. • Dietetics and SALT: Option appraisal to be presented to Exec Committee by July 2024. • Mental Capacity Act training: internal compliance target now met and ongoing monitoring in place. Additional and bespoke specific training delivered for medical staff.	Assurance
Patient Safety Council Assurance Report	• Terms of Reference under review and focus on divisional reporting going forward.	Assurance

	• Policies and Standard Operating Procedures harmonisation ongoing. • Nursing Audits presented - increase in the overall Trust performance for Nursing Care Indicators (NCI) and above 90% target- Q4 = 90.14% • Learning from Claims - failure/delay diagnosis is a theme. • Medicines Safety Group - overall compliance with medicines safe and secure storage has improved in Q4. • Assurance requested for future reports regarding articulation of actions, particularly on Nursing Care Indicators and outreach audits for hydration. • Assurance received regarding risk to the Trust from recent Measles outbreaks. • Community clinics not currently part of medicines safe and secure storage audits - baseline audit to be completed by pharmacy to establish further support. Chief Pharmacist supporting.	
Patient Safety Update (Incidents/PSII/Never Events) Quarterly 4 Report	• 9,000 incidents reported in Q4 - slight reduction against Q3. 99.5% are no harm/ low harm / near miss. • Changes to national reporting metrics between Q3 and Q4. • Plan to deliver a Trust wide clinical incident reporting tool for MWL - currently remain on two systems. • No Never Events in Q4 • 9 PSII's currently on tracker. Details of each incident and Learning Review reported to the Committee. Immediate issues and actions also detailed. • Pressure Ulcers: Focus on validation of pressure ulcer reporting - Trust has now moved to one consistent assessment tool. • PSIRF: Update report to be provided in September 2024 to include update on national reporting systems and assurance on the implementation and successes/immediate outcomes on PSIRF actions.	Assurance
Maternity & Neonatal Services Q4 Report	• Maternity Incentive Scheme (MIS): The Trust's compliance against for all 10 Safety Actions has been accepted. • Review of Induction of Labour has commenced - findings to be presented to the Committee. • Assurance given on CO (carbon monoxide) monitoring at 36 weeks – compliance has improved (Whiston 95.1 % Ormskirk 80.5%) with continued focus to reach 100% compliance.	Assurance

	• Referral to smoking services continues to increase referral rates to over 90% in April 2024. • 2 perinatal mortalities in Q4 – both had MDT reviews. Shared learning has been disseminated across both maternity units. • No Never Events in Q4. • 1 StEIS report – initial review: no significant areas of learning. • 2 MNSI cases reported in Q4 and also 2 MNSI reports received during Q4 from incidents in August and September 2023. Safety recommendations received for both cases. These have been adopted by the Trust. • Saving Babies Lives: Progress with compliance overall noted. Element 4 – actions taken following reduction in compliance. • CQC inspection reports noted, including on-going improvement plan. • Workforce: Report detailed staffing, vacancies and recruitment in both Maternity and Neonatal Units. Staffing service review / business case is required to ensure staffing standardisation across both sites in the 2 Maternity Units. • Complaints and Claims (past 10 years) detailed. • Maternity Red Flags – 44 red flags in Q4. 34 related to triage breeches. All related to increased triage activity and acuity. Improvement actions and alignment of processes across both sites undertaken. On-going monitoring in progress. • Assurance on Local Maternity and Neonatal System (LMNS) engagement with positive feedback. • Whiston Neonatal Unit was noted outlier in Q4 with 16 closures. • Chief Pharmacist will support a Medication Safety report for both Neonatal units. This will be reported as a section within quarterly Maternity & Neonatal report. • Committee requested more information regarding patient experience, other than FFT data, to be included in future reports.	
Nurse Safe Staffing	• Assurance was provided that Trust has safe staffing levels. • Care Hours per patient day (CHPPD) - Trust reports 7.6 hours against national average 7 hours. • Staff sickness reviews continue. • Temporary workforce reviews ongoing with a move away from agency utilisation. • Positive time to hire and recruitment pipeline for RN/HCAs.	Assurance

	• Supplementary Care - steering group in place. • Noted that the Safe Staffing focus remains aligned to the Francis report.	
Medicines Storage & Security Report Q3 & Q4	• Improvements noted at Whiston & St Helens between Q3 & Q4. Some areas need additional support to further improve compliance with the key medicine's safety metrics. • Southport & Ormskirk sites also have areas in need of additional support to improve compliance. • Assurance was provided by the Chief Pharmacist that immediate improvement actions are undertaken in real time with areas which are non-compliance with the audits. • The Chief Pharmacist assured provision of ward-based Pharmacy technician / link nurses is being considered for areas currently without this resource. A business case is currently under development for Southport and Ormskirk Hospitals to provide this resource at those sites. • Future reporting will be aligned to divisional structures. • Alignment of auditing systems / processes / scoring across all sites to be undertaken. Legacy S&O sites to be audited in the future using the Tendable system. • Focus required to ensure medication trolleys are tethered and secure. On-going monitoring of this issue is required, together with consideration of other safe storage options. • Assurance required for legacy StHK Community sites. Audits /actions need to be undertaken on these sites. • Medicines Safety and Quality Link Nurse Group forum to be extended across the Trust.	Assurance
PIVC Cannular Improvement Plan	• Plan developed in response to MRSA bacteraemia's in 2023/24 related to peripheral cannulas. • Focus - on ensuring patients are receiving reliable care. • 0 MRSA : Q4 and Q1 (to date). • Harmonisation of Aseptic NonTouch Technique (ANTT) systems and processes across MWL including training materials, content of learning package and training needs analysis. • RCA key learning: care and maintenance of lines, monitoring of VIP scores, adherence with dressings and cannula packs. • External audits by cannula providers and on-going Cannula spot checks added to IPC team plan.	Assurance

	• Aim going forward is for point prevalence audits to be undertaken. • MRSA screening compliance - April 24: 98% Whiston site. S&O sites compliance to be confirmed – data currently being validated. Target 85%. • Pre-operative team MRSA screening process mapping commenced.	
Patient Experience Council Report	• Cancer Patient Experience policy approved and submission to Patient Experience Network National Awards (PENNA) awards. • Patient story - Maternity Ormskirk site - positive support to mental and physical health-learning taken forward regarding parents' wishes to inform on the sex of the baby. • Interpreter/Deafness Resource Centre services and patient information leaflets under review for MWL harmonisation. • Provision for meals to relatives of patients on end-of-life pathways under review. • Healthy eating options across MWL remain a focus.	Assurance
Quality Spot Checks - Final Report	• MIAA - Limited assurance report. • Shared learning and improvement plan in place and assurance on an improving position. • Accountability and responsibility by nursing leads across MWL with multi-disciplinary team (MDT) engagement around DNACPR. • Pause to review measures - ongoing auditing. • Focus on delivering 5-star nursing - conference 21 June.	Assurance
Clinical Effectiveness Council Report	• Assurance from Medical Emergency Team (MET) for legacy STHK. Improvements from previous presentations maintained. • Planned Care – Anaesthesia rota gaps for consultant on call. Locum recruitment in place and business case in preparation for speciality doctors to provide cover for maternity rota at Ormskirk. • Awaiting response from Lancs and Cumbria ICB re business case for Paediatric Dietetic service - currently a solo service. Identified as a fragile service. • Spinal Injuries Unit (SIU) - need for increased therapies offer - review of resource required. • Improvement in maternity KPI's relating to stop smoking.	Assurance
NICE Guidance Compliance Report	• Q3 update for legacy STHK and full update for legacy S&O.	Assurance

	• Aligning processes currently for MWL and portal to assist with management and guidance across MWL to support a single report. • Assurance NICE guidance is being analysed, appraised, implemented where possible and reasons evidenced where not possible.	
CQC Single Assessment Framework.	• Single assessment framework presentation deferred to future committee meeting.	Noted
Any Other Business	• Nil	
Effectiveness of the Meeting	• Received via Jonathon Peacock, Chief Pharmacist • Assurance received from all areas presenting.	
Alerts:		
• Nil		
Decisions and Recommendation(s):		
The Board is recommended to note the report, alerts and the assurances sought by the Committee.		

Committee/Council/Group Assurance Report			
Title of Meeting	**Trust Board**	**Date**	29 May 2024
Agenda Item	**TB24/039 (8.3)**		
Committee being reported	Strategic People Committee		
Date of Meeting	20 May 2024		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
SPC 0524/003 – Minutes of the previous meeting	The Committee reviewed the minutes of the meeting held on the 15 April 2024 and approved them as a correct and accurate record of proceedings.	Decision
SPC 0524/004 Action Log and Matters Arising	The committee reviewed the outstanding and approved the completed actions. • SPC 0124/06- Big Conversation Update and what we can do around developing the culture further for MWL- presented at the May meeting. • SPC 0223/005 – Workforce Dashboard has been combined with the SPC action 0324/005- Workforce Dashboard and this will be presented at June's meeting. • SPC 0424/006 – An update report on Health, Work and Well Being (HWWB) Did Not Attend (DNA) was reported to the PPC in May. An update to SPC will be included on the June agenda. • SPC 0324/007 HWWB Operational Plan annual assurance update with respect to the Lead Employer (LE) and LE sickness absence were combined and included in the SPC 0524/009 – LE Annual Report and assurance update presented on the May meeting.	Assurance
SPC 0524/005 – Workforce Dashboard	The CPR dashboard was presented focusing on the key indicators for the SPC. The following points were noted: • Mandatory training exceeded target at 87.5% for April, against the target of 85%. • Appraisal compliance decreased in April (down from 82% to 79.2%). Compliance on the legacy S&O sites has improved from 69.8% to 72.8%.	Assurance

	The decrease in compliance is typical of the appraisal window and is expected to recover. • The recovery plan for appraisals requested by People Performance Council (PPC) doesn't appear to have had any effect to date so the PPC is seeking an explanation and further action. • All staff sickness remains above target (5.4%) but the Trust continues to see positive improvements. Sickness rates for all staff groups on the last rolling 12 months shows an overall static position. • Health Care Assistants (HCA) sickness absence has been improved and reduced to 8.9%. • The reduction in sickness is attributed to improved adherence to the Attendance Management policy which has been evidenced by an increased in the number of staff who are on stages and levels. • The HR Operations teams continue to work proactively with managers to reduce the number of absences with particular attention paid to HCA absences and specifically absences relating to stress, anxiety or depression as the main reasons for sickness absence. The HCA Working Group has been established and will focus on understanding the drivers for sickness absence within this staff group. The formation of this group has been delayed however the first meeting is scheduled for June and an update will be provided to the June SPC. • Turnover in month and over a rolling 12-month period is below target (0.8% and 12.8% respectively). • Time to hire is 41.8 days approaching to the target 40 days. • Stress/Anxiety/depression remains the main reason of sickness absence. • The establishment of the vacancy control panel hasn't resulted in the overall time to hire exceeding the target for non-clinical posts. • The Medical turnover position now excludes foundation doctors. A report was sent to the PPC for monitoring actions. • A different approach has been proposed to collecting exit interview data from the medical workforce to understand how turnover can be reduced.	

	• There is now an enhanced induction for Specialty Associate Specialist (SAS) doctors and a specific induction progress for International Medical Graduates (IMG's) to improve turnover rates. • A SAS doctors task and finish group has been established to focus on education and developing the SAS doctors workforce to improve retention to address a reported lack of training opportunities which had been quoted as reason for leaving.	
SPC 0524/006 – MWL People Plan- End of Year Update 2023/24	• The MWL People Plan 2022-25 aligned with the National People Plan, will be refreshed this year. • The plan focuses on four pillars: Looking after our people, people belonging in the NHS, growth for the future, and new ways of working and the action plan summarised the year-end quarter 4 position. • Q2 and Q3 updates are not available due to the merger of the two legacy organisations and the need to align legacy actions. • Objectives brought to the attention of the Committee by exception were those behind target and not achieved in year. These were in relation to: o The approval of HR Policies and procedures. This was due to reduced capacity of the medical workforce as part of the Local Negotiating Committee (LNC) to review and approve the policies due to industrial action. It was confirmed that positive discussions are currently taking place with the LNC about a solution to clear the backlog. o The reduction in agency spend was not achieved. This continues to be robustly monitored by the Premium Payments Scrutiny Council and the Executive Committee and remains a challenge.	Assurance
SPC 0524/007 – Update regards to the next steps in developing the MWL culture following the launch of the new Trust Values	The Strategic People Committee received an update on the next steps in developing the MWL culture following the launch of the new Trust Values and the following key points were noted: • The new MWL values were launched following the big conversation last year, focusing on kindness, openness, and inclusivity.	Assurance

	• The values were created by staff for staff, with engagement with key stakeholders through HR, resourcing, Learning and Organisational Developments (OD), and HR Commercial Services. • HR operations standard templates, disciplinary policy was updated to ensure the values were embedded and there is a continues review to ensure that any legacy reference to values and behaviours are moved and replaced. • The resourcing team updated their interview packs and applicant support, ensuring that new values were embedded. • The induction process, leadership programmes, and appraisals were updated prior to launch. • The team talks were updated, and any further OD interventions were supported. • HR Commercial Services department have updated their websites and corporate communications with the new values and behaviours. • Future engagement includes virtual face-to-face coffee mornings, leadership meetings, and regular updates, the team are also visiting all sites to promote the values and new Trust Objectives for 2024/25. This will include meeting with Board members on culture and engagement through one-to-one meetings. • The team are also visiting key committees and councils to provide updates. • Brand ambassadors are being considered to support the culture and objectives of five-star patient care	
SPC 0524/008 – Looking After Our People – Workforce Retention	A paper and presentation were received, and the following highlights were noted: • The NHS directly employs over 1.7million people nationally. Retaining our workforce has been a “hot topic” for many years with national NHS Turnover currently 12.7%. • The long-term workforce plan (LTWP) was published in June 2023 and in December 2023, additional documents from NHS Employers were released, including an employer briefing and a retention resource pack. • There is an improvement in turnover in the NHS workforce by 1.38% between 2022/23 and	Assurance

	2023/24, and by 1.36% in March 2023 compared to March 2024. • The MWL turnover data has been analysed into four categories: staff groups, age groups, reasons for leaving, and staff survey results. • The main staff groups need focusing on retention are Additional Clinical Services 20.5% of leavers, Nursing and Midwifery 28.03% and Admin & Clerical 18.83% of leavers. Reasons for leaving include promotion, work life balance, and further education. • The age groups of leavers are under 35 48% and over 55 20%. • The important of flexible working, compassionate leadership feedback and recognition, and career development were emphasised as the key themes based on the Staff Survey results. • In Additional Clinical Services the staffing gaps, development pathways and flexibility are key issues. • A significant number of nursing and midwifery staff are leaving the organisation who are under the age of 40. The reason for leaving within the first four years of service is stated as 9% due to work life balance, 11% promotion and 46% due to relocation. • The Nursing and Midwifery workforce is stable with a vacancy level of 5.43%. • 22% of the admin and clerical staff leavers are under 35 with less than a year's service are on fixed term contracts. 19% of these staff leave for promotion, almost 6% go to other NHS organisations, and 13% go into education and training. • Admin and Clerical staff leavers all ages and first 4 years of service have 16.5% leaving for promotion, with 8.6% going to other NHS organisations, 14% leave on fixed term contracts and 7% state work life balance. • The workforce KPIs for admin and clerical are positive with a 4% sickness rate, 10.95% turnover, 89.32% stability and 2.87% vacancies. • To increase retention, we need to improve how we engage with our workforce. The focus should be on stay conversations, career development, coaching, mentoring, team development	

	programs, flexible working options, and career and development. In addition, MWL should consider enhancing talent pools, talent schemes, succession planning, training, and apprenticeships to support career progression.	
SPC 0524/009 – LE Annual Report and assurance update	The Lead Employer Annual Report and Assurance update was presented, and the following key points were noted: • Lead Employer employs c.13,000 doctors, dentists, and public health trainees across 8 NHS England regions. Key achievements include: o A monthly well-being calendar with mindful sessions and plans for targeted sessions for 2425. o The LE HR Operations team have been through an organisational change process to ensure the service is fit for purpose and has the capacity to support doctors in training (DIT) on long term sickness absence. o An employee relations case tracker and 72-hour review checklist have been implemented. o A series of E-forms with logic and automation initiatives have been implemented resulting in positive feedback from stakeholders. o There has been an increased focus on stakeholder engagement, including monthly training and host-specific information sessions. o The LE training app has been relaunched and has been positively received. • Strategic Priorities for the 2024/25 o Review of contracts for renewal in the next 12 to 18 months. o Acceleration of implementation of Robotic Process Automation for greater efficiencies. o Maintaining the agreed level of contribution. • Improving Working Lives Initiative o Collaboration with NHS England to deliver the improving working lives initiative. o Support for processes with all stakeholders to reduce overpayments for DITs. o Review of processes impacted by rotation, with a focus on improving adherence to the 8-week work schedule.	Assurance

	○ Exploration of opportunities to expand the lead employer model as they arise. There is the potential for a further 1,000 DITs in 2024/25 as an existing region plans to expand the LE model. ○ There is a national focus on standardising and reducing repetition in statutory and mandatory training for DITs. • Challenges and Learning ○ Need to clarify the LE's role and responsibilities with host organisations. ○ Hosts need to improve the timeliness and accuracy of the reporting of sickness absence to enable the LE to provide appropriate well-being support.	
SPC 0524/10 ED&I SMART Objectives	The Strategic People Committee received a presentation, and the following key points were noted that the NHS now has two frameworks, the ED&I Workplace Plan: 6 High Impact Actions and the Equality Delivery System (EDS) Domain 3 "Leadership" <u>High Impact Action 1</u> "Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process". <u>Equality Delivery System 3A</u> "Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities". Trust Board are required to agree ED&I SMART Objectives as follows: • Board and Executive Team members are to agree a minimum of 1 EDI/Health Inequality SMART Objective in 2024 Appraisal round. • Boards are to collate and review collective EDI/Health Inequality SMART targets. • Boards are to collate a progress report on the implementation of the individual and collective SMART Targets or submit individual responses	Assurance

	to the EDI Team no later than 31st December each year for reporting in the Equality Delivery System assessment. • All direct reports of Executive Directors to have EDI / High Impact (HI) SMART Objectives in 2024 Appraisal round. • Trusts are to add an EDI / High Impact (HI) action section into the Staff Appraisal form for the 2025 appraisal round for all members of staff. Trusts are required to embed ED&I into strategies with the following time scales: • All Workforce Strategies and Operational Plans to have EDI and HI actions embedded within them at their next review and no later than December 2025. • All non-workforce Trust Strategies and Operational Plans to have EDI and HI actions embedded within them at their next review date and no later than the 5th of April 2027. • Where a department does not have a Strategy/Operational Plan, to set EDI/HI actions and stretch objectives no later than 5th April 2025. Next steps • The ED&I Team will have individual conversations with the Executive Directors to draft objectives. • The Director of Corporate Services to support Chair and Non- Executive Directors (NEDs) with their ED&I Objectives • ED&I events and activities will be developed to support discussions. • The appraisal form will be updated for 2025.	
SPC 0524/11 - Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Reports from the People Performance Council and the HR Commercial Services Council.	Assurance
SPC 0524/12- Annual refresh Strategic People Committee Terms of Reference	The Strategic People Committee members recommended the refresh Strategic People Committee Terms of Reference to be approved by the Trust Board.	Assurance

SPC 0524/13 Strategic People Committee Effectiveness Review 23-24	It was noted that the effectiveness review accurately reflects the progress and performance of the Strategic People Committee. The SPC committee approved the annual workplan. It was noted that due to the CPR needing to be approved by the Executive Committee on a Thursday, all papers with the exception of the CPR and VOP/PPC assurance reports when these meetings also fall on the Thursday prior to the SPC will be distributed as per the TOR. The CPR will be sent out on the Friday prior to the meeting. Going forward, when possible, the meeting will be moved to later in the week.	Assurance
SPC 0524/14 - Items for Escalation to Trust Board	Feedback from the committee indicated, this meeting has been effectively chaired.	Assurance
SPC 0524/15 Any Other Business	It was noted that the Payroll Team won the award for the excellence in Payroll Services	Assurance
Alerts:		
• None		
Decisions and Recommendation(s):		
• None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Board Meeting**	**Date**	29 May 2024
Agenda Item	**TB24/039 (8.4)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	23 May 2024		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
MWL FC24/082 – Director of Finance and Information Update	• Cheshire and Merseyside (C&M) system meeting with National executives to discuss current status of financial plan, awaiting feedback. • Committee discussed current controls and updates	Assurance
MWL FC24/083 - Annual Meeting Effectiveness Review	• Review held and commentary discussed, minor areas identified for improvement. • Purpose and the remit of the Finance and Performance Committee remain appropriate, and meetings are judged as effective.	Assurance
MWL FC24/084 – Integrated Performance Report Month 1 2024/25	• Bed occupancy across MWL averaged 104% in April equating to 78 patients – a decrease from 106% in March. • Average length of stay for emergency admissions is similar across both main sites with an overall average of 8.45 days, the impact of non-Criteria to Reside (CTR) patients has increased by 2.4% in April, being 21.5% at Organisation level (23.4% STHK and 18.3% S&O). • 4-Hour performance decreased in April achieving 75% mapped (all types), national performance 74.4% and providers across C&M averaging 72.1%. • 18 Week performance in April for MWL was 61.9%, S&O 67.6% and STHK 59.8%. National Performance (latest month March) was 57.2% and C&M regional performance was 56%. • Diagnostic performance in April for MWL was 89%, S&O 81.4% and STHK 93.4%. Cheshire and Merseyside Acute and Specialist Trust	Assurance

	Provider Collaborative (CMAST) was top in the country for April. • The Trust had 2,551 52-week waiters at the end of April (162 S&O and 2,389 STHK) and no 78-week waiters. • Cancer performance for MWL in March increased to 78.1% for the 14-day standard.	
MWL FC24/085 – Finance Report Month 1 2024/25	• The Trust is reporting a deficit of £4.9m which includes a technical adjustment of £1.1m relating to Public Finance Initiative (PFI) remeasurement. The unadjusted I&E is in line with the Trust plan. • The Trust's combined 2024/24 Cost Improvement Programme (CIP) target is £45.2m of which £9.0m is non-recurrent. As at Month 1, the Trust has transacted CIP of £8.9m in year and £8.1m recurrently. • At Month 1, agency spend is £1.8m to date, 3.6% of total pay costs. Premium Payment Scrutiny Council review and address the drivers of agency costs where possible. • The Trust has a closing cash balance of £6.4m at Month 1 with a planned requirement of £38.9m revenue support for 24/25 which is yet to be agreed. • Better Payment Practice Code (BPPC) has been achieved but has been impacted by a large volume of small value agency invoices where the Trust has outstanding queries. • The capital plan for the year is £48.4m (including PFI Lifecycle). Spend to date is £1m in line with plan. The plan requires external Public Dividend Capital (PDC) support (£17m) which has not yet been drawn down.	Assurance
MWL FC24/086 – 24/25 Planning & Budget Setting Process	• Committee discussed current plan position and the additional ask for MWL.	Assurance
MWL FC24/087 – Implied Efficiency/ Productivity	• Overview of what implied efficiency/productivity means and looks like for MWL and how this compares to others.	Assurance
MWL FC24/088 – Month 1 2024/25 CIP Programme Update Alongside:	• Total targets for 24/25 is £45.2m in year and £36.2m recurrently. • There is currently a delivered/low risk value of £18.2m in year (39% of the £45.2m target) and £17.1m recurrently (47% of the £36.2m target).	Assurance

MWL FC24/091 – Women's & Childrens Division CIP Presentation	• Presentation included update to the committee on progress for 2024/25 along with examples of CIPs identified and cost controls in place to ensure effective use of existing resources. • Committee noted the update and was assured by the report and presentations.	
MWL FC24/089 – Elective Care Recovery Update	• Referral to Treatment (RTT) – met target to have zero 78 week waits by the end of March and are predicting to meet the target for zero 65 weeks by the end of September. • MWL Theatre Strategy and Improvement Group set up to oversee the development and implementation of improvement plans for Theatres to embed GIRFT and Model Hospital principles across all MWL sites. • MWL demonstrated ongoing improvement in uncapped Theatres utilisation, capped utilisation under comprehensive validation exercise. St Helens has one of the highest volumes of cases per session in the region. • Activity performance at M1 is adverse to plan due to repatriation of orthopaedic patients, consultant sickness and challenges in services delivered by external consultants. This is expected to be recovered over the course of the year.	Assurance
MWL FC24/090 – National Cost Collection update	• Report received detailing the costing processes in place at MWL to support the National Cost Collection for 2023/24 • Board sign off that these processes are appropriate sought.	Approval
Assurance Reports from Subgroups:	• 15.1 MWL FC24/092 – Procurement Council • 15.2 MWL FC24/093 - CIP Council • 15.3 MWL FC24/094 - Capital Planning Council • 15.4 MWL FC24/095 –Estates & Facilities Management Council • 15.5 MWL FC24/096 – IM&T Council Update	Assurance

Alerts

None

Decisions and Recommendation(s):

MWL FC24/090 – National Cost Collection (NCC) update

Committee recommend the Board approve the costing process used at MWL to support the submission of the 2023/24 NCC and confirm that NHSE guidance will be followed; appropriate costing and capture systems are in place, the deadline will be met, and the self-assessment check list will also be completed.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	29 May 2024
Agenda Item	**TB24/040**				
Report Title	Aggregated Incidents, Complaints and Claims Report				
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery & Governance, Director of infection Prevention and Control				
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery & Governance, Director of infection Prevention and Control				
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 Quarter 3 and Quarter 4 2023-24.

Executive Summary

Incidents

- 7,219 in Q3 and 6,173 incidents reported in Q4 at STHK.
- 2,671 in Q3 and 2,831 incidents reported in Q4 at S&O.
- 6,127 patient safety incidents in Q3 and 4,737 patient safety incidents reported in Q4 at STHK.
- 2,083 patient safety incidents in Q3 and 2,183 patient safety incidents reported in Q4 at S&O.
- 40 patient safety incidents graded as moderate or above during Q3 and 25 patient incidents of moderate or above during Q4 at STHK.
- 21 patient safety incidents graded as moderate or above during Q3 and 19 patient incidents of moderate or above during Q4 at S&O.

- STHK highest number of incidents reported relate to:
  - Lack of/delayed availability of facilities 1,986 during Q3 and 502 during Q4.
    Pressure ulcers remain one of the highest reported categories on STHK Datix with Q3 having 827 incidents (580 were not MWL acquired and 247 were Trust acquired). During Q4, 971 incidents were reported (591 were not MWL acquired and 380 were Trust acquired).
- S&O highest number of incidents reported relate to:
  - Bed Management = 312 during Q3 and 245 during Q4 (includes sub-categories such as 12 hours breaches, delay transfer to wards & mixed sex breaches from critical care and others)
  - Pressure Ulcer = 248 during Q3 and 208 during Q4.

Complaints

- The Trust received 96 first stage complaints in Quarter 3 and responded to 116.
- The Trust received 130 first stage complaints in Quarter 4 and responded to 99
- Clinical treatment was the main reason for complaints, in line with previous quarters
- Emergency Department remained the main areas to receive complaints

Claims

- In Q3 the Trust received 18 new confirmed claims, but 116 requests for medical records
- In Q4 the Trust received in16 new confirmed claims, and 78 requests for medical records.

PALS

- The Trust received 1,099 PALS enquiries in Q3, and 1,077 in Q4 (not including signposting)

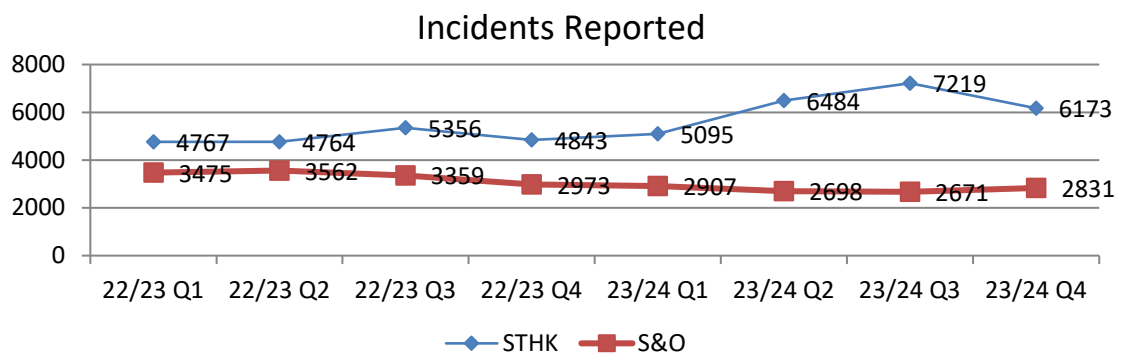
The new report presents combined data (where available) for the whole of MWL.

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 Aggregated Incidents, Complaints and Claims 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

1. Introduction

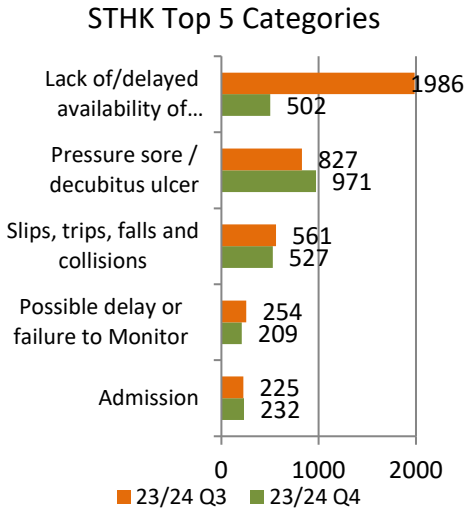
This paper includes reported incidents, complaints, PALS contacts, claims and inquests during quarter 3 and 4 2023-24, highlighting any trends, areas of concern and the learning that has taken place. The Trust uses Datix to record incidents, complaints, PALS and claims, with two different Datix systems currently in use from legacy organisations.

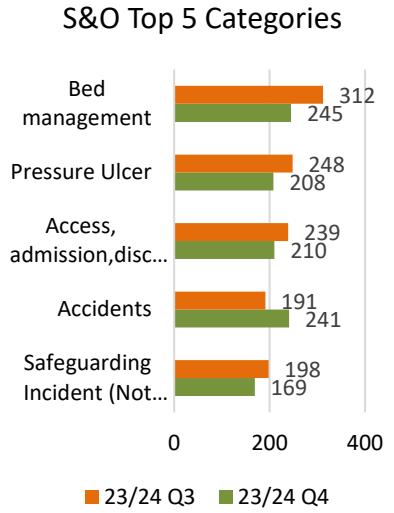
2. Incidents

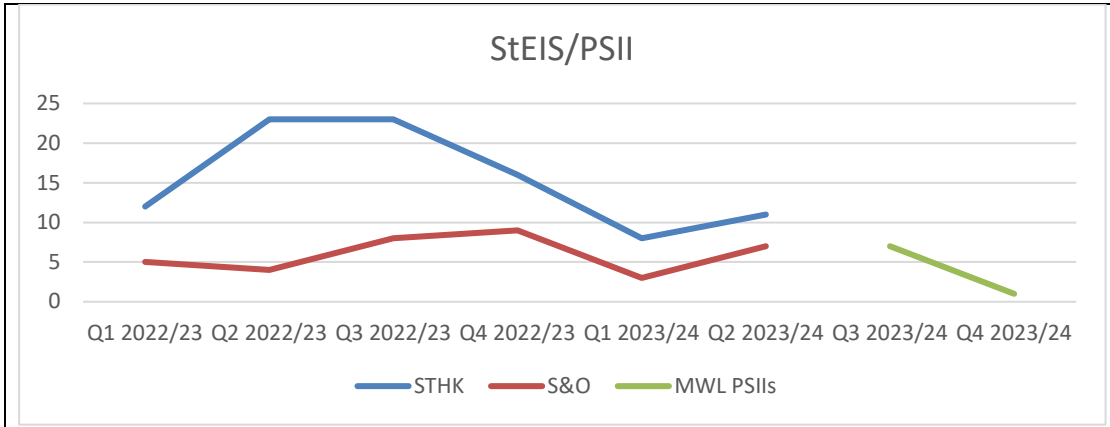


STHK Q3	STHK Q4	S&O Q3	S&O Q4	
6127	4737	2083	2183	Incidents affecting patients
411	388	275	265	Incidents affecting staff
640	1018	299	368	Incidents affecting the Trust or other organisation
41	30	14	15	Incidents affecting visitors, contractors or members of the public

- STHK sites recorded a notable rise in total incidents during Q2/Q3. This is a result of a lack of availability of beds in ED (Top category in Q2/Q3). Processes are now in place, and we have now noted a large reduction of these incidents in Q4.
- Pressure ulcers remain one of the highest reported categories on STHK Datix with Q3 having 827 incidents (580 were not MWL acquired and 247 were Trust acquired). During Q4, 971 incidents were reported (591 were not MWL acquired and 380 were Trust acquired).
- Bed management incidents remain the highest reported incidents at S&O (includes sub-categories such as 12 hours breaches, delay transfer to wards & mixed sex breaches from Critical Care and others)
- StEIS reportable incidents at STHK have significantly dropped in comparison to the last financial year. StEIS framework was closed at the end of Q2 and Patient Safety Incident Response Framework (PSIRF) was launched on 1st October 2023. Both STHK and S&O now report to PSIRF as a combined service.







STHK	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Moderate	19	16	14	16	25	22	30	20
Severe	8	10	11	10	5	9	8	4
Death	2	3	8	5	3	7	2	1
Total	29	29	33	31	33	38	40	25
S&O	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Moderate	12	16	11	21	12	9	20	17
Severe	0	3	6	4	2	8	1	1
Death	1	0	3	0	1	0	0	1
Total	13	19	20	25	15	17	21	19

2.1. Duty of Candour

Duty of candour was completed for all cases reported via StEIS during Q2. Duty of candour is completed for all patient safety incidents graded as moderate or above harm.

3. Complaints

Indicator	2019-20	2020-21	2021-22	2022-23	2023-24	2023-24	2023-24	2023-24
					Q1	Q2	Q3	Q4
Total number of new complaints (S & O figures in brackets)	325	251	266 (274)	213 (247)	54 (39)	101*	96*	130*
Response to first stage complaints within agreed timescale	93.4%	94%	80% (59%)	75.67% (51%)	72.9% (55%)	75%*	60.3%*	53.5%*
Second stage complaints	36	23	32	38	12	16*	8*	12*

*Combined figures for MWL

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Outcomes

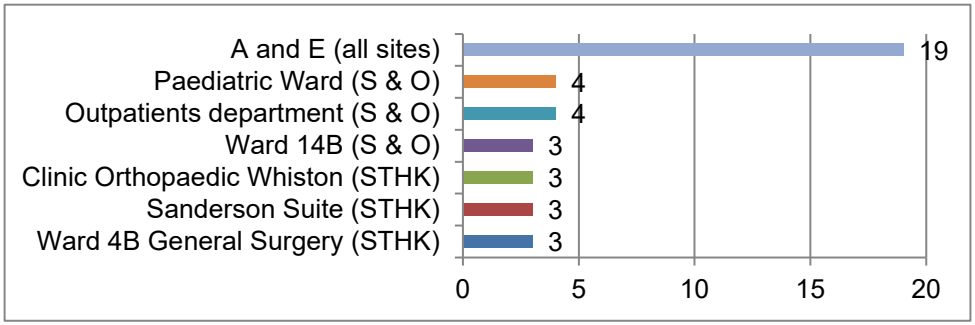
	23/24 Q3	23/24 Q4
Not Upheld Locally	37 (31.9%)	20 (20.2%)
Partially Upheld Locally	57 (49.1%)	64 (64.7%)
Upheld Locally	22(19%)	15 (15.1%)
Total	116	99

Complaints by Subject (Top 5 reasons)

	Q3	Q4
Clinical Treatment	54	69
Patient Care/ Nursing Care	11	17
Values and Behaviours (Staff)	7	13
Communications	12	15
Admissions and Discharges (excl.delayed discharge re care package)	9	5

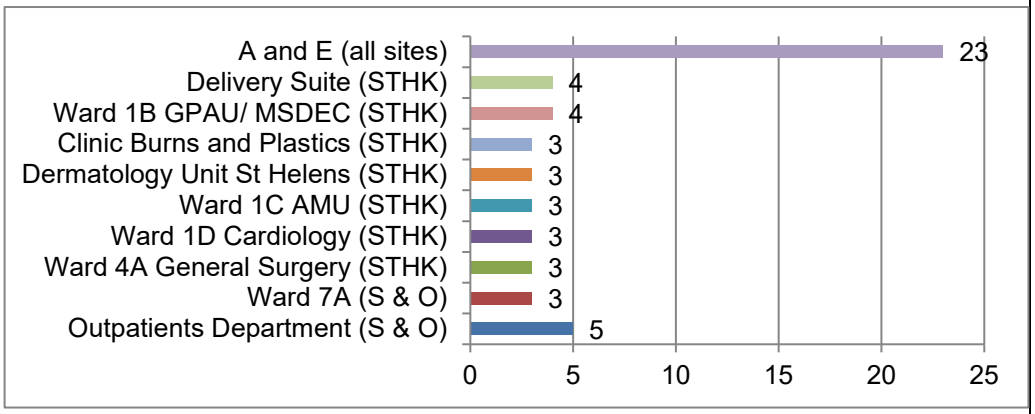
Complaints by Location

Quarter 3



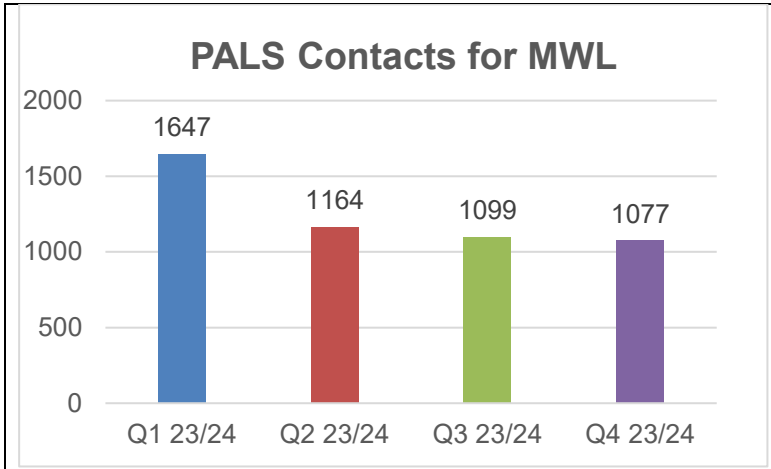
12 departments/services had two complaints during Q3, and 32 had one complaint during that period.

Quarter 4



44 departments/services had one complaint during Q4, and 16 had two complaints during that period.

4. PALS



Main causes of contacts with PALS
Quarter 3
STHK:
1. Communications
2. Admissions and discharges (excluding delay due to care package)
3. Clinical treatment
4. Appointments
5. Waiting Times

S&O
1. Clinical Care
2. Communication
3. Values/behaviours and attitude
4. Length of waiting time for appointments
5. Patient property

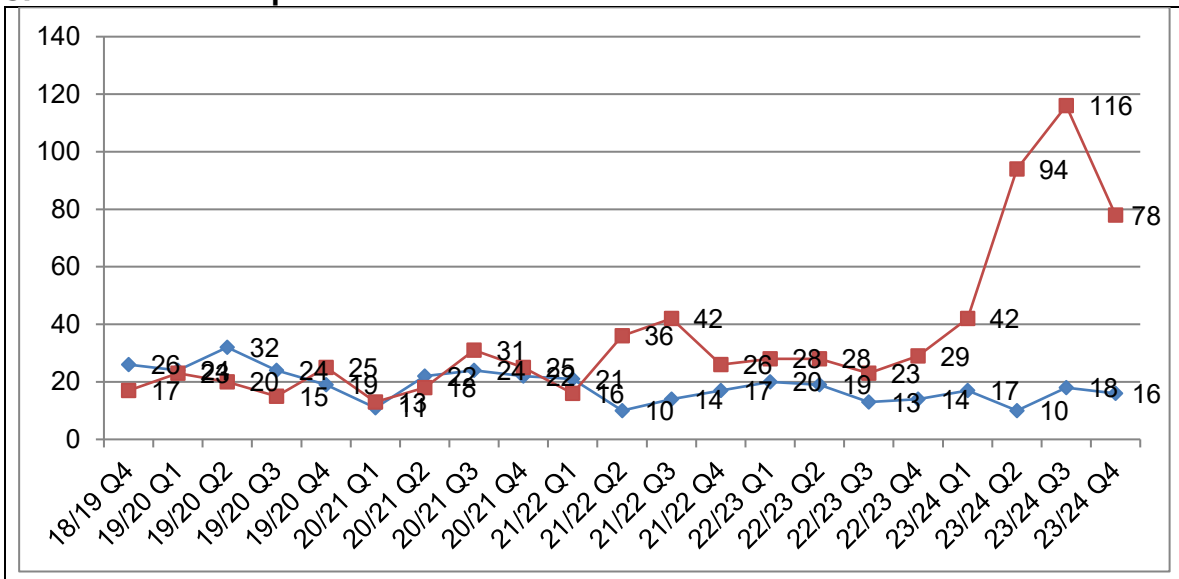
Quarter 4

STHK:
1. Communications
2. Admissions and discharges (excluding delay due to care package)
3. Appointments
4. Clinical Treatment
5. Waiting Times

(These are the same top 5 issues as in Q3)

S&O
1. Clinical Care
2. Communication
3. Values/behaviours and attitude
4. Length of waiting time for appointments
5. Discharge

5. Claims and Inquests

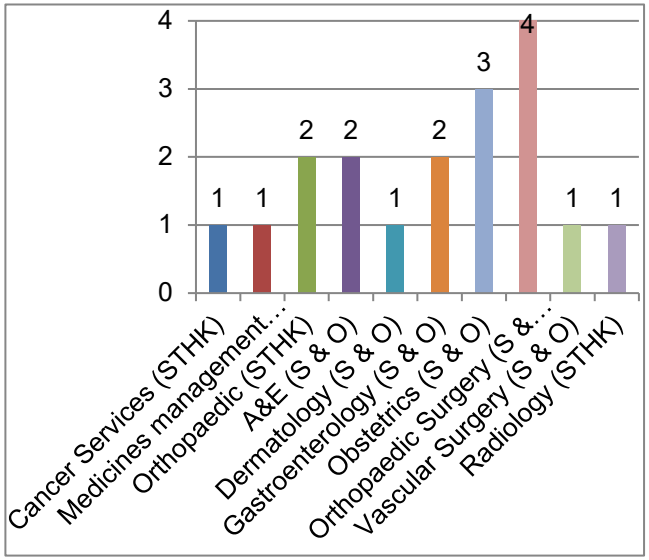


*Combined data for MWL is included from Q1 2023/24

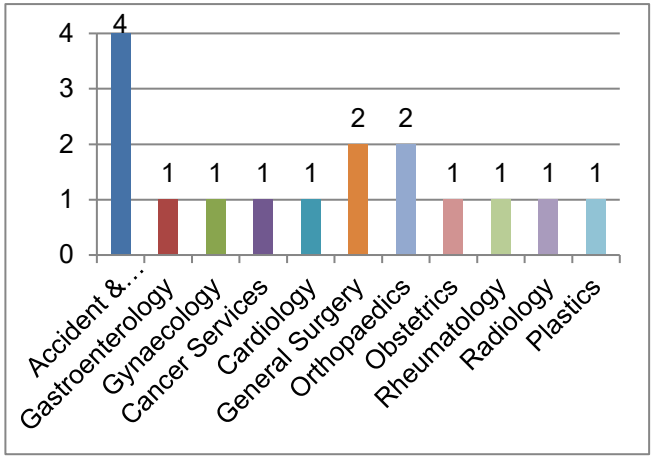
It is of note that the significant increase in pre action requests for records (red line on graph) appears to have reduced somewhat from the high point in Q3. This is likely to be related to the forthcoming fixed costs regime for some lower value clinical negligence claims

Claims by Speciality

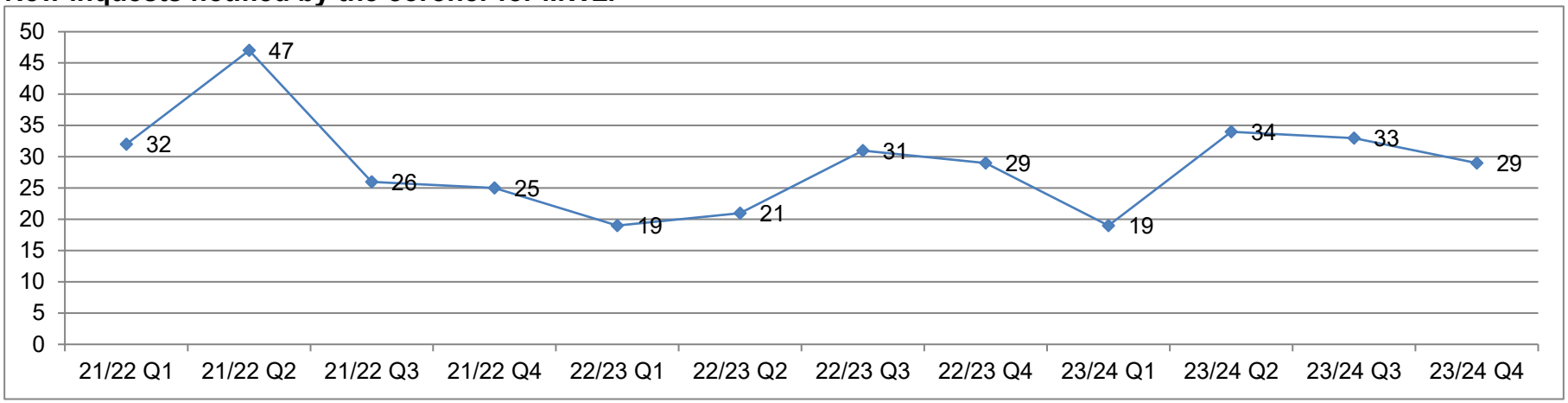
Quarter 3



Quarter 4



New inquests notified by the coroner for MWL.



*Combined numbers of inquests for MWL

Since the establishment of MWL on 1 July 2023 the Trust has received slightly over 10 inquests per month.
The Trust closed 21 inquests during Q4.
The Trust has not received any Prevention of Future Death notices following the merger.
The Coroner required additional reassurance in relation to one inquest which concluded in Q4.

6. Lessons Learned

6.1. Dissemination of learning from Incidents

A summary of actions taken from incidents is provided to the Quality Committee and the Trust Board via the StEIS report. Incidents are a standing agenda item on the Patient Safety Council, Care divisional 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 Scrutiny and Assurance Meetings. Examples of these lessons and actions are detailed below.

- Outsourced a sample of radiology reports to review by external Radiologists with a key focus on CT scans. A report will then be created with any discrepancies from these.

- The importance of the national guidelines was reiterated within Radiology and Trust wide to ensure that regular follow-up imaging is achieved when necessary.

- An audit was completed to determine current compliance in Radiology with following the British Thoracic Society (BTS) guidelines with regards to the management of pulmonary nodules.

- Developed a pathway for treating patients with low sodium.

- Training provided for all nursing and medical staff in gynaecology on trust policy of Deteriorating Patient.

- Standards for expected length of stay for all surgical patients developed and shared with all staff.

6.2. Learning from Complaints and PALS

A summary of key learning from complaints is provided to the Quality Committee and to the Patient Experience Council, with examples below:

- Involve family in discharge process e.g. Dementia advocate. Ensure Dementia Passport completed.

- Wound care - wound to be monitored regularly and bandages changed when required.

- Ward Manager to remind all trained staff including discharge co-ordinator to discuss new medication and the continuation of previous medication with patients when being discharged.

- Reiteration to staff of the need to ensure patient details are checked, both from a safety (incorrect medications) and potential data protection breach perspective

- Training around potential gynaecological/ovarian pathology diagnosis in the Emergency Department

6.3. Learning from Claims

A summary of key learning from claims is presented to the Quality Committee and to the Patient Safety Council, with a focus on ensuring learning in those cases with no previous trust investigation. Examples in relation to closed cases from Q3 and Q4 below:
Scarring following forceps delivery.

- Obstetrician to ensure that the patient has been counselled and consented about the potential for use of forceps at time of caesarean section, including the potential risks of facial scalp injuries to the baby.

- Obstetrician to check correct placement of forceps on the lateral aspects of the head before traction is applied.

- Ensure that all facial/head trauma from instrumental birth is reviewed by the paediatric team at the time of birth or shortly afterwards with involvement of plastic surgical team for review of trauma, to be arranged by paediatric team, as appropriate.

END

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	**29 May 2024**
Agenda Item	**TB24/041**			
Report Title	Quality Account 2023/24			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Action Required	X	**To Approve**		**To Note**

Purpose

To submit to the Board the final draft version of the Quality Account for 2023/24 for review and approval.

Executive Summary

The final draft of this year's Quality Account has been completed in line with the National Health Service (Quality Accounts) Regulations 2010 as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012. The deadline to publish the Account on the Trust's website is 30 June 2024.

The Quality Committee reviewed the draft Quality Account at the meeting on 21 May 2024 and recommended to the Board for approval.

The Acting Director of Nursing, Midwifery and Governance and Deputy Director of Compliance presented the draft Account to a number of partners including commissioners and Healthwatch at an event on 17 May and the written feedback from our partners will be included in the Quality Account when received. However, the verbal feedback on the day was extremely positive with no significant requests for amendments.

There was no longer a requirement for the Account to be reviewed by our External Auditors.

The final draft is attached as Appendix 1.

Financial Implications

No direct costs arising from this report.

Quality and/or Equality Impact

The Quality Account provides a review of the Trust's quality objectives and provides an overview of how quality is maintained across the Trust.

Recommendations

The Board is asked to review and approve the Quality Account.

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Quality Account 2023-24

Presented by:

Lynne Barnes, Acting Director of Nursing Midwifery and Governance

Anne Rosbotham-Williams, Deputy Director of Compliance

A year in the life of MWL

The Trust by numbers

70,232
Day cases

210,870
A&E attendances

85,759
Admissions from A&E (exc planned attendances)

7,913
Elective admissions

249,915
First outpatient attendances

524,529
Follow up outpatient attendances

70.3%
Patients treated in 18 weeks of referral (national target 92%)

95,062
Inpatients (non-elective exc maternity)

5,941
Births

10,635
Staff employed

Key highlights in 2023-24

- Formation of new Trust, **Mersey and West Lancashire Teaching Hospitals NHS Trust**, following 18 months of collaboration
- Whiston Hospital was awarded **excellence in acute and emergency care** in the Parliamentary Awards in July 2023

Key highlights in 2023-24

- Winners of the Browne Jacobson Award for Excellence in Employee Engagement at the Healthcare People Management Association **Excellence in People Awards** 2023 for improvement practices and ensuring staff with disabilities and long-term health conditions are supported effectively
- Number one teaching hospital in the North West over all elements in the latest **patient-led assessment of the care environment** (PLACE) and in the top ten in the country for cleanliness

Key highlights in 2023-24

- Number of individual staff awards including the following British Journal of Nursing awards:
  - Gastrointestinal Nurse of the Year for Lead Macmillan Upper Gastrointestinal (GI) Cancer Nurse Specialist, Barbara Ashall
  - Urology Nurse of the Year for Urology Education Programme Lead, Eleri Phillips

Key highlights in 2023-24

- **National staff survey -** first full survey as MWL, only 3 months after merger
  - 1st in staff engagement/advocacy sub theme in NW region and Cheshire and Mersey for acute and community trusts
  - 1st in we are compassionate and inclusive/compassionate culture sub theme in NW region and Cheshire and Merseyside for acute and community trusts
  - Equal 1st in morale/work pressure sub theme in Cheshire and Merseyside
  - 3rd across NW region (out of 18) and Cheshire and Merseyside (out of 8) for the full Staff Engagement People Promise them

- Whiston, St Helens and Newton hospitals **ranked second in the country** and best in the region compared to other general acute and combined trusts in the latest **inpatient survey**

Key highlights in 2023-24

- Southport Hospital **won the Nursing Times Critical and Emergency Care Nursing category** for an initiative to support families and staff when a patient dies through the Pause Campaign
- Sylvia Sinclair, Deputy General Manager with partners Medirest received the MyCleaning Lifetime Achievement Award
- **Winner of the Macmillan Professional Integration Excellence award** - Upper Gastrointestinal Team
- Haematology team awarded the **Myeloma UK Clinical Service Excellence Programme** accreditation in recognition of outstanding care and dedication to patients with myeloma

Challenges

- Continuing to align systems and processes from predecessor organisations, strengthening progress already made
- 5 CQC assessments in 4 months (December to March)
- Delivery of national targets and recovery programme with ongoing periods of industrial action
- 6 MRSA bacteraemia with focussed action being taken to improve aseptic non-touch technique competency particularly during care of invasive devices
- 1 never event (wrong size lens implant in Ophthalmology) with the following actions taken:
    - Revision of the storage of the implants
    - Review and update of the policy for the Local Safety Standards for Invasive Procedures (LocSSip) and local safety checklists
    - Embedding pause/stop moment during the handling of implants in theatre as recommended by the centre of perioperative care and NatSSIPs
    - Training updated and delivered locally

Progress in achieving 2022-23 quality objectives - safe

Implement and embed the national Patient Safety Incident Response Framework (PSIRF)

- PSIRF implemented in October 2023
- Patient Safety Incident Response Plan 2023 -24 launched
- PSIRF team in place
- Patient safety incident investigation (PSII) reports are reviewed by the Executive-led weekly safety panels
- 7 PSIIs at various stages of progress at end of Q4 2023-24 for MWL
- Training continues on both safety specialist functions and for the wider MWL workforce

Progress in achieving 2022-23 quality objectives - safe

Continue to ensure the timely and effective assessment and care of patients in the Emergency Department

- **Q4 audits found:**
  - 100% of patients audited had observations recorded with appropriate escalation
  - Median time to first clinical assessment was 129 minutes at Whiston and 94 minutes at Southport
  - Q4 NEWS audits show a 100% compliance for completion with 100% appropriate escalation at Whiston and 95% at Southport
  - Whiston retired CQuIN data for quarter 4 2023-24 states 84.1% adults were screened and 90.4% adults received first dose of antibiotics.. Southport Advancing Quality monthly benchmarking highlighted 100% National Early Warning Scores recorded within 1 hour of hospital arrival within quarter 4, and 80% IV fluids commenced within 1 hour of sepsis diagnosis and 62.5% of antibiotics given within the hour at end quarter 4, with improvement actions in place.
  - Above 80% compliance with risk assessments

Progress in achieving 2022-23 quality objectives - effective

Ensure patients in hospital remain hydrated

- **Red jugs Q4 audits**
  - STHK 95% compliant
  - S&O 72% compliant following launch mid-year
- **Fluid balance audits**
  - STHK 81% compliance
  - S&O over 85% of fluid balance charts are completed fully
- **MWL Advancing Quality Acute Kidney Injury**
  - Trust is ranked first in the local trusts participating. Most recent completed month is December 2023.

Progress in achieving 2022-23 quality objectives – patient experience

Improve the effectiveness of the discharge process for patients and carers

- **StHK**
  - Inpatient survey 2022 showed improvement in majority of discharge scores
  - Audits demonstrated compliance of 98% for providing discharge booklet
  - Achieved 18.4% discharges before noon in Q4 with continued focus on early discharges through the support of Patient Flow Lead Nurses and Discharge Lounge
- **S&O**
  - Inpatient survey 2022 showed similar results to the previous year
  - 100% of patients audited received the discharge booklet
  - Achieved just below 20% of discharges before noon in Q4
- **MWL**
  - Discharge data for patients with no criteria to reside highlights that no patients were delayed due to waiting for medications.

Progress in achieving 2022-23 quality objectives – patient experience

Improve the overall experience for women using the Trust's Maternity Services

Maternity survey 2023 results for the areas of focus showed that the majority of scores improved:

- **Ormskirk**
  - Women and partner involvement maintained the scores other than induction and postnatal
  - Access to medical history of mother and baby showed an improvement except for during birth
  - Information for induction of labour and physical recovery after birth improved significantly
- **Whiston**
  - Infant feeding showed significant improvement.
  - Women and partner involvement showed an improvement other than induction
  - Access to medical history of mother and baby showed an improvement
  - Improvement in the scores relating to delayed discharge

Informing the quality objectives 2024-25

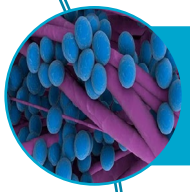
Reviewed progress in achieving last year's objectives

Sought the views of staff and stakeholders, including members of key governance Councils and via SurveyMonkey

94 online responses received with high level of agreement with the proposed objectives

Quality objectives 2024-25

Continue to ensure the timely and effective assessment and care of patients in the Emergency Department



Reduce the incidence of methicillin-resistant Staphylococcus aureus (MRSA) healthcare associated bacteraemia infections to meet the zero threshold

Ensure patients in hospital remain hydrated

Improve the effectiveness of the discharge process for patients and carers

Improve the overall experience for women using the Trust's Maternity Services

Measuring and monitoring the quality objectives

- Each quality objective has an Executive Director lead and progress in delivery is monitored by the Quality Committee and the Board.

Objective	Rationale	Measurement
Continue to ensure the timely and effective assessment and care of patients in the Emergency Department	The Trust remains committed to providing the timely assessment and delivery of appropriate care to maintain patient safety, whilst also responding to increased demand for services.	• All patients requiring triage are either triaged within 15 mins or have a baseline set of observations within 15 minutes based on monthly audits • First clinical assessment median time of <2 hours over each 24-hour period • Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits. • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring
Reduce the incidence of methicillin-resistant Staphylococcus aureus (MRSA) healthcare associated bacteraemia infections to meet the zero threshold	The Trust has seen an increase in healthcare associated infections and remains committed to improving patient safety.	• Achieve minimum aseptic non-touch technique compliance of 85% for Level 1 (theory) and Level 2 (practical). • Achievement of 95% for MRSA screening • 90% compliance with visual infusion phlebitis (VIP) monitoring

Measuring and monitoring the quality objectives - continued

Objective	Rationale	Measurement
Ensure patients in hospital remain hydrated	Effective hydration improves recovery times and reduces the risk of deterioration, kidney injury, delirium and falls	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • High compliance with Advancing Quality (AQ) audit results
Improve the effectiveness of the discharge process for patients and carers	A continuing theme from patient feedback is the need to improve the discharge experience for patients and their carers	• Improved inpatient survey satisfaction rates for receiving discharge information • Improved audit results (minimum 75%) for patients receiving the discharge from hospital booklet • Achievement of 20% target for patients discharged before noon during the week • Review of discharge data to confirm reason for delay is not due to waits for take home medication
Improve the overall experience for women using the Trust's Maternity Services	The Trust remains committed to providing the best possible experience for women accessing Maternity Services, particularly in areas rated lower that we would like in the most recent national survey	• Demonstrable improvements in the key areas from previous national surveys shown through regular inhouse surveys and feedback from women receiving maternity care and delivery of the agreed action plan • Create a MWL Maternity Strategy to support delivery of the national three-year maternity plan

What our patients said about us…

St Helens Hospital
Wonderful staff
For the last few months I have been taking my 94 year old nan; after treatment the staff are absolutely wonderful and go above and beyond. Today my nan was unwell whilst there with palpitations and the staff rushed to her aid and made her their priority. Also the doctor that saw her made her feel like a queen and really valued. I cannot express how impressed I am with everyone in this department it's like the hospital have employed all the nice people from the world in this one place.

ECG Department – Southport Site
We received a very caring and professional service. The healthcare professional was very thorough and took time to explain the procedure. Thank you for all you do for our community.

Physiotherapy – Ormskirk site
The assessment I received was excellent and I completely understood my symptoms after it which made me feel relieved. Was given exercises to complete and very happy with the appointment. I felt that the physio really knew what she was talking about and I was very happy with her explanation.

What our patients said about us…

Ward 1B- Medical Assessment Unit.
Firstly, my father was seen very quickly and secondly and most importantly the staff were absolutely fantastic. Professional, polite and very understanding which was very reassuring to my father. They explained everything with a bedside manner that I believed was a thing of the past. The Dr even made a follow up call to myself later that day to check on my father and informed me that he made some telephone calls to chase up a home visit the following week. Please pass on my sincere appreciation to him and thank him for his professionalism. Thank you.

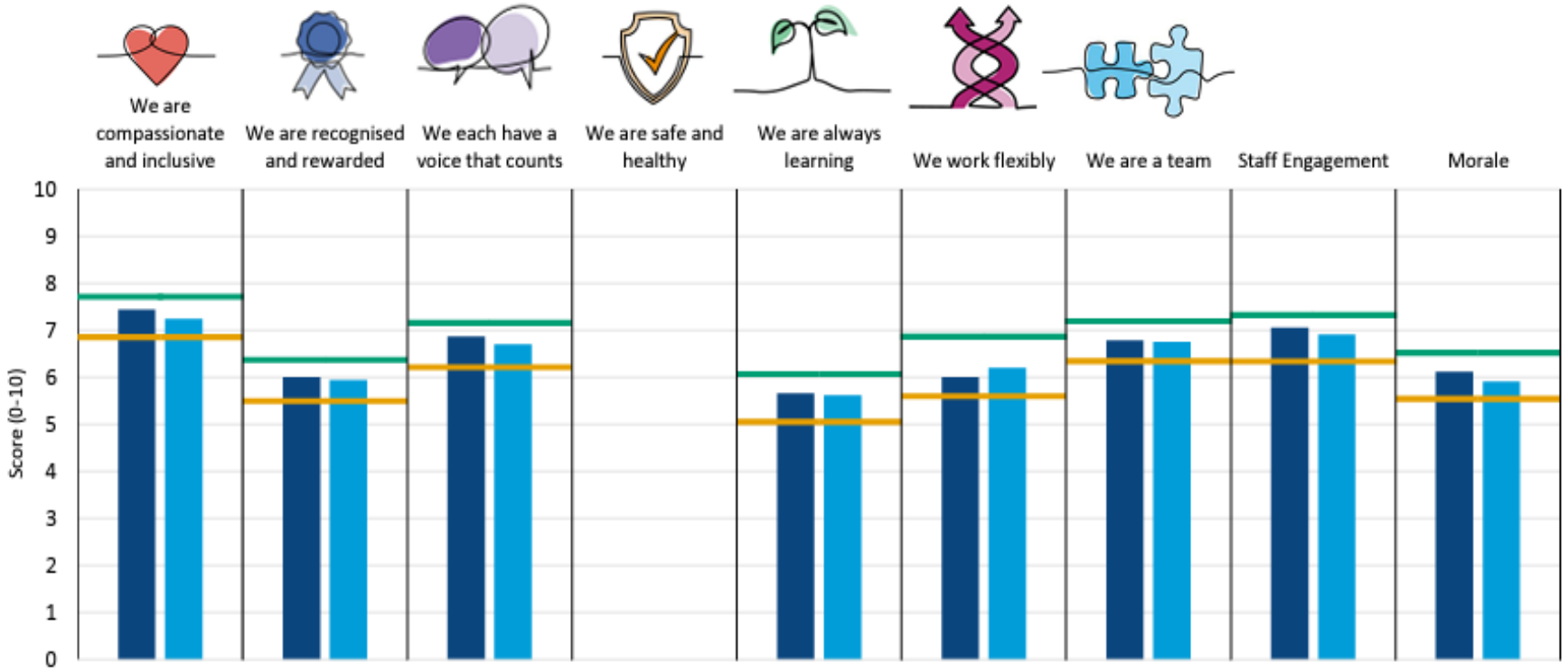
Newton Hospital
Mum has since been transferred to Newton for rehabilitation and to a team of amazing and patient focused people; every single one of them, are worth their weight in gold.

Childrens Ward - Ormskirk site
My little boy was looked after amazingly. He had great interactions with the play specialists which he absolutely loved whilst recovering. Thank you.

Maternity Whiston
We had an amazing experience today. We didn't wait long. Staff were all lovely and Nikki was so bubbly, made our scan experience fabulous. We would definitely recommend Whiston to all our friends; it is such a clean, friendly, lovely place to have a baby.

What our staff said about us…

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.44	6.01	6.86	-	5.65	6.00	6.78	7.05	6.12
Best result	7.71	6.37	7.16	-	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	-	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	-	5.05	5.60	6.35	6.34	5.54
Responses	3906	3908	3855	-	3766	3862	3895	3913	3912

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

NHS

Mersey and West Lancashire Teaching Hospitals

NHS Trust

Any Questions?
Thank you

Draft Quality Account 2023-24

OUR VISION
5 star patient care

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

OUR VALUES

We are KIND

We:
- Treat every individual with respect
- Are compassionate in our support of patients and colleagues
- Are friendly and welcoming and always introduce ourselves
- Care for each other as we care for our patients
- Are polite and value each other's thoughts and ideas

We are OPEN

We:
- Are always listening and learning
- Encourage and support two-way communication
- Are honest, fair and open with others
- Take responsibility for our actions and always aim to improve
- Develop our services in the best interests of our communities

We are INCLUSIVE

We:
- Value everyone's cultural, social and personal needs
- Celebrate our differences and support each other
- Listen to all voices
- Work as a team and learn from each other
- Challenge prejudice and promote acceptance

#TeamMWL

What our patients said about us in 2023-24

Burney Breast

Excellent Service

I was referred today, to Burney breast unit; fortunately everything is fine. I just had to take time to mention the wonderful staff team and consultants. They are all so happy, respectful and totally professional and you really do feel like a person and not just a number. The waiting time was also excellent, it made my anxiety lessen because only after about 10 minutes, my name was called, the nurse introduced herself by name and it immediately made me feel at ease. Thanking all the staff in this unit.

Sanderson Suite – St Helens Hospital

Great treatment

The treatment I received from everyone in the Sanderson Suite (Pain Clinic) was over and above what I expected. I was a little nervous initially but their kindness and consideration was outstanding and helped put me at ease – can't thank them all enough.

St Helens Hospital

Wonderful staff

For the last few months I have been taking my 94 year old nan; after treatment the staff are absolutely wonderful and go above and beyond. Today my nan was unwell whilst there with palpitations and the staff rushed to her aid and made her their priority. Also the doctor that saw her made her feel like a queen and really valued. I cannot express how impressed I am with everyone in this department it's like the hospital have employed all the nice people from the world in this one place.

Physiotherapy – Ormskirk site
The assessment I received was excellent and I completely understood my symptoms after it which made me feel relieved. Was given exercises to complete and very happy with the appointment. I felt that the physio really knew what she was talking about and I was very happy with her explanation.

Newton Hospital
Mum has since been transferred to Newton for rehabilitation and team of amazing and patient focused people, every single one of them are worth their weight in gold

Endoscopy Unit – Ormskirk site
I was so very impressed by the kindness and consideration shown by all staff in this unit, by the care taken at every step and all the clear explanations and reassurance given. There is a really good team atmosphere and it impacts very positively on the patient experience. Everyone was very friendly and this put me in a very relaxed mood. A huge thank you to everyone for their hard work and professionalism and for the warm, friendly environment which makes all the difference. Ten Stars!!

ECG Department – Southport Site
We received a very caring and professional service. The healthcare professional was very thorough and took time to explain the procedure. Thank you for all you do for our community.

Ward 1B- Medical Assessment Unit.

Firstly, my father was seen very quickly and secondly and most importantly the staff were absolutely fantastic. Professional, polite and very understanding which was very reassuring to my father. They explained everything with a bedside manner that I believed was a thing of the past. The Dr even made a follow up call to myself later that day to check on my father and informed me that he made some telephone calls to chase up a home visit the following week. Please pass on my sincere appreciation to him and thank him for his professionalism. Thank you.

To say I had a good experience was an understatement. The staff that treated me showed me the upmost kindness that I have never experienced in the NHS. I was extremely nervous. The staff were easy to talk to and ask questions too.

Sexual Health Services – St Hugh's Bootle

I had a small surgery at the hospital as a day case. I found everyone to be lovely and really welcoming. Ranging from the healthcare assistants, the nurses, right way to the surgery staff. Everyone was really professional and checked in with me. They were a pleasure.

F Ward - Ormskirk site

Contents

1. Section 1

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

We are pleased to present the Trust's 15th annual Quality Account, which demonstrates our ongoing commitment to ensuring we provide the highest quality of care to our patients and the communities we serve.

2023-24 continued to present many challenges for staff with ongoing demands on an already stretched workforce. All our staff work incredibly hard to provide the best care and treatment for our patients in a wide range of different settings.

On 1st July 2023 St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and Southport and Ormskirk Hospital NHS Trust (S&O) came together to form a new Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). This was the culmination of work that had been undertaken during the previous 18 months to develop a new organisation to ensure sustainable services for the populations of Merseyside, West Lancashire and beyond.

MWL has retained the outstanding Care Quality Commission (CQC) rating and has maintained contact with our CQC relationship manager throughout the year. The Trust has continued to monitor key quality indicators via the monthly comprehensive Corporate Performance Report, which is reviewed by the Board and its Committees.

I was, however, extremely disappointed that during the year there were six methicillin-resistant staphylococcus aureus (MRSA) bacteraemia and one never event relating to wrong lens size implant in Ophthalmology. Actions have been taken following these as part of the Trust's commitment to learning from incidents and these are outlined in more detail in section 3.

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

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

In addition, the Trust reviewed and updated the ward accreditation programme, to ensure it is fit for purpose for the new organisation. A number of quality ward rounds with members of the Trust Board took place throughout the year to see and hear first hand how staff are striving to provide the best possible care for patients that is safe, effective, caring, responsive and well-led.

We continue to work with our local Healthwatch partners to improve our services. Healthwatch representatives are key members of the Patient Experience and the Patient Safety Councils, both of which report to the Trust Board's Quality Committee, and the Equality and Diversity Steering Group which reports to the People Performance Council. This ensures effective external representation in the oversight and governance structure of the Trust. Meetings have continued to be held virtually to maximise attendance.

The Trust has a Patient Participation Group, which met quarterly throughout the year and patients have continued to share their experiences of their care via patient stories for the Board and the Patient Experience Council.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting the particular challenges faced during the year. It outlines our quality improvement priorities for 2024-24.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2023-24 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate. We trust that it provides you with the confidence that high quality patient care remains our overarching priority and that it demonstrates the care and services we have continued to deliver during the ongoing challenges in 2023-24.

I remain extremely proud of all our staff who continue to give the best of themselves to care for the people who need us. I would like to thank all our staff for everything they continue to deliver during the most challenging times we face.

Ann Marr OBE
Chief Executive
Mersey and West Lancashire Teaching Hospitals NHS Trust

1.2. Summary of quality achievements in 2023-24

Quality of services overall
Outstanding rating awarded by the CQC, the best possible rating, in the latest Trust report received in March 2019. This has remained unchanged following the formation of the new Trust in July 2023 and following recent maternity inspections.

Well-led
- Whiston Hospital was awarded excellence in acute and emergency care in the Parliamentary Awards in July 2023
- Winners of the Browne Jacobson Award for Excellence in Employee Engagement at the Healthcare People Management Association (HPMA) Excellence in People Awards 2023 for improvement practices and ensuring staff with disabilities and long-term health conditions are supported effectively
- Number one Teaching Hospital in the North West over all elements in the latest patient-led assessment of the care environment (PLACE) and in the top ten in the country for cleanliness, demonstrating the commitment of all staff to ensure our patients are treated in the best environment and receive the highest quality of care
- Employment Services Team won National Payroll Innovation Award at National Payroll Awards 2023 for their Employment Services Automation Programme
- St Helens & Knowsley Preceptorship Team awarded a Cavell Nurses' Trust star for their work championing preceptorship
- Nursing Times Workforce Summit Awards 2023 shortlisted for
  - Critical Care Team at Southport Hospital for Best Workplace for Learning & Development for Senior Staff Nurse Role Enhancement Programme. This scheme focused on developing Band 5 nurses with a range of development opportunities
  - Critical Care Team for Best Employer for Staff Recognition & Engagement category for innovative 'What 3 Words' campaign. Taking inspiration from the popular app, they produced a short survey to find out what members of the team liked the most and what would make their working lives better
  - Preceptorship Team covering St Helens & Knowsley in Preceptorship Programme of the Year for their pathway work supporting newly qualified clinicians
- Finalists in the HSJ Consultancy Partnership Award with BP3 and Payroll
- Awarded silver in the HSJ Healthtech Partnership Award with Patchwork and MWL for bank staff
- Communications Team won the best NHS Charity Campaign at the NHS Communications Awards
- Members of the following:
  - Armed Forces Covenant (re-signed 2023)
  - Defence Employer Recognition Scheme (Armed Forces, member 2020)
  - Disability Confident Scheme Leader (level 3 the highest level, reaccredited in 2023 to reflect the inclusive and accessible recruitment process used by the organisation, the way it makes workplace adjustments and in ensuring staff are given relevant equality training)
  - Dying to Work Charter (member 2023)
  - NHS Rainbow Badge Accreditation (LGBT) (Bronze accredited 2022)

- NHS Sexual Safety Charter (member 2023)
- Veterans Aware (Armed Forces reaccredited 2023, reaffirming the commitment to the armed forces community)

- Highly commended in the Pride of St Helens awards for Charity Champion (Denise Littler), Over the Rainbow LGBT for Pride of St Helens and Dave Platt, Gardeners for Pride of Place
- North West Bloom Gold Award for best NHS Garden

Staff

- Lesley Harrison, Community Nurse Lead received the Queen's Nurse Award
- Helen Day, Paediatric Diabetes Specialist Nurse at Ormskirk Hospital, won a scholarship at the International Society for Paediatric and Adolescent Diabetes - ISPAD Diabetes Science School for Allied Health Professionals conference in Rotterdam in October 2023. Only 15 candidates worldwide were chosen for the all-inclusive scholarship to attend a week of learning on diabetes care
- Lead Macmillan Upper Gastrointestinal (GI) Cancer Nurse Specialist, Barbara Ashall, was named Gastrointestinal Nurse of the Year and Urology Education Programme Lead, Eleri Phillips won Urology Nurse of the Year in the British Journal of Nursing Awards (BJN) for their outstanding commitment to patients and their profession
- Sue Ashton, Dispensing Assistant based at Southport Hospital, was highly commended in the 'Against All Odds' category at Preston College's 'Exceptional Employer and Apprentice' Awards 2024 and MWL won the 'Large Employer' category beating more than 750 other employers who work alongside Preston College
- Four physiotherapy clinical educators, Ella Brighouse, Rotational Physiotherapist, Lee Worrell, Outpatients Physiotherapist, Matthew Dennies, Clinical Lead Therapist, Trauma and Orthopaedics and Emily Pickup, Senior Physiotherapist, Stroke Team were recognised by students on placement from the University of Liverpool. They were nominated in the Practice Placement Educator Excellence Awards for their outstanding support, guidance, reassurance and kindness
- Sylvia Sinclair, Deputy General Manager with partners Medirest received the MyCleaning Lifetime Achievement Award
- Andrew O'Donnell, Portering Team Lead, received the award for Leadership of the Year Award at the MyPorter Awards 2024

- **National staff survey -** first full survey as MWL, only 3 months after merger
  - 1st in staff engagement/advocacy sub theme in NW region and Cheshire and Mersey for acute and community trusts
  - 1st in we are compassionate and inclusive/compassionate culture sub theme in NW region and Cheshire and Merseyside for acute and community trusts
  - Equal 1st in morale/work pressure sub theme in Cheshire and Merseyside
  - 3rd across NW region (out of 18) and Cheshire and Merseyside (out of 8) for the full Staff Engagement People Promise theme

Patient Safety

- 98.3% average registered nurse (RN)/midwife safer staffing fill rate for the year, above the 90% target
- Reductions in incidents resulting in harm in 2023-24 compared with 2022-23:

- No medical device incidents MWL Trust wide resulting in moderate or above harm
- 2.71% reduction in legacy STHK inpatient falls per 1000 bed days, decreasing from 7.297 falls per 1000 bed days in 2022-23 to 7.099 in 2023-24
- Infection control incidents MWL-wide have reduced by 58.99% from a total of 1073 in 2022-23 down to 440 during 2023-24

Patient experience

- Whiston, St Helens and Newton hospitals were ranked second in the country and best in the region compared to other general acute and combined trusts in the latest inpatient survey results (2022)
- Southport Hospital won the Nursing Times Critical and Emergency Care Nursing category for an initiative that support patients' families and their own staff after a patient sadly dies on the unit through the Pause Campaign where staff and families come together for a minute's silence in memory of the patient
- Palliative Care Team at Whiston were highly commended In the Nursing Times Critical and Emergency Care Nursing category for the care provided to palliative patients in the Emergency Department (ED)
- Continued to achieve over 94% inpatient recommendation rate for Friends and Family Test responses

Clinical effectiveness

- Winner of the Macmillan Professional Integration Excellence award - Upper Gastrointestinal Team
- Haematology team awarded the Myeloma UK Clinical Service Excellence Programme (CSEP) accreditation in recognition of its outstanding care and dedication to patients with myeloma
- Liverpool University Partnership Award presented to Liverpool Centre for Cardiovascular Sciences (LCCS) with whom Whiston Stroke Team are key partners in hosting a number of clinical trials and academic clinicians, as well as working jointly on research to improve stroke and cardiovascular care for patients
- Diabetes Team at Whiston and St Helens hospitals were shortlisted at the Quality in Care Diabetes Awards for their intensive support package for glucose optimisation in type 1 Diabetes during pregnancy
- Macmillan Skin Cancer Nurse Specialists and Cancer Support workers voted best poster at the National Melanoma FOCUS Conference. Posted included information about the upcoming project which will roll out the first ever personalised, self-management programme to support high risk skin cancer patients
- The Mersey Regional Burns Unit won two awards at the Journal of Wound Care Awards, held at the Imperial War Museum in London:
  - Professor Shokrollahi's collaborative research with Liverpool University and Manchester Metropolitan University won Gold in the 'Best Research' category for innovative research
  - The team also won Gold in the 'Most Progressive Society' category, relating to their work on sustainability in the NHS.

1.3. Celebrating success

The Trust has continued to share positive comments from patients and carers via the weekly Thank You Thursday messages sent to all members of staff. In addition, the Employee of the Month Award recognises and rewards the ongoing dedication and commitment of staff throughout the year.

The STHK Annual Staff Awards were held in July 2023, where the Trust celebrated the many achievements of staff, including the Employee of the Year. The paediatric department was voted the winner of the St Helens Star People's Choice Award. S&O held its Time to Shine Awards in October 2023 to reward staff for their outstanding contributions to patient care.

MWL's staff award ceremony will be held on 10th May 2024.

2. Section 2

2.1. About us

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) came into being on 1st July 2023, bringing together St Helens and Knowsley Teaching Hospitals NHS Trust with Southport and Ormskirk Hospital NHS Trust to create the new organisation. The formal joining of the two organisations came after eighteen months of close working via a collaboration agreement.

The Trust now provides acute and community services to the populations of St Helens, Southport, Knowsley, Ormskirk and Halton, with some regional and specialist services covering Cheshire and Merseyside or the whole of the North West Region, North Wales and the Isle of Man. The Trust also provides primary care services at Marshalls Cross Medical Centre in St Helens.

MWL provides healthcare services to approximately 650,000 people across Cheshire and Merseyside and West Lancashire. These populations experience considerable health inequalities and inferior health outcomes for the more deprived residents when compared nationally.

2.1.1. Our services

MWL provides adult and children's acute and community services and has five hospital sites:

- Whiston Hospital
- Southport Hospital
- Ormskirk Hospital
- St Helens Hospital
- Newton Community Hospital

Clinical services are also delivered from a number of community clinics, with corporate and support services also based in a number of locations.

Whiston Hospital delivers adult and paediatric emergency and urgent care services, Southport Hospital provides adult emergency services and Ormskirk Hospital provides children's emergency services. St Helens Hospital provides outpatient, day case surgery, intermediate care and rehabilitation services. Marshalls Cross Medical Centre provides primary care services.

The future configuration of emergency care services at Southport and Ormskirk is being reviewed by the Shaping Care Together Programme which includes representation from the Trust, the Integrated Care Systems for Cheshire and Merseyside and Lancashire and South Cumbria and from each of the Place Partnerships who serve the populations of Southport and West Lancashire. It is expected that options for the future configuration of urgent and emergency care (UEC) services for these populations will be consulted on during 2024-25.

Maternity services are delivered from the Whiston and Ormskirk sites.

The Mersey Burns Unit is located at Whiston Hospital and the Regional Spinal Rehabilitation Unit is on the Southport Hospital site.

MWL is now part of the Mid-Mersey and North Mersey stroke networks and houses the hyper acute stroke unit (HASU) which serves the population of St Helens, Knowsley, Halton and Warrington.

2.1.2. Our communities

MWL now provides services to a cross section of very affluent and extremely deprived communities, living in built up urban areas with poor housing stock and some more rural communities.

The boroughs of St Helens, Knowsley, Halton and parts of Liverpool have large health inequalities and inferior health outcomes for the more deprived residents. The St Helens joint strategic needs assessment (JSNA) outlines significant differences of life expectancy of up to 10.4 years for males and 9.2 years for females between wards. Gross weekly earnings in St Helens (£576) and Knowsley (£572) are on average lower than the North West (£578) and national (£613) averages. Knowsley has the highest deprivation score of the Trust's local areas at 43.0, compared to the national average of 21.7. The socio-demographic inequalities are also highlighted in the child and maternal health profiles, with 20.9% (6,893) of children living in relative low-income families in St Helens and 23.5% (7,071) in Knowsley.

Sefton Local Authority covers Southport and Formby and scores 27 for levels of deprivation compared to 21.7 average in England. Southport and West Lancashire are also areas with an ageing demographic profile when compared to the national average. It is estimated that one in three people in Sefton and one in four people in West Lancashire will be 65 and over by 2036, exacerbating long term health and care demand pressures.

2.1.3. Our Partners

MWL is a member of the Cheshire and Merseyside Integrated Care System (ICS). Cheshire and Merseyside ICS is one of the biggest ICSs in England covering a large geographical area with a population of approximately 2.6 million people. Cheshire and Merseyside has high levels of deprivation, with 33% of the population living in the most deprived 20% of neighbourhoods in England. The ICS vision is to ensure that everyone in Cheshire and Merseyside has a great start in life and gets the support they need to stay healthy and live longer.

MWL is a member of both the Cheshire and Merseyside acute and specialist trusts provider collaborate (CMAST) and the mental health, learning disabilities and community services provider collaborative because of the range of services it delivers.

West Lancashire is part of the Lancashire and South Cumbria ICS and as such MWL is working with two ICS and 6 Place-based partnerships.

The Trust had good partnership working with colleagues in each of the Local Authority Adult and Children's Social Services departments and works very closely with them to ensure safe and appropriate discharges for people leaving hospital.

The Trust also works closely with Liverpool, Edge Hill, and John Moores Universities to support the next generation of healthcare professionals.

The Trust works with the local Healthwatch across its catchment and is fortunate to have a large group of volunteers who support our work and help improve the experience for patients.

Geographical area where MWL services are provided

1	Southport & Formby Hospital	12	Albion Street Clinic
2	Ormskirk Hospital	13	Lowe House
3	Whiston Hospital	14	Mill Street Medical Centre
4	St Helens Hospital	15	St Helens Urgent Treatment Centre
5	Newton Community Hospital	16	Fingerpost Medical Centre
6	Knowsley College	17	Jubilee Court
7	Rainhill Clinic	18	Wheelchair Service
8	Four Acre Medical Centre	19	St Hugh's House
9	Haydock Medical Centre	20	Southport Centre for Health & Wellbeing
10	Garswood Medical Centre	21	Horton Lodge
11	Rainford Health Centre		

2.1.4. Our activity

The Trust Board is committed to delivering safe services and high-quality care, set within the context of the continued demand for urgent and emergency care and the increased waiting times for patients as the NHS continues to recover its elective activity position in the aftermath of the COVID-19 pandemic and as a result of ongoing industrial action. The Trust continues to be one of the busiest acute hospital trusts in the North West of England, as shown by the table below.

	2022-23	2023-24	% change 2022-23 to 2023-24
Outpatient attendances (seen)	736,323	774,444	5.18%
Non-elective admissions (less Obstetrics)	85,872	95,062	10.70%
Elective admissions	74,305	78,145	5.17%
Births	5,982	5,941	-0.69%
Emergency Department attendances (as reported)	172,917	178,629	3.30%
Emergency Department attendances (excluding GP Assessment Unit)	164,457	168,153	2.25%

The average length of stay for non-elective admissions was 7.3 days for 2023-24 compared to 7.3 days for 2022-23 and 6.5 days in 2021-22.

2.1.5. Our staff and resources

The Trust's annual total income for 2023-24 was £884m. This is made up of £817m Mersey & West Lancashire Teaching Hospitals NHS Trust and £67m months 1-3 Southport and Ormskirk Hospital NHS Trust.

Mersey & West Lancashire Teaching Hospitals NHS Trust employs over 10,500 members of staff. In addition, the Trust is the Lead Employer for Health Education North West, Midlands, East of England, South West, Thames Valley Region and Palliative Care London and is responsible for over 12,500 specialty doctors, dentists and public health trainees based in hospitals, general practice, dental and Local Authority placements throughout England.

The Trust's average rolling 12 months' staff turnover rate in 2023-24 was as follows:

Q1 – 14.00%
Q2 – 13.10%
Q3 – 12.04%
Q4 – 12.86%

The average was 12.80% for acute teaching hospitals in the North West and 11.30% for acute teaching hospitals nationally (data to December 2023).

The Trust strives to meet the best standards of professional care whilst being sensitive and responsive to the needs of individual patients. Following the formation of Mersey and West Lancashire Teaching Hospitals NHS Trust, clinical services are now organised within four divisions:

- Medicine and Urgent Care
- Surgery
- Women and Children
- Clinical Support and Community Services

A range of corporate services continue to contribute to the efficient and effective running of all our services, including human resources (HR), education and training, informatics, research and development, finance, governance, estates and facilities management.

The Trust has aligned its workforce plans to the NHS People Plan and NHS Long Term Workforce Plan to ensure sustainable pipelines to attract and retain nurses, midwives, operating department practitioners (ODPs) and allied health professionals (AHPs).

Key achievements for 2023-24 include:

Train

The Trust benefited from overseas recruitment in 2023-24 which saw the arrival of 65 international nurses meeting our target of 65, which is a huge achievement as part of our workforce strategy. This follows a successful intake of 129 international nurses in 2022. All nurses benefited from a dedicated education and training programme, including a preceptorship period to support them with their transition to working in the Trust and the UK.

The Preceptorship Pathway continues to evolve in line with Trust needs, ensuring patient safety trends noted from clinical areas are addressed during training. We are providing additional clinical and pastoral support to all 259 new registrants with our Preceptorship Champions. In 2023 we provided 3,548 hours of support across the Trust which contributed to the reduction in the attrition rate from 12.5% to 4.6%.
In 2023-24, 135 new substantive healthcare support workers (HCSW) and 159 bank HCSWs were inducted and on-boarded via the healthcare academy on Whiston and St Helens sites. This induction programme has now been rolled out to phlebotomists, theatre dule role practitioners and will shortly be in place for radiology support assistants. On Southport and Ormskirk sites, 32 were inducted and on-boarded via the NHS Professionals (NHSP) Care Certificate programme. Both programmes work well and support new healthcare support workers for 12 weeks (or more where needed) during the onboarding and induction process. Attrition of those trained via the academy continues to be low.

There is now a formalised pathway for career development open to all healthcare support workers, which supports access to functional skills (maths and English), level 2 and 3 health and social care national qualification, trainee nursing associate (TNAs) and additionally registered nurse degree apprenticeship (RNDA) for those nursing associates and assistant practitioners who wish to train to be RNs. Five

RNDA trainees commenced in March 2024. The RNDA is a two-year top up programme run via the University of Central Lancashire. This work has been completed collaboratively with workforce development leads to ensure we can grow our own workforce, invest in our unregistered staff and support them to 'learn whilst they earn'. All elements of the talent management pipeline will be fully functional by the end of 2024.

There is also a year-on-year growth of trainee advanced clinical practitioner posts supporting registered non-medical staff to progress and develop clinically, for example, the Trust recruited 15 in 2023, who began training in September 2023. The Trust has submitted a bid for a further 24 for 2024-25.

Retain
Due to the success of the internal transfer scheme on Whiston and St Helens sites, this has now been rolled out Trust-wide. In 2023-24, 50 staff transferred via the scheme with 29 of those being nurses or healthcare assistants (HCA).

Vacancy gaps across band 5 registered staff in safer staffing areas across all sites has reduced significantly over the last 12 months. Due to the reduction in vacancies, no off-framework agency usage in ward areas has been required since April 2023 on Whiston and St Helens sites.

A dedicated AHP workforce development plan has been progressed this year. MWL AHPs provide system-wide care to assess, diagnose, treat and discharge patients. Like many services both locally and nationally, there are recruitment challenges. However, overall vacancy rates have improved currently standing at 6.93%. In July 2023, legacy STHK appointed its first AHP workforce lead on secondment for 12 months. This post will support ongoing projects while developing an AHP workforce strategy aligned to the national AHP strategy and NHS Long Term Workforce Plan. There are several areas of workforce development across the Trust, including increased numbers of level 6 professional apprenticeships offered for operating department practitioners (ODPs), occupational therapy (OT), physiotherapy and radiography. In addition, the Trust is providing an increased number of placement and development opportunities for student AHPs, early career support and clear career pathways to attract and retain AHPs into the MWL workforce. Following investment, Therapy Services have 1.8 full time dietitians working in upper GI cancer, alongside the upper GI clinical nurse specialists and palliative care. The service has been recognised by Macmillan and Pancreatic Cancer UK as an exemplar service.

A new e-form for resignations and leavers was rolled out across the Trust in February 2024, which aims to capture more accurate and timely information relating to leavers to enable earlier conversations to take place around alternative options available to the staff member rather than leaving the Trust, as well as to inform future retention strategies.

As part of our ongoing commitment to the on-boarding and induction experience of our international recruits, following a successful bid, Whiston and St Helens sites were awarded funding by NHS England to implement an International Recruitment

Accommodation Officer for 12 months. This role has enhanced existing support networks in the Trust and local area for international recruits, including building relationships in the local community and ultimately finding and providing advice on affordable housing options. The role has become a single point of contact for our international cohorts and stakeholders across MWL and is now critically supported by sustainable processes and procedures for future international recruits, including a greater understanding of how to address the needs of new arrivals. Due to the success of the role at Whiston and St Helens, it is now being rolled out at Southport and Ormskirk sites. Through this project, the Trust has enhanced its reputation for welcoming and supporting international employees and providing them with a safe, helpful and informative route to make their arrival and stay in the UK positive.

On Southport and Ormskirk sites, it was identified that there was further support required for international arrivals for the September and November 2023 cohorts. A new clinical educator role was introduced for a period of 6 months, specifically to support the international nurses with their arrival in the UK and to support with their objective structured clinical examination (OSCE) training, alongside the support they received from Whiston colleagues. This role has been vital as it has allowed the nurses to have a consistent point of contact, throughout their transition to the UK.

The average medical and dental vacancy rate for 2023-24 was 35.5. The organisation has made significant progress in reducing the junior gaps and to ensure safe staffing, with numbers, particularly across medical specialties, slightly above establishment. The Trust continues to onboard foundation year one doctors though the Deanery and in 2023, 42 joined the Trust through this route. The Trust has collaborated with Masaryk University, Brno, Czech Republic, in the recruitment of newly qualified doctors who trained in Brno using the English syllabus since 2014. The Trust has made offers to an additional 145 doctors through these means since 2016 with a further 60 Brno doctors being interviewed at the end of March this year. These new recruits join the Trust for two years as Clinical Fellows at foundation year one and two, to support the wards and fill vacancies. All actions have led to a significant reduction in the number of bank and agency medical bookings, however there is still further work to be done to reduce the number of consultant vacancies. Work is now moving forward to look at how we utilise the benefits of the increased number of services and ability to offer a wider variety to consultants as a method of attraction.

Please refer to section 3.1.1 for further information on the Trust's work in 2023-24 on enhancing and supporting equality, diversity and inclusion in the workplace.

Reform

Part of the bringing together of the two former Trusts required a workforce systems consolidation project. The aims and objectives of the project are to successfully merge legacy workforce systems together. The project commenced in October 2023. The merger of the master workforce system Electronic Staff Records (ESR) was successfully completed at the end of February 2024 and the merger of the Trac recruitment system was successfully completed in March 2024.

Improvements have been made in time to hire over the last 12 months, with an

emphasis on improving the candidate on-boarding experience and reducing delays along the recruitment pathway to ensure staff can be deployed safely and efficiently. This is particularly the case for nursing and midwifery and healthcare assistant recruitment, having seen the benefits of centralised recruitment processes, ending the year on 37.9 days' time to hire for nursing and 34.2 days for healthcare assistants.

Implementation of e-rostering achieved 98% for non-medical areas. As part of the Trust's approach to flexible working, team-based rostering is to be piloted in some nursing areas, with a view to rolling out to all areas in the longer term. The use of team-based rostering allows staff to have more flexibility and control of their work/life balance, whilst still maintaining roster compliance and safeguarding of hours worked in line with roster rules.

A joint approach to medical job planning and activity-based rostering will be rolled out across all sites for 2024-25. This will provide a deeper assurance of the clinical activity, delivered, or cancelled, when and with what cost implications. Supporting the NHS Commissioning for Care Principle 3 – 'providing the right care, in the right place, at the right time.'

Safer Staffing

Nursing and midwifery safer staffing levels are reported externally, with details of the total planned number of hours for registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate as a % for nights and days on each ward. Agency, bank, overtime and extra time hours are included in the actual hours worked totals in accordance with the guidance.

The safer staffing figure, however, does not analyse skill mix or the impact of temporary staff on a shift-by-shift basis, which can affect the quality of care provided.

The acceptable monthly fill rate is 90% and over, which at times, can be challenging to achieve. The average RN/midwife safer staffing fill rate for the year was 98.5% for St Helens and Whiston sites, above the 90% target and higher than the 94.18% rate achieved last year. For Southport and Ormskirk sites this was 98.09%, an increase from 97.79% in the previous 12 months. Work is underway to align and amalgamate safe staffing reporting processes and data.

The Trust also reports Care Hours per Patient per Day (CHPPD), which is calculated from the total actual hours worked in a month divided by the monthly total inpatients in the ward at midnight. The Trust's position is reported monthly as part of the mandated safer staffing report.

The Trust continues to work incredibly hard to maintain patient safety at all times, using a range of approaches to ensure available staff are deployed effectively across the whole Trust. The actions taken include:

- Ward managers cancelling management days to work clinically
- Matrons/specialist nurses working clinical shifts
- Increasing the daily matron staffing meetings to twice daily at times of increased pressure, led by the Director of Nursing, Midwifery and Governance, with

members of the temporary workforce resourcing team attending. Staffing levels across the Trust are reviewed at each meeting, with every area identifying any gaps identified for the following 24 hours and the number of patients requiring supplementary care (1-1 or bay tagging) on each ward. Staff moves are then jointly agreed to provide the safest care possible
- A plan for further moves, should this be required for unexpected absence, is communicated by the matrons covering the late shift to the operational site managers and the general manager on call each day
- Working with the Trust's staff bank and external agencies to provide staff to cover each shift for areas experiencing last minute gaps due to sickness

Supporting our Staff

The Trust continues to appreciate the lasting impact of the COVID-19 pandemic on our staff, the cost-of-living crisis and industrial action which is affecting staff and the wider organisation. To help support staff and limit the impact of this a Financial Wellbeing guide continues to feature as part of the wider health and wellbeing offer to staff. The support focused on how to access assistance, where to get help with household bills including energy, food, childcare and discounts for NHS staff.

Further to this, a series of health and wellbeing events took place across the organisation throughout the year in 2023 with themes around cost-of-living, as well as health and wellbeing support. These events hosted over 100 stalls providing a range of information and resources for staff, as well as practical and informative sessions, attended in-person or virtually. On one of the events at Whiston Hospital, over 300 staff attended in-person and engaged with services such as Citizen Advice Bureau and money saving and advice experts. Staff took part in exercise sessions such as Pilates, tai-chi and sought advice and support from other local experts in health and wellbeing.

The Health, Work and Wellbeing Department (HWWB) continues to provide a wide range of supportive services, including Occupational Health (OH) and those listed below:
- The Wellbeing Hub which supports staff affected by physical or non-physical health matters that can have an impact both in and outside of work. Support is available for all staff, including those that have been affected by COVID-19
- Mental wellbeing – stress, anxiety, depression and other diagnosed conditions – delivered by counsellors, mental health nurses and psychologists
- Physical wellbeing – targeted support for musculoskeletal conditions, injury, or other diagnosed conditions, delivered by PhysioMed, physiotherapists and OH clinicians
- General health – any other health related condition(s) that staff feel may be impacting on their work – delivered by OH clinicians or onward referrals to specialist support
- Financial wellbeing - key resources and top tips to help staff limit the impact of rising living costs
- Trust staff can engage with all the resources, including self-referrals via a dedicated staff intranet site which has a specific wellbeing section
- The additional promotion of wellbeing apps (free to use and access) including meditation, mental health in the workplace, mindfulness and sleep aides

- Staff wellbeing events and engagement sessions to promote and support wellbeing and resilience, including mindfulness, sleep hygiene, stress, relaxation and building resilience
- Rugby League Cares (RLC), which is a charity commissioned by NHS England to provide support via engagement sessions for staff. These include mental fitness and team building. RLC also support with recruitment via community engagement programmes

The Trust's Wellbeing Network continues to grow and consists of champions for the health and wellbeing agenda. There are currently over 100 Health and Wellbeing Champions, 30 Mental Health First Aiders and a Wellbeing Guardian all driving the network forward with support from the Wellbeing Lead and Wellbeing Coordinator. The Wellbeing Network publishes monthly newsletters, which are disseminated throughout the organisation to help promote the health and wellbeing service and support available to staff.

2.1.6. Technology and information

The Informatics Department at MWL has worked at pace during 2023-24, playing an instrumental part in delivering new innovative solutions that enhance digital innovation throughout the Trust. This includes supporting the new organisation to operate as one team to providing resilient, robust and reliable IT systems, we continue to work hard on enhancing digital maturity for our clinical services, alongside improving communication with patients, all of which works towards supporting the delivery of 5-star patient care.

Careflow Electronic Patient Record (EPR)

Our suite of solutions which integrate to form our electronic patient record has been enhanced greatly throughout 2023-24, some of these enhancements are detailed below:

- **Workspace –** Workspace gives our clinical teams a comprehensive overview of each patient's condition in a single view, bringing together vital observations, pathology results, clinical documentation, referrals, photography and more at a single glance. Workspace also provides the ability to context launch systems outside of the Careflow suite, such as picture archiving and communication system (PACS), to be launched from the patient's record in a single click, which is a huge benefit for clinicians, providing efficiency. This is currently in place at our St Helens and Knowsley sites, with a view to implementation throughout Southport and Ormskirk by the end of March 2024
- **Careflow Connect Rollout –** Careflow Connect is a single digital platform for patient handovers across clinical specialisms. As part of our electronic patient record (EPR), this system has improved efficiency for patient specialist referrals and improved mobile working, allowing clinicians to view patient results from a mobile device. During 2023-24, Careflow Connect has been rolled out across all five sites
- **Patient Flow –** Patient Flow is an electronic digital white board solution that allows us to provide highly visible patient safety information such as most recent

early warning scores and trends, also ensuring compliance with nursing risk assessments rather than the write on/wipe off board that was previously in place. Another solution that is part of our EPR, this has been implemented across all five sites with phase 2 developments in place around bed management

- **Narrative –** All historic clinical noting forms were upgraded to narrative at our St Helens and Knowsley sites. This has given staff an improved user experience and the ability to complete documentation on handheld devices, alongside mobile carts and desktops. We are now building new documentation at pace in narrative, removing paper processes and allowing clinical staff to work more efficiently, therefore removing the need for manual collection of data for reporting
- **ePMA Rollout -** electronic prescribing and medicines administration (ePMA) was implemented in ED at Whiston and the Spinal Unit at Southport and Ormskirk in 2023-24 with a plan in place to continue the rollout across Southport and Ormskirk wards, theatres, outpatients and ED. EPMA allows for the removal of the paper prescription charts and the recording of prescribed medication electronically. This has improved patient safety around prescribing and drug administration, for example, in flagging patient allergy information and safety prompts for dosage timing, significantly reducing drug error incidents
- **Order Comms** – Order comms is the electronic ordering of clinical tests and investigations within Careflow EPR. The utilisation of Order Comms for the wider organisation has enabled the incorporation of internal referrals and investigations therefore, removing the need for paper processes and manual data collection, allowing clinical staff to work more efficiently
- **EMIS** – The Early Supported Discharge Team, Occupational Therapy and Health and Wellbeing teams are now onboarded onto EMIS, the Egton medical information system, at our Southport and Ormskirk sites, enabling them to review GP records as appropriate to support the patients' care
- **Patient Waiting List Validation –** As waiting lists continued to grow across the NHS, the new waiting list validation process allows patients to digitally confirm if they still require an appointment. The implementation of the new system brought with it a range of benefits, including:
    - Reducing waiting lists so that patients who no longer require an appointment are removed from the waiting list
    - Reducing number of people not attending an appointment as they no longer require treatment
    - Freeing up administrative time from multiple calls to make new and more appointments
    - The ability to monitor and update results in real time

The solution has improved waiting list efficiency and has provided reassurance to patients who are on the waiting list.

- **Attend Anywhere** – Attend Anywhere is a video clinic system which allows patients to be reviewed by their specialist teams from the comfort of their own home. Many patients prefer video clinics to coming into hospital, for reasons of convenience (less time out of the day, no car parking or mobility issues, avoidance of COVID and other viral illnesses). Alongside being beneficial for patients, video clinics are also beneficial for colleagues as they allow for more patients to be seen in a session and allow clinical staff to run their clinics from any location. This platform has now been extended to sites across St Helens and Knowsley

- **Electronic Discharge Letters –** The implementation of discharge letters with Paediatrics ED has led to the removal of paper processes, allowing clinical staff to work more efficiently, speeding up the process of documentation delivery to GPs. This applies to our Ormskirk sites
- **Digital Nurse Collaboration –** The Digital Nurses continue to work in collaboration with the Healthcare Academy and Preceptorship programme to deliver clinically led education around the use of clinical digital systems. All new healthcare assistants (HCAs), nurses and AHPs joining the Trust receive this education and the feedback has been overwhelmingly positive
- **Migration –** In 2023, Southport and Ormskirk migrated from Aintree's instance of Chemocare to St Helens instance of Chemocare supporting the prescribing of chemotherapy for patients undergoing cancer treatment. Within sterile services, Southport and Ormskirk migrated from Meditrax to HESSDA & HESA allowing clinical staff to work more efficiently
- **BadgerNet –** The latest strategy has agreed to replace the existing maternity solution with BadgerNet, with a pilot due to go live in April 2024. Badgernet will provide an electronic hand-held record for all pregnant people, working with organisations across Cheshire and Merseyside to ensure the right information is available for mothers and babies wherever they receive care. This will also enable us to meet the latest digital maternity and safety standards

2.1.6.1. Technical

- **Printing –** The new multi-function device printing means more reliable and more secure printing across all sites
- **Office 365 –** All staff are now on a single instance of Office 365, a cloud-powered productivity platform, which means the wider teams across all five sites can communicate and collaborate much more easily using email and Teams. Microsoft Teams provides a workspace for real-time collaboration and communication, meetings and file sharing
- **Cyber Security** – There has been a real focus on cyber security to prevent vulnerabilities across the estate, removing, upgrading or replacing end of life solutions which are at the end of their contracts. This has removed potential vulnerabilities on the network and ensures that all steps are taken to keep our data and systems secure.
- **Wireless Upgrades –** There has been a full wired upgrade at the Southport and Ormskirk sites, with a wireless upgrade underway which will enable staff to visit any site with a wireless device and be able to access any of their usual systems from that site. This upgrade provides a more reliable experience with better coverage and a faster connection than the previous wireless. The ability for staff to roam from any site and access any system or data gives our teams much more flexibility to move resources between sites

Our overall aim is to ensure that IT equipment is always available which means ensuring personal computers, laptops and mobile devices are modern, capable of running modern software/applications and can be managed securely. With this in mind, we have replaced approximately 800 computers/laptops and 200 mobile devices (iPads) to ensure that staff can access the systems swiftly and easily

wherever they are. The service has deployed a solution called Endpoint Analytic Monitoring which alerts the information technology (IT) team to potential issues with any of devices. This means we can proactively visit the computer/laptop and fix or replace before the member of staff is even aware it has an issue, meaning they are less disrupted when trying to access solutions and data.

2.2. Summary of how we did against our 2023-24 Quality Account objectives

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

2.2.1. Progress in achieving 2023-24 quality objectives

Quality Domain: Patient Safety		Update	Achievement
Objective	Measurement		
Implement and embed the national Patient Safety Incident Response Framework (PSIRF).	Approval of business case for required staffing to implement and maintain PSIRF	PSIRF was implemented in October 2023 and the Patient Safety Incident Response Plan 2023 -24 was launched. The PSIRF team is in place and will increase following the divisional restructure across MWL. The executive-led weekly safety panel review patient safety incident investigation (PSII) reports when completed. Process aligned across MWL to agree if for PSII or for other learning reviews. 7 PSIIs at various stages of progress at end of Q4 2023-24 for MWL. Training continues on both safety specialist functions and for the wider MWL workforce.	Achieved
	Development of Trust-wide education plan		
	Launch and implementation of PSIRF in line with national requirements		

Quality Domain: Patient Safety		Update	Achievement
Objective	Measurement		
Continue to ensure the timely and effective	All patients waiting longer than 15 minutes for triage	Whiston: The average time to triage was 35 minutes in Q4, which is an improvement from 38.5 minutes in Q1. 100% of patients audited had observations	Achieved

Quality Domain: Patient Safety		Update	Achievement
Objective	Measurement		
assessment and care of patients in the Emergency Department	have a baseline set of observations recorded, with appropriate escalation action taken in a timely manner	recorded at the end of Q4 with appropriate escalation. Southport: Appropriate escalation and level of observation was taken in 100% cases reviewed.	
	First clinical assessment median time of <2 hours (120 minutes) over each 24-hour period	Whiston: The median time to first clinical assessment for Q4 was 129 minutes. Whilst daily attendance has stayed the same, acuity and patient flow have had a major impact on the time to first assessment. There are Trust and system wide actions being taken to improve patient flow.	Virtually achieved
		Southport: The median time to first clinical assessment for Q4 was 94 minutes	Achieved
	Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits	Whiston: Monthly audits continue to be completed to monitor compliance with NEWS. The audits for Q4 show a sustained compliance of 100%. Southport: 100% of cases had appropriate frequency of observations in line with the Policy and 95% of patients had a medical team review within 60 minutes at year end	Achieved
	Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring	Whiston: The retired commissioning for quality and innovation (CQuIN) data for Q4 2023-24 states 84.1% adults were screened and 90.4% adults received first dose of antibiotics. A number of actions are ongoing to improve performance. Southport	Screening is below 90% target with improvement actions in place

Quality Domain: Patient Safety		Update	Achievement
Objective	Measurement		
		Advancing Quality monthly benchmarking highlighted 100% National Early Warning Scores recorded within 1 hour of hospital arrival within Q4, and 80% IV fluids commenced within 1 hour of sepsis diagnosis and 62.5% of antibiotics given within the hour at end Q4. Improvement actions are ongoing.	
	Documented evidence that patients have had timely risk assessments and relevant related actions confirmed by regular audits	Whiston 89% compliance for patients receiving timely risk assessments by end Q4. Southport: • Falls – 83% • Alcohol Screening – 93% • Body Chart - 92% • Manual Handling – 85%	Virtually achieved

Quality Domain: Clinical Effectiveness		Update	Achievement
Objective	Measurement		
Ensure patients in hospital remain hydrated	Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place	STHK Q4 audits highlighted 95% of patients identified as requiring assistance with fluids and/or risk of dehydration had a red jug in place.	Achieved
		S&O Red jugs were introduced in Q2 and by Q4 were being used for 74% of appropriate patients. There is an action plan in place to educate staff and improve usage.	Measure not achieved with actions in place to improve
	Quarterly audits to ensure fluid balance charts are up-to-date	STHK The Q4 Nursing Care Indicator scores were • Nutrition and hydration 96%	Measure not achieved with actions in place to

	and completed accurately	• Fluid balance 81% S&O Audits demonstrate that over 85% of fluid balance charts are completed fully There are improvement plans to address this and the objective is being carried forward to 2024-25.	improve
	Quarterly audit of most dehydrated patients to ensure appropriate treatment in place, including IV fluids/fluid balance	MWL Advancing Quality (AQ) audit results rank the Trust first (best) in the local peer group. Most recently published data for December 2023. Stop nephrotoxic drugs within 24 hours of the 1st AKI alert - 100% Serum creatinine test repeated within 24 hours of 1st AKI alert – 84% Specialist renal or critical care discussion within 24 hours of 1st AKI 3 alert – 93% This provides assurance that patients were appropriately hydrated. In addition, the Trust commenced the roll out of an AKI risk assessment to be completed within 6 hours of admission.	Achieved

Quality Domain: Patient Experience			
Objective	Measurement	Update	Achievement
Improve the effectiveness of the discharge process for patients and carers	Improved Inpatient Survey satisfaction rates for receiving discharge information.	Whiston Inpatient survey 2022 showed improvement in most scores relating to discharge. Southport: The 2022 inpatient results showed similar results to the previous year.	Majority of scores improved

Quality Domain: Patient Experience			
Objective	Measurement	Update	Achievement
	Achievement of 20% target for patients discharged before noon during the week	Whiston Achieved 18.4% discharges before noon in Q4. There remains a continued focus on early discharges through the support of Patient Flow Lead Nurses and Discharge Lounge S&O Achieved just below 20% of discharges before noon in Q4	Virtually achieved
	Improved audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet	Whiston Audits demonstrated compliance of 98% and above. S&O 100% of patients audited received the discharge booklet.	Achieved
	Baseline audit of sample of delayed discharges to identify if delay in receiving take home medications was the primary factor in the delay, with target to reduce this in subsequent quarterly audits	Discharge data for patients with no criteria to reside highlights that no patients were delayed due to waiting for medications.	Achieved

Quality Domain: Patient Experience			
Objective	Measurement	Update	Achievement
Improve the overall experience for	The Trust remains committed to providing the best	Maternity survey 2023 results for the areas of focus: Ormskirk: Women and partner involvement maintained the scores other than	Majority of scores improved

Quality Domain: Patient Experience			
Objective	Measurement	Update	Achievement
women using the Trust's Maternity Services	possible experience for all the women accessing our Maternity Services, particularly in the areas which were rated lower that we would like in the most recent national survey.	induction and postnatal. Access to medical history of mother and baby showed an improvement except for during birth. Information for induction of labour and physical recovery after birth improved significantly. Whiston Infant feeding showed significant improvement. Women and partner involvement showed an improvement other than induction. Access to medical history of mother and baby showed an improvement. Improvement in the scores relating to delayed discharge.	

2.3. Quality objectives for improvement for 2024-25

The Trust's quality objectives for 2024-25 are listed below with the reasons why they are important areas for quality improvement. The views of stakeholders and staff were considered prior to the Trust Board's approval of the final list. The consultation included an online survey that was circulated to staff, commissioners and patient representatives, as well as being placed on the Trust's website for public participation.

The consultation was undertaken using SurveyMonkey with 94 responses received, an increase from the 58 received in last year's survey. There was a high level of agreement with the proposed objectives, all receiving over 90% positive responses, with the highest being 97% support for timely and effective assessment of patients in the Emergency Department and 96% for ensuring patients remain hydrated. The lowest scoring question was improving the overall experience for women using the Trust's Maternity Services at 91%.

Further suggested objectives covered the following areas, deteriorating patients/sepsis, nutrition, waiting times for appointments/procedures, communication/involvement of patients/carers in their care, increased staffing/staff training, falls/pressure ulcers, cancer care and overall patient experience. These were not included in the final list for this Quality Account, however, all responses were shared with Executives for wider consideration and inclusion in Trust workstreams.

Quality Domain: Patient Safety				
Objective	Rationale	Lead Director	Measurement	Governance Route
Continue to ensure the timely and effective assessment and care of patients in the Emergency Department	The Trust remains committed to providing the timely assessment and delivery of appropriate care to maintain patient safety, whilst also responding to increased demand for services.	Chief Operating Officer	All patients requiring triage are either triaged within 15 mins or have a baseline set of observations within 15 minutes based on monthly audits	Quality Committee
			First clinical assessment median time of <2 hours over each 24-hour period	
			Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits.	
			Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring.	

Quality Domain: Patient Safety				
Objective	Rationale	Lead Director	Measurement	Governance Route
Reduce the incidence of methicillin-resistant Staphylococcus aureus (MRSA) healthcare associated bacteraemia infections to meet the zero threshold	The Trust has seen an increase in healthcare associated infections and remains committed to improving patient safety.	Director of Nursing, Midwifery and Governance	Achieve minimum aseptic non-touch technique compliance of 85% for Level 1 (theory) and Level 2 (practical).	Quality Committee
			Achievement of 95% for MRSA screening	
			90% compliance with visual infusion phlebitis (VIP) monitoring	

Quality Domain: Clinical Effectiveness				
Objective	Rationale	Lead Director	Measurement	Governance Route
Ensure patients in hospital remain hydrated	Effective hydration improves recovery times and reduces the risk of deterioration, kidney injury, delirium and falls	Director of Nursing, Midwifery and Governance	Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place	Quality Committee
			Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately	
			High compliance with Advancing Quality (AQ) audit results	

Quality Domain: Patient Experience				
Objective	Rationale	Lead Director	Measurement	Governance Route
Improve the effectiveness of the discharge process for patients and carers	A continuing theme from patient feedback is the need to improve the discharge experience for patients and their carers	Chief Operating Officer	Improved inpatient survey satisfaction rates for receiving discharge information	Quality Committee
			Improved audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet	
			Achievement of 20% target for patients discharged before noon during the week	
			Review of discharge data to confirm reason for delay is not due to waits for take home medication	

Quality Domain: Patient Experience				
Objective	Rationale	Lead Director	Measurement	Governance Route
Improve the overall experience for women using the Trust's Maternity Services	The Trust remains committed to providing the best possible experience for all the women accessing our Maternity Services, particularly in the areas rated lower that we would like in the most recent national survey	Director of Nursing, Midwifery and Governance	Demonstrable improvements in the key areas from previous national surveys shown through regular inhouse surveys and feedback from women receiving maternity care and delivery of the agreed action plan.	Quality Committee
			Create a MWL Maternity Strategy to support delivery of the national three-year maternity plan.	

2.4. Statements of assurance from the Board

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

2.4.1. Review of services

During 2023-24, the Trust provided and/or sub-contracted £736m NHS services. This is made up of £675m Mersey & West Lancashire Teaching Hospitals NHS Trust and £61m months 1-3 Southport and Ormskirk Hospital NHS Trust.

Mersey and West Lancashire Teaching Hospitals NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2023-24 represents 97% of the total income generated from the provision of NHS services by Mersey and West Lancashire Teaching Hospitals NHS Trust for 2023-24.

The above figures relate to income from patient care activities. The remaining total operating income arose from other sources such as NHS North West Deanery for the education and training of junior doctors and services provided to other organisations, such as Information Technology (IT), Human Resources (HR) and Pathology Services.

2.4.2. Participation in clinical audit

2.4.2.1. Participation in Quality Account audits 2023-24

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

The Trust participates in two national confidential enquiry programmes, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries across the United Kingdom (UK) (MBRRACE–UK). It should be noted that some audits are listed as one entity on the published list, but involve a number of individual projects being undertaken under this single heading, for example, NCEPOD had 6 audit projects undertaken.

In July 2023 St Helens and Knowsley Teaching Hospitals NHS Trust merged with Southport and Ormskirk Hospital NHS Trust to form a new organisation, Mersey and West Lancashire Teaching Hospitals NHS Trust. Clinical Audit reporting remained separate during 2023-24, therefore we have highlighted this in the tables below.

During 2023-24, 53 national clinical audits and 7 national confidential enquiries covered relevant health services that the former St Helens and

Knowsley Teaching Hospitals NHS Trust provides.

During that period, St Helens and Knowsley Teaching Hospitals NHS Trust participated in 93% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

During 2023-24, 50 national quality account clinical audits and 7 national confidential enquiries covered relevant health services that the former Southport and Ormskirk Hospital NHS Trust provides.

During that period, Southport and Ormskirk Hospital NHS Trust participated in 94% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table below shows:

- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust was eligible to participate in during 2023-24
- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust participated in during 2023-24
- The national clinical audits and national confidential enquires that St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust participated in, and for which data collection was completed during 2023-24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	STHK	S&O
1.	Adult Respiratory Support Audit	Yes	Yes	Completed	Completed
2.	Nephrostomy Audit (British Association of Urological Surgeons (BAUS))	Yes	Yes	Continuous monitoring	Continuous monitoring
3.	Breast and Cosmetic Implant Surgery	Yes	Yes	Continuous monitoring	Not applicable
4.	Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme (CMP)	Yes	Yes	Continuous monitoring	Continuous monitoring
5.	NCEPOD Testicular Torsion	Yes	Yes	Completed	Completed
6.	NCEPOD Endometriosis	Yes	Yes	Completed	Completed
7.	NCEPOD Community Acquired Pneumonia	Yes	Yes	Completed	Completed
8.	NCEPOD Juvenile Idiopathic Arthritis	Yes	Yes	Active	Active
9.	NCEPOD End of Life Care	Yes	Yes	Active	Active
10.	NCEPOD Rehabilitation	Yes	Yes	Active	Active

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	STHK	S&O
	following Critical Illness				
11.	Elective Surgery National Patient Reported Outcome Measures (PROMs) Programme	Yes	Yes	Continuous monitoring	Continuous monitoring
12.	Royal College of Emergency Medicine (RCEM) Mental Health Self Harm	Yes	Yes	Completed	Completed
13.	RCEM Infection Control	Yes	Yes	Completed	Completed
14.	Epilepsy 12 - (round 3) Paediatrics	Yes	Yes	Continuous monitoring	Continuous monitoring
15.	National Audit of Inpatient Falls	Yes	Yes	Continuous monitoring	Continuous monitoring
16.	National Hip Fracture Database	Yes	Yes	Continuous monitoring	Continuous monitoring
17.	Improving Quality in Crohn's and Colitis	Yes	Yes	Continuous monitoring	Continuous monitoring
18.	Learning disability mortality review (LeDeR) - learning from lives and deaths of people with a learning disability and autistic people	Yes	Yes	Continuous monitoring	Continuous monitoring
19.	Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE–UK) – Maternal Infant and New-born	Yes	Yes	Continuous monitoring	Continuous monitoring
20.	National Diabetes Core Audit (NDA)	Yes	Yes	Continuous monitoring	Continuous monitoring
21.	National Pregnancy in Diabetes Audit	Yes	Yes	Continuous monitoring	Continuous monitoring
22.	National Diabetes Foot Care Audit	Yes	Yes	Continuous monitoring	Continuous monitoring
23.	National Diabetes Inpatient Safety Audit	Yes	Yes	Continuous monitoring	Continuous monitoring
24.	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Continuous monitoring	Continuous monitoring
25.	National Asthma & Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) Paediatric Asthma Secondary Care	Yes	Yes	Continuous monitoring	Continuous monitoring
26.	NACAP Adult Asthma Secondary Care	Yes	Yes	Continuous monitoring	Continuous monitoring
27.	NACAP Chronic Obstructive Pulmonary Disease (COPD)	Yes	Yes	Continuous monitoring	
28.	National Audit of Cardiac Rehab	Yes	Yes	Continuous monitoring	Continuous monitoring
29.	National Audit of Care At The End Of Life (NACEL)	Yes	Yes	Active	Active

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	STHK	S&O
30.	National Audit of Dementia (round 6)	Yes	Yes	Active	Active
31.	National cancer audit collaborating centre - national audit of metastatic breast cancer	Yes	Yes	Continuous monitoring	Not applicable
32.	National cancer audit collaborating centre - national audit of primary breast cancer	Yes	Yes	Continuous monitoring	Not applicable
33.	National Cardiac Arrest Audit (NCAA)	Yes	Yes	Continuous monitoring	Continuous monitoring
34.	National Cardiac Audit Programme (NCAP) (includes the Myocardial Infarction National Audit Programme - MINAP)	Yes	Yes	Continuous monitoring	Behind Schedule
35.	National Heart Failure Audit	Yes	Yes	Continuous monitoring	Behind Schedule
36.	2023: Audit of Blood Transfusion: National Institute for Health and Care Excellence (NICE) QS-138			Active	Active
37.	National Clinical Audit Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	Continuous monitoring	Continuous monitoring
38.	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Continuous monitoring	Continuous monitoring
39.	National GI Cancer Programme: Bowel Cancer (NBOCA)	Yes	Yes	Continuous monitoring	Continuous monitoring
40.	National audit oesophago-gastric cancer (NAOGC)	Yes	Yes	Continuous monitoring	Continuous monitoring
41.	National Joint Registry (NJR)	Yes	Yes	Continuous monitoring	Continuous monitoring
42.	National Lung Cancer Audit (NLCA)	Yes	Yes	Continuous monitoring	Continuous monitoring
43.	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Continuous monitoring	Continuous monitoring
44.	National Neonatal Audit Programme (NNAP)	Yes	Yes	Continuous monitoring	Continuous monitoring
45.	National Ophthalmology Audit (NOD) & National Cataract Audit	Yes	Yes	Continuous monitoring	Continuous monitoring
46.	National Prostate Cancer Audit (NPCA)	Yes	Yes	Continuous monitoring	Continuous monitoring
47.	National Vascular Registry (NVR)	Yes	Yes	Continuous monitoring	Not applicable
48.	National Perinatal Mortality Review Tool (PMRT)	Yes	Yes	Continuous monitoring	Continuous monitoring
49.	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Continuous monitoring	Continuous monitoring
50.	Serious Hazards of Transfusion:	Yes	Yes	Continuous	Continuous

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated	STHK	S&O
	(SHOT) UK National Haemo-Vigilance Scheme			monitoring	monitoring
51.	Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes	Completed	Completed
52.	National Major Trauma Registry (NMTR) ED – formerly Trauma Audit and Research Network (TARN)	Yes	Yes	Project delayed nationally	Project delayed nationally
53.	United Kingdom (UK) Cystic Fibrosis Registry	Yes	Yes	Continuous monitoring	Continuous monitoring
54.	Fracture Liaison Service Database	Yes	No	No capacity to participate	No fracture liaison service within Trust
55.	Perioperative Quality Improvement Programme	Yes	No	No capacity	No capacity to participate
56.	British Hernia Society Registry (BH Registry)	Yes	Not started	This project is not due to start until Nov 2024	This project is not due to start until Nov 2024 – ready to register Trust
57.	RCEM Care of Older People	Yes	No	Failed to complete	Completed
58.	2023: Bedside Transfusion Audit	Yes	Not started	New not started yet - delayed	New not started yet - delayed

2.4.2.1. Other National Audits participated in during 2023-24 (not on Quality Account list)

National audits
East Midlands National Breast Pain Audit
Gap Score Missed Case Audit
Respond: National Quality Audit
Acute Oncology Passport: Pilot Study
Completion Mastectomy for ductal carcinoma in situ/sentinel lobe node biopsy
Management of the Open Abdomen: National Open Abdomen Audit
Identification of Difficult Airways in Critical Care Units
National Axial Spondyloarthritis Society Aspiring to Excellence Time to Diagnosis Audit
Surgical Management of Breast Cancer in Patients with Previous Breast Augmentation with Implants
National Children and Young People Diabetes Programme
Mandatory Surveillance of healthcare associated infections (HCAI)
Mandatory Surgical Site Infection (SSI) Surveillance Service (Total Hip and Knee Replacements)
Collaborative Acute Aortic Syndrome Project

The reports of 52 national clinical audits were reviewed by the provider in 2023-24 and Mersey and West Lancashire Teaching Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Outcome/actions STHK	Outcome/actions S&O
Intensive Care National Audit & Research Centre		
ICNARC (CMP) CMP= Case mix Programme	STHK - The latest report showed that from April - Sept 2022 the quality indicator dashboard of 11 quality indicators were all green across the board for our Trust.	The case mix programme is an audit of patient outcomes from critical care units covering England, Wales and Northern Ireland. The results for this are reported separately in the Quality Account
NELA		
National Emergency Laparotomy Audit (NELA)	The Trust continues to participate in this national audit and results are within the expected parameters. Regular reports are shared with staff at the Clinical Effectiveness Council and local Quality Improvement (QI) - Clinical Audit meetings.	The Trust continues to participate in this national audit and results are within the expected parameters. Regular reports are shared with staff at the Clinical Effectiveness Council and local QI-Clinical Audit meetings.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Surgical & Medical/Child Heath Programme		
Completed studies during 2023-24: • Community Acquired Pneumonia • Testicular Torsion • Endometriosis	Active studies during 2023-24: • Juvenile Idiopathic Arthritis • End of Life Care • Rehab following Critical Illness	Active studies during 2023-24: • Juvenile Idiopathic Arthritis • End of Life Care • Rehab following Critical Illness
Studies under development:		
NCEPOD Epilepsy Care (adults) 2022 Report 'Disordered Activity'	Report reviewed and disseminated at the Trust's ED QI-Audit meeting. Report actions recommended pertaining to ED are already covered in the current Seizure Pathway.	Report disseminated and discussed.
Transition from Child to Adult Health 'The Inbetweeners' Report June 23	Report disseminated and discussed. Gap analysis underway	Gap analysis for recommendations completed and shared at paediatric governance meeting
Crohn's Study 'Making the Cut'	Report disseminated and discussed.	Awaiting completion of the recommendations gap analysis

Audit Title	Outcome/actions STHK	Outcome/actions S&O
Report July 23	Gap analysis underway	
National Paediatrics Diabetes Audit (NPDA)		
National Paediatric Diabetics Audit (NPDA) Note: HbA1c is Haemoglobin A1c which measures the average blood glucose (sugar) levels for the last two to three months	STHK 2021-22 data presented at the Paediatrics audit meeting: Key Successes: 98.4% % of all children and young people (CYP) had HbA1c check in 2021-22 year. Compared to 61% in 2020-21. Our median (unadjusted) HbA1c for CYP with Type 1 diabetes is 57.5 mmol/mol (improved from 62 mmol/mol last year) 100% of newly diagnosed CYP with Type 1 diabetes had all key care processes at diagnosis Key improvements needed: Did not attend (DNA) rates Low capture of sick day rules & blood ketone testing Low capture of foot examinations in data Blood pressure (BP) readings high in some patients Actions: DNA Rates: Any patient who did not attend and is admitted to the ward is to be seen as an opportunity for undertaking of annual review investigations during that admission including doing HbA1c. Telephone reminders by Diabetes Administrative staff the week prior to clinic attendance Key worker to investigate barriers to clinic attendance Low capture of sick day rules & blood ketone testing: Check during every clinic appointment to ensure being ticked Discuss with HiCom in next meeting, if it is a software issue	S&O – 2022-23 The mean HbA1c for children and young people with Type 1 diabetes was 59.9 mmol/mol. The overall health check completion rate is 93.2%, compared to 90.8% for England and Wales 42% were using closed loop systems compared to 15% in England and Wales nationally

Audit Title	Outcome/actions STHK	Outcome/actions S&O
	Low capture of foot examinations in data: Improved documentation in Twinkle of foot examinations Discuss with HiCom Reminder from admin staff as to key processes to be completed, especially if patient DNA previous annual review appointment BP readings high in some patients: If BP is noted to be high by clinic staff, this needs to be repeated before end of clinic If BP continues to be high, team to arrange for manual BP check with hospital at home team	
Emergency Dept		
RCEM National Quality Improvement Project (QIP) Infection Control 2021-22	The results showed: 249/260 96%cases conformed to standard 1A (COVID 19 screening at triage) 56/63 89% cases conformed to standard 2 (documented vulnerability requiring isolation were isolated) 12/15 80% cases conformed to standard 3 (potentially infectious requiring isolation were isolated) Inability to isolate all potentially infectious or vulnerable patients in side rooms – due to overcrowding in ED and physical capacity (number of cubicles available).	The aim of this audit was to identify current performance in ED against clinical standards and compare the results nationally. Performance was measured against 6 clinical standards. -33% of patients were screened on arrival for COVID symptoms (1A) -4% of patients with a documented vulnerability should be isolated in a side room (2) -86% of patients were isolated when identified as being potentially infectious (3) – this is above the national mean of 81.82%

2.4.2.2. Local clinical audit information

The reports of 488 local clinical audits were reviewed by the provider in 2023-24 and Mersey and West Lancashire Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/actions
Anaesthetics	
STHK - Post-op adult acute pain management (using continuous regional analgesia wound infusion or nerve block)	• Patients reported higher satisfaction scores with the pain team in the group that had rectus sheath catheters. • Staff becoming familiar with a new analgesia technique • New service established which can now be expanded to other areas of local anaesthetic infusions eg for rib fractures • New pumps have been purchased.
STHK - Anaesthetics record keeping Q1 & Q2 2023-24	77% of the standards fully met and reminder of standards given for each quarter where there were gaps in compliance found.
S&O - Pre-operative assessment patient survey	This project was undertaken to provide evidence as part of the Anaesthesia Clinical Services Accreditation process. Over a 2 week period patients in both Southport and Ormskirk Hospitals were asked to complete the survey. The responses indicated patients were very satisfied with the care they were provided before their operation.
S&O Audit of Obstetric Anaesthetic Documentation	This project was requested as part of the Ockenden action plan and looked at documentation of anaesthetic charts used for maternity patients. The audit found that 61% of documentation standards were fully met. Improvement areas have been shared with the anaesethetic team. Improvement areas have been shared with the anaesthetic team and it has been agreed to audit more regularly to driving improvement.
Burns & Plastics	
STHK - Hidradenitis Suppuritiva (HS) – A single surgeon experience	The audit found minimal recurrence rate and good outcome in surgical group of graft and flap reconstruction. only 50% underwent medical treatment. The following actions have been implemented: • A dedicated multidisciplinary (MDT) HS service • Involvement of dermatologists in the service
STHK - Improving Adherence to deep inferior epigastric perforators (DIEP) Protocol using Standardised Ward Round Entry Stickers	A re-audit was carried out from 18th May 2023 to 1st July 2023 reviewing implemented changes from initial audit (presented in May 2023) following revisions to the ward round sticker after feedback from nursing staff and clinicians. Compliance for prescribing prophylactic enoxaparin for patients with body mass index >30 and for those receiving neoadjuvant chemotherapy increased from 48% to 100% in the re-audit after implementing key recommendations. Compliance for prescribing postoperative antibiotics increased from 61% to 73% in the re-audit after implementing key recommendations.

Audit Title	Outcome/actions
STHK - Holistic Therapy Service evaluation survey	The survey found: • Positive that great satisfaction to service provided • Positive benefits to patients
STHK - Measuring the data completeness of burns admission pro formas	Successful measurement of data completeness of burns pro forma. Suggested changes made to improve the data completeness of burns pro forma to improve data submitted for the national audits and increase sample size within the unit. Actions: • Daily reviews of the pro forma to ensure completed • Dissemination of information at junior doctor inductions for every new group • In version 4.3 a column for N/A criteria to be included, to improve the accuracy of future improvement – such as inhalational injury or urinary catheter • A re-audit will be conducted in future to assess any improvements following actions of this audit
STHK - Assessment of adherence in skin cancer operation notes	The audit noted improved compliance in certain areas of the new pro forma. Actions: • Pro forma layout will be amended to encourage increased compliance.
Critical Care	
STHK - Critical Care Record Keeping Q1 2023-24	Overall 70% of standards met. Actions: • Ward clerks ensure adequate labels. • All staff to ensure stickers of patient ID on each sheet • Reminder to all staff of standards given
S&O - regional quality standards audit	Participation in regional quality standards audit which looks at various aspects of critical care. We have developed a local patient and relative feedback via QR code to encourage feedback.
Dermatology	
STHK - Regional Audit of Janus Kinase (JAK) Inhibitor Use	All patients treated with a JAK inhibitor drug were previously trialled on a systemic agent as dictated by guidelines. More than 90% of patients had baseline investigations done. There are no guidelines regarding frequency of monitoring – despite this most patients were regularly monitored when on JAK inhibitor. Actions: • Improve the performance of baseline and 16 week Dermatology Life Quality Index (DLQI) and Eczema Area and Severity Index (EASI) scoring • Consider stopping JAK inhibitor if inadequate response at 16 weeks. • Ensure lipid and TB screening done for all patients for initiation of a JAK inhibitor. • Improve counselling regarding possible adverse events such as clots, stroke, smoking, diverticulitis.

Audit Title	Outcome/actions
Emergency Department (ED)	
STHK - Direct referral to Surgical Assessment Unit (SAU) for stable abscess patients	Planned/Completed Actions: • Direct referral pathway from ED triage nurse to SAU created completed • Use Careflow for out of hours referral so the list can be picked up by the SAU coordinator in the morning
STHK - Head Injury Advice QIP	• Identified that all patients presenting with head injuries who met the audit inclusion criteria were appropriately receiving safety netting advice from clinicians • After message of the week teaching, identified that a greater proportion of patients presenting with head injuries who met the audit inclusion criteria, received head injury leaflet advice and verbally told to avoid sport • Identified current gap in advice given upon discharge to younger patients specifically presenting with head injuries from sport • No specific gradual return to play advice available to give to paediatric patients by clinicians on discharge Actions: • Current paediatric head injury advice leaflet/adult head injury advice leaflet to be updated to contain information on a gradual return to play as per new guidance.
STHK - QIP: Review of Patients in ED: Suspected Cauda Equina Pathway	Between May-June 2023 114 Patients returned to same day emergency care (SDEC) after lumbar magnetic resonance imaging (MRI) scan 20% of MRI scans requested to exclude ?Cauda equina were deemed inappropriate as per national guidance. Resulting in patients re-attending the ED to be reviewed with their scan results. Actions: • Aim is to reduce the number of inappropriate scans – which in turn will reduce the numbers of re-visits to ED for review • Posters will be placed in the SDEC area of the ED displaying the results of the audit and will serve as a prompt/reminder to only request appropriate scans. It will also display where the national guidance on Cauda equina can be found for reference • Results of the audit will also be discussed at doctors handover by the ED consultants as a “learning point” and part of the “message of the week”. • Re-audit planned for Feb 2024.
STHK - Open fracture management in the ED	The audit found some areas for improvement. Actions: • Education for clinical and nursing staff re importance of prompt antibiotic administration • Clear antibiotic guidance as part of open # pro forma • Area to document neurovascular status in new open # pro forma • Reminder on open # pro forma to upload photography
S&O – The management of paracetamol overdose	Audit of newly introduced pathway for the management of paracetamol overdose. The audit found that some areas of the

Audit Title	Outcome/actions
in the ED	pathway had improved including prescribing NAC on the pathway prescription chart and the of prescribing N-acetylcysteince accurately. Improvements required have been shared with the department.
S&O – Management of Deep Vein Thrombosis (DVT) in acute care	Audit aimed to see whether Southport ED department were diagnosing and managing lower limb DVTs in line with local guidelines that are based on NICE guidelines. The audit demonstrated an improvement in practice from the previous audit. The one area requiring improvement was ensuring the patient had an ultrasound on the same day.
S&O – Audits linking to the Trust's quality priorities	There are 3 audit projects which link to the Trust's quality priorities looking at patients who wait more than 15 minutes for triage and their monitoring, completion of nursing risk assessments in ED and the escalation of patients who have an early warning score of 5 or above. The results of these projects are fed back monthly to the quality improvement group.
Ear, Nose and Throat (ENT)	
STHK - ENT Record Keeping Q2 23/24	79% of the standards met fully. Actions: • All ENT staff reminded to make a conscious effort to improve and make sure all standards are met. • Social history is applicable to only ward emergency in patient admission. ENT Patients are largely day case surgery/surgical patients admitted from clinic.
General Medicine	
STHK - DVT prophylaxis in patients diagnosed with Stroke	Actions: • Discussion of Venous thromboembolism (VTE) and intermittent pneumatic compression have been held at every huddle on ward 5C • Poster created inside huddle room as a reminder regarding intermittent pneumatic compression • Information provided to ward juniors about VTE prophylaxis in stroke patients • Stroke nurses have an assigned VTE champion • National clinical stroke guidelines 2023 is out and this is being followed for VTE prophylaxis The second audit cycle shows improvement.
STHK - Audit of early lactate levels monitoring in adult patients with sepsis	Planned Actions • New guidelines provided • Re-education and training for staff on the sepsis pathway • Re-iterate the importance of early intervention and management repeat lactates and early referral to critical care • Promote the role of the sepsis nurse specialist
STHK - VTE Assessment	Interventions carried out prior to second cycle helped achieve a 2% improvement in the study. Actions recommended: • Parent admitting ward should perform VTE risk assessment before transferring to another ward • Education/teaching sessions about VTE risk assessment in ward

Audit Title	Outcome/actions
	• Work with IT to implement VTE risk assessment pro forma in ED • Time of starting prophylaxis and filling up of risk assessment pro forma should be at the same time
STHK - From seen to scan: Time taken for patients presenting with a transient ischaemic attack (TIA) to have a Carotid Doppler +/- endarterectomy	The audit noted a fairly high percentage of patients received a carotid doppler within 24 hours of specialist assessment in TIA clinic 68%. Currently adhering to the best practice standard of ensuring that patients with suspected TIAs receive their carotid doppler scans within a 36-hour timeframe. High number of inappropriate referrals found. Actions completed: • Findings presented to stroke governance meeting for action • The stroke team will screen the referrals prior to TIA clinic to increase TIA clinic being utilised appropriately
STHK - Optimisation of fluid prescribing QIP (2nd cycle)	Documentation to prescribe intravenous (IV) fluids, fluid status of patient and fluid balance in last 24 hours have all improved since the first cycle. Actions: • Good documentation practice reiterated • Fluid balance recording has improved significantly - to continue improvement, it needs to be easily accessible to doctors - ensure access is shown during induction period and that it can be seen on Careflow vitals
STHK - Intermittent pneumatic compression stocking compliance in stroke patients (re-audit 3rd cycle)	Overall compliance of using intermittent pneumatic compression as VTE prophylaxis in stroke patients has improved from 24% to 86% in 3 years. Further actions: • Trial of putting intermittent pneumatic compression paper checklist in patient admission packs/or in with the devices themselves • Further staff education on wards on importance of thrice daily intermittent pneumatic compression checks and ensure documentation on both ePMA and intermittent pneumatic compression charts reflects this • Clinicians to prescribe intermittent pneumatic compression four times daily to prompt nursing staff to correctly chart intermittent pneumatic compression status on ePMA
STHK - Review of deaths on Ward 2A: a Quality Improvement Project (QIP)	The audit notes some high percentages of compliance against the areas audits. Actions/recommendations: • The results have been shared with Specialist Palliative Care Team • All patients who are recognised as dying should have their care supported with the individual care and communication record (ICCR) • 100% of patients should have had discussions around prognosis/deterioration • Specialist Palliative Care Team to be involved in haematology MDT if possible • Ensure documentation regarding choice to continue active

Audit Title	Outcome/actions
	treatment where this is appropriate to ensure personalised care
S&O – Retinal monitoring for hydroxychloroquine in rheumatology patients at Southport Hospital	Hydroxychloroquine has been used widely for the treatment of several rheumatologic conditions, including systemic lupus erythematosus and rheumatoid arthritis. One of the adverse effects of hydroxychloroquine treatment includes toxic retinopathy leading to irreversible vision loss. Aim: To identify prevalence of all patients on hydroxychloroquine for 5 years or more for rheumatological problems who have been referred for ophthalmology review for retinal toxicity. Recommendations • Mindful documentation of the duration of hydroxychloroquine treatment (with specific mention of the year and month of starting this) and the hydroxychloroquine related risk factors for retinal toxicity by rheumatology care providers during patient visits. • For hydroxychloroquine patients undergoing eye screening outside the Southport hospital system, requesting the results of the relevant report from the ophthalmologist and updating the results in the patient notes.
S&O – Audit of keep me here form	The keep me here form is an electronic form which has been introduced by the dementia team with the purpose of ensuring that once the form has been introduced this group of patients should not be moved from their current ward unless clinically necessary. This audit indicated that 98% of patients audited with dementia/delirium and having a keep me here form had no unnecessary ward moves.
AMU (Acute Medical Unit)	
STHK - Fundoscopy on Acute Medical Unit (AMU)	Useful feedback from staff regarding barriers to performing fundoscopy. Positive experience of trial of new fundoscopy equipment on AMU – good staff engagement with project. Actions: • Teaching on AMU • Papilloedema pathway • Procurement of new digital ophthalmoscope • Supply of tropicamide drops now on AMU
General Medicine - Cardiology	
STHK - Recognition and treatment of iron deficiency anaemia in chronic heart failure patients	The audit found further improvements needed in the reviewed areas. Actions Completed: • Posters containing the guidelines for iron studies and IV Iron Therapy have been displayed on the wards
STHK - Recognition and treatment of iron deficiency anaemia (IDA) in chronic heart failure patients (re-audit)	Significant improvements were demonstrated compared to the previous audit in testing for IDA and patients recognised to have IDA treated appropriately with IV iron therapy. Recommendation of testing for IDA incorporated into existing Heart Failure Protocol. Poster implemented to increase compliance of both testing and

Audit Title	Outcome/actions
	treatment of IDA.
STHK – computerised tomography (CT) coronary angiogram completion calcium score and completion stratified for age	Actions Implemented: • Controlling heart rate before the scan. Heart rate to be included in the request form • Clinicians to consider if coronary stent is present at the time of request. This has now been added to the request form. These changes are now a mandatory part of the electronic request form and must be completed to proceed with the request.
General Medicine – Endocrinology/Diabetes	
STHK - Optimization of IV fluid prescribing	Audit findings shared and further education delivered to the team.
STHK - Daily dynamic discharge planning facilitating early ward discharge	• A discharge coordinator on Ward 3C reduced the number of delayed discharges due to social issues from 59.1% to 29.4% • Improved MDT approach and board round meetings led to an improvement in Occupational Therapist/Physio Therapist related delayed admissions from 31.8 to 5.9% • Overall, the number of delayed discharges reduced from 22 to 17 following the implementation of actions from the first audit cycle. Actions recommended: • Creation of a delayed discharge pro forma for completion by Ward 3C discharge co-ordinator to reduce missing information. • The delayed discharge pro forma to include a section of “Did the To Take Out (TTO) medications delay the discharge?” in order to audit this information accurately in the next cycle • Re-audit for cycle 3 following implementation of the delayed discharge pro forma and increased awareness at board rounds
STHK - Monitoring, management and follow-up of steroid-induced hyperglycaemia in the inpatient setting	Planned Actions: • Present the guidelines to the respiratory team (doctors, nurses and pharmacists). • Present the findings of audit cycle 3 and reinforce the guidelines to the staff on ward 2A • Hold a brief teaching session for junior doctors • Raise awareness about the need for emergency steroid cards amongst doctors and the pharmacy team • inform the staff of 2A, 2B and 2C regarding the need for patients to be followed up by their GP if identified with steroid induced diabetes
STHK - Management of adult inpatient hypernatraemia	Completed/ongoing actions: • Promote early referral to the dietetics inpatient team for clinical management of patients requiring nasogastric (NG) feeding • Agree, finalise and disseminate the inpatient hypernatremia guidelines • Promote timely monitoring of NG fed inpatients • Education and review of audit findings to dieticians and inpatient diabetes nurse specialists on clinical criteria for

Audit Title	Outcome/actions
	hyperosmolar hyperglycaemic state (HHS) • New United States/European guidelines on management of HHS which were presented at the European Association for Study of Diabetes meeting in Hamburg (Oct 2023) These will be published imminently in Diabetologia and will inform revision to the MWL adult diabetes guidelines held on the Trust website • The dietetics team have undertaken to use outcomes from this audit to update their education content and improve fluid and electrolyte monitoring and management of inpatients, particularly in the frail and elderly during NG feeding
STHK - Insulin incidents prior to the use of the Insulin Safety Medicine Binder: a QIP	Actions completed: • Binder was promoted during Nurses Day and Insulin Safety week (May 23). It will continue to be promoted as part of staff teaching. • To undertake a project reviewing meal times and insulin administration on a sample of 7 wards to identify any trends (May 23).
Respiratory Medicine	
STHK - Audit of oxygen prescription & national early warning score (NEWS) record across respiratory wards	Oxygen delivery record on NEWS charts corresponds with clinical use in over 80% of patients across respiratory wards. When oxygen is prescribed on ePMA, target saturation prescription corresponds clinically in 92.9% (this is close to British Thoracic Society (BTS) recommendation of 95%). Documentation of target saturation in clinical notes improved following quality improvement intervention. Planned actions: • Re- education of respiratory medical team with regards to importance of oxygen prescription • Discussion with pharmacy/IT teams with regards to enhancing oxygen prescription systems • Educational sessions for nursing staff, with regards to importance of accurate recording of oxygen use on NEWS charts. • Re-audit of NEWS chart record of oxygen delivery following these actions.
STHK - Chest drain insertion	Completed actions: • Project findings and new pro forma presented to ED continuing professional development (CPD) meeting and to be available in Resus • Pro forma amended as per recommendations – new boxes for drain type and method of securing uploaded to Trust intranet for use • Medical registrars and juniors informed of pro forma • AMU department presentation given to juniors
Biochemistry and Immunology	
STHK - Reviewing serum free light chains (SFLCs) – following test repatriation and replacement of urine	The audit showed: • Overall the improved Thrombin-Antithrobin Complex (TAT) following repatriation of the test is significant. Reduction from an average TAT of 19 days to <1 day. It has permitted cases of early identification of monoclonal gammopathies,

Audit Title	Outcome/actions
Bence Jones protein (BJP) TAT = Thrombin-Antithrobin Complex- It is a marker of net activation of coagulation.	particularly in primary care and inpatient settings, leading to prompt and timely referral to Clinical Haematology and treatment where appropriate. • Increase in SFLC requests from primary care and out-patient departments in line with guideline recommendations • Reduction in number of BJP from primary care in line with guideline recommendations • Evidence to support the movement towards including SFLC in 'myeloma screen' and 'myeloma monitoring' care sets in line with guideline recommendations Actions: • Investigate number of SFLC requests not done due to minimum retesting interval and identify any trends in requestors • Discuss findings of audit with Preston Immunology clinical team. Identify how samples were transported, stored and analysed as a sampling exercise if required • Clarify if internal validation of sample stability different from inclusion forming unit exists
Community – Cardiac Nursing	
STHK - Secondary prevention after a myocardial infarction	Most patients have an assessment with a cardiac nurse within 10 days of discharge as per NICE guidance. All patients who are offered cardiac rehabilitation are offered a choice of rehab settings for the exercise component depending on their ability as per NICE guidance. Some patients were not fully titrated within NICE guidance time scale and were not offered an assessment by the community cardiac nurses outside of normal working hours Actions: • Nurses to undertake the nurse prescribing course if there is available funding • The service will consider the benefits of working outside of normal working hours between 8am-17.30 for phone assessments
Haematology	
STHK - Investigation of underlying causes in patients with a multiple transfusion request	100% of patients had their full blood count (FBC) checked before having blood transfusion. Further improvements needed. Actions: • Presented transfusion teaching/ findings to incoming junior doctors at their induction who mostly request blood units.
S&O – The use of prothrombin complex concentrate (PCC)	PCC is the recommended treatment for major bleeding in patients taking oral anticoagulants such as warfarin, apixaban, edoxaban and dabigatran. Its effectiveness is dependent on timely administration. Delays to treatment beyond one hour are common and adversely affect outcomes. • This audit found that 3/5 standards achieved above 90% compliance. The main areas requiring improvement are ensuring the PCC is given within an hour and that the traceability is completed fully.

Audit Title	Outcome/actions
S&O – Audit of transfusion authorisation record (TAR) sheet/bedside audit	This audit aimed to monitor blood collection and administration in a ward setting including completion of the TAR sheet to ensure patient safety during a blood transfusion. 80% of standards in this audit achieved our target giving the project significant assurance.
Histopathology	
STHK - Audit of Renal Cell Carcinoma Specimens during a 3-year period (2017-2019) at Whiston Hospital	Actions: • Turnaround time improvement - When a surgical specimen arrives in the lab, a member of the uropathology team should be immediately informed in order to assign/allocate the case for cut up-diagnosis. • Use of immunohistochemistry for renal tumours - A panel of immunohistochemistry corresponding to the histological appearances/differential diagnosis has been proposed and circulated
STHK - Audit of NICE recommendations: Assessment of compliance for MMR testing in colorectal cancer MMR = Mismatch Repair	Successful audit now completed as per guidelines. We are adequately assessing MMR status. 100% MLH-1 (MMR subtype) is being appropriately referred for further investigations. Actions: • 26% not assessed on index biopsy. Have switched to in-house testing, re-education of reporting pathologists/dual-reporting with specialists
STHK - Cervical cancer reporting according to NHS Cervical Screening Programme (CSP) guidance and RCPath cancer dataset	Our Histology reports showed generally good compliance with NHS CSP guidance and RCPath cancer dataset. Findings have been shared with Pathologists/Gynaecology and Colposcopy staff to further improve results in areas requiring it.
STHK - Audit and reaudit of cervical loop biopsies for Warrington colposcopy service	90% of loops were in 1 piece (adheres to NHS screening programme guidance for loop biopsy specimens of a target of 80%). Clinical details included in 100% of cases Stating type of transformation zone is improving – needs further improvement Actions: • Results shared and updates given. Re-audit planned in 12 months (August 2024) to check improvements have been embedded
General Surgery	
STHK - eVTE, VTE Prophylaxis & Medication Reconciliation Evaluation	Actions planned: • Paper eVTE assessments implemented in ED, plan to extend electronic eVTE assessment in ED • Staff made aware of requirements of assessment and safe prescription/omission
STHK - Complication rates post breast surgery	Low rate of complications requiring admission or operation Significant expected outcomes such as seroma Identified a need to ensure regular review of complications.

Audit Title	Outcome/actions
	Actions: • Patients to be counselled that seroma are expected outcomes not a complication by Breast Care Nurse on consent form • Adverse outcomes to be monitored in prospective database • Discuss all complications in breast specific morbidity meeting • Obtain Copelands Risk Adjusted Barometer (CRAB) data for breast unit compared to surrounding hospitals.
STHK - Creating general surgery consent forms to standardise the consenting process	Actions planned to improve documentation: • Create pre-filled consent forms with the risks for the 4 surgical procedures reviewed in the audit (action approved by the Trust Consent lead) • Compile a standardised list of risks for each procedure, to include in the pre-filled consent forms
STHK - Review of practice: endoscopic inguinal hernia repair	The audit met the relevant NICE standards of care. No actions needed.
STHK - General Surgery Record Keeping Q1& Q2 23/24	60% of the standards fully met Actions: • Time to be given on ward rounds to ensure that criteria is met • Additional patient labels to be placed in the medical notes to aid completion • Checks on completion of documentation to be completed during the ward round • Trust Record Keeping Policy (for clinical records) to be shared with all staff • Approved list of abbreviations to be discussed within the care group and made available for reference. • Ad hoc checks/audits on discharge/transfer checklist and alterations completion
S&O – TTO and discharge summary	• Discharge summaries are important medical records that summarise a patient's hospital admission, for the benefit of both the general practitioner (GP) and the patient • Poorly completed discharge summaries can negatively impact on the quality of clinical care provided, the safe transfer of care to the community, as well as patient safety and experience • TTO acts as a prescription to order the drugs they need to take home with them • This audit indicated the compliance was overall good with improvements required in documenting the discharge team and any medication change with rationale.
S&O – Limiting overnight stay	The project looked at same day discharge following surgery with the target of 75% of elective hernia surgery being performed as day cases. The audit found that 40% our patients were staying overnight and the audit looked at possible reasons for this. Reasons for overnight stay included urinary retention, surgical complication, social issues and patient preference. The actions for this audit include ensuring it is clear at booking whether the patient is suitable for same day surgery, for example do they someone at home when they are discharged. It is

Audit Title	Outcome/actions
	important to identify social reasons before the operation.
Obstetrics & Gynaecology	
STHK - An audit to evidence women's choices following a shared and informed decision-making process	Actions: • Since February 2022 – membrane sweeping has been introduced from 39 weeks gestation, this can reduce the need for induction of labour • The use of Propess instead of Prostaglandin gel requiring less vaginal examinations. Can remain in situ for 24 hours or longer up to 30 hours under specific circumstances • Use of a balloon catheter as an option instead of prostaglandins • Bleep-holder paperwork completed to note delays in transfer to Delivery Suite and action taken to reduce this happening • Audit of pain relief in labour particularly re-siting of epidurals to be commenced to assess effectiveness, response times etc. • Audit comparing induction of labour methods
STHK - Management of shoulder dystocia: reaudit to check compliance with S004 BPI =brachial plexus injury	Improvement in cord blood gases documentation in comparison with the last audit. No cases of BPI cases (improvement compared to last audit) Good overall completion of shoulder dystocia checklist Overall appropriate clinical management in all shoulder dystocia cases. Some further improvements needed. Actions: • Incorporate debrief in daily postnatal rounds by 1st on call/ registrar on call- to be documented in doctor's postnatal checklist • Clear documentation of Datix on Careflow - circulate reminders regarding documentation of discussions in the notes.
STHK - OASI – Management and follow up OASI = Obstetric Anal Sphincter Injury	OASI – incidence = 2.6% (below national average) Initiation of current OASi pathway = 84% Laxatives, Antibiotics and physiotherapy = >90% initiation rate 100% repaired in theatre by appropriately qualified operator (or supervised properly by someone trained) Actions: • Establish dedicated OASI clinic • Education re documentation (ongoing)
STHK - Use of Cooks Catheter for induction of labour in patients with a previous C Section	Standards regarding indication, fetal monitoring and duration of cervical ripening balloon (CRB) in situ met Largely appropriate reasons for induction Actions: • Ensure medical staff and midwifery staff are documenting mechanical induction when patients are attending for Cooks Catheter on Labour ward • Improve counselling for vaginal birth after caesarean (VBAC) patients regarding induction if previous section was for failure to progress and success rates • Use induction diary to trace all patients who attended for Cooks Catheter on Delivery Suite and re-audit data for 2023

Audit Title	Outcome/actions
STHK - Fetal Growth Restriction (FGR) Audit: Maternity Incentive Scheme – Year 5 – Element Two GAP = Growth Assessment Protocol ANC = Antenatal Clinic	100% compliance met for: • High risk women had a doppler requested for 22-24 weeks gestation • Assessment for FGR at booking • Assessment for aspirin at booking • Had a growth chart generated Further improvements needed: assessment for FGR and aspirin at 16 weeks. Actions: • Completing and documenting the GAP and aspirin risk assessments at booking and 16 weeks has been reiterated via Quality and Safety newsletter and staff safety huddle • Reminder “pop-up” to be setup on Medway system • Practice educator midwife to add to the learning from audit on the midwifery study day • Meeting with ANC and community managers to address improvements in women attending for 15-16 week antenatal assessments • Further re-audit planned
STHK - Audit of electrical fetal monitoring and intermittent auscultation	Documentation at the beginning of the trace has improved and maintained 100% compliance since June. Fresh eyes stickers were updated and changed to accommodate the new NICE guidance released, following this change compliance within audit has improved Actions: • Emails sent to relevant staff members with results of the audit • Global email sent to all staff via fetal surveillance monthly update with themes from the audit
STHK - Stillbirth audit 2022	100% of cases had a Datix and had a full review. 85% attended for a consultant debrief. All patients had contact for follow up care. • Training for post mortem - consultants and obstetricians to attend annual update • All staff to encourage uptake of smoking cessation services with pregnant women
S&O – Induction of labour for reduced fetal movements	This audit was undertaken to provide evidence for Ormskirk Hospital’s Saving Babies Lives 3 assessment. The audit was undertaken to ensure appropriate use of induction of labour and that reduced fetal movements should not be the only indication for induction prior to 39 weeks. 100% compliance was achieved with the audit as all of the cases audited had another reason documented for induction of labour and reduced fetal movements was not the sole reason. Supplementary reasons included fetal growth restriction, social concerns, epilepsy and unstable lie.
S&O – Audit of consultant attendance in line with Royal College of Obstetricians and Gynaecologists (RCOG) roles and responsibilities.	This audit was undertaken to ensure a consultant is present in all the situations recommended by the RCOG including complex caesarean sections, twin delivery and breech deliveries. The audit found that in all cases apart from 2 a consultant was present and the 2 cases had a clear reason. Case 1 the patient had an undiagnosed breech delivery and Case 2 a senior doctor

Audit Title	Outcome/actions
	discussed the case with the consultant. This audit will be repeated to ensure continued compliance with the standard.
S&O – Review of WHO safety checklist	The Surgical Safety Checklist is a simple tool designed to improve communication and teamwork by bringing together the surgeons, anaesthesia providers and nurses involved in care to confirm that critical safety measures are performed before, during and after an operation. The results of this audit demonstrated significant assurance and the main area requiring improvement which was time out of surgery was presented at the joint obstetric anaesthetic audit meeting to improve dissemination of information to all team members.
S&O – Audit of antenatal obstetric documentation	Undertaken regularly to provide assurance that a complete and comprehensive obstetric review has taken place and that the documentation reflects that. The most recent audit demonstrated a good level of documentation with it being clear what grade of doctor was writing the entry, diagnosis and management plan with clear evidence of actions required. The improvement for this project Is to ensure the entry is in Situation, Background, Assessment, Recommendation format (SBAR).
Orthopaedics	
STHK - Reliability of ultrasound in diagnosing acute extensor tendon injuries of knee	The audit found that the ultrasound group had a higher discrepancy from the intraoperative findings, 48.9% compared to MRI group of 13.8%. Therefore, MRI scan is now recommended to diagnose acute extensor tendon injuries of knee.
STHK - Tranexamic acid in primary joint arthroplasty surgeries: hip, knee	The audit showed 70% compliance with NICE guideline. Actions: Surgeons to check with Anaesthetist while doing World Health Organisation (WHO) checklist in theatre if tranexamic acid is given. Re-audit recommended
STHK - Orthopaedics - Annual Consent Audit 1st cycle & 2nd Cycle	The audit showed some good documentation practice. Further improvements are needed: Actions Planned: • Ward staff to ensure there are adequate stickers in patient file • Educate our team and patients – with e-learning and increasing awareness at induction 2nd cycle Stickers are informative, easy to use and safe. Stickers significantly improve our consent compliance. Use of stickers continues to be encouraged.
STHK - Consent 4 audit	The audit found some good documentation reaching 100%. There are still some improvements needed. Actions: • Explain importance of documentation of capacity assessments, not just the final decision with trainees. • Education regarding Independent Mental Capacity Advocate (IMCA) warranted • Direct trainees to the Trauma and Orthopaedic Trello page, where consenting is covered and details of how to fill out consent 4 forms.

Audit Title	Outcome/actions
	• Also ensure each trainee goes through how to consent and fill out consent forms including the consent 4 forms with their clinical supervisor at the start of the posting.
STHK - Orthopaedic VTE assessment and prescription audit cycle 2	To increase compliance suggest actions: • Move the eVTE to ePMA and make it mandatory • eVTE form could be modified to give message to clinicians to now prescribe any thromboprophylaxis (pharmacological or mechanical) once they have been completed. Can advise to prescribe and withhold if not appropriate to be given yet (e.g. planned surgery) • Expanding the ward dashboard used by pharmacists to include a column on whether the eVTE assessment has been completed or not
STHK - A Retrospective study on acromioclavicular joint reconstruction using LockDown™ technique	Completed Actions: While taking the consent for fixation of acromioclavicular joint disruptions. The results of this survey are communicated to the patients for a better-informed decision. This has been included in the discussions since May 2023
STHK - Documentation of neurovascular assessment in supracondylar humerus fractures	Pre-operative documentation of neurovascular status was found to be satisfactory. Further improvements are needed in post-operative documentation. Actions: • Use of a suggested pro forma for completion to improve standards
STHK - Assessment and management of osteoporosis and prevention of fragility fractures FRAX = Fracture Risk Assessment Tool	The audit showed improvements between the 1st and 2nd cycles in the following areas: • FRAX score documentation • Vitamin D blood testing • More patients considered for bisphosphonate treatment • Replacement of calcium and vitamin D has improved for patients that require this
Palliative Care	
STHK - Mouth care at the end of life (dying patient)	Spot check audit, following the findings of the same audit undertaken in 2022, shows evidence that mouth care is taking place for this vulnerable group. Ward doctors are now starting to prescribe products to support mouthcare. Junior doctors supported this audit and have developed their own knowledge, presented to junior doctors with positive feedback. Actions: • ICCR allows for all staff to have guidance on mouth care and provides provision for documentation (especially HCAs) • Communication with family and ward staff on the importance of mouth care plan • Frequency, equipment, medications, who can provide mouthcare • Champions in education programme should be used as an intervention to measure improvement in undertaking and

Audit Title	Outcome/actions
	documenting mouth care over a set time period for all staff • Tooth brushes should be used • Audit recommended annually
Paediatrics	
STHK - Retrospective review of the Paediatric High Dependency Unit	Actions: to update the Trust's local guideline for admission to the paediatric High Department Unit to reflect the national guideline
STHK - Annual Paediatric record keeping audits 2022-23	Some good results noted throughout the year with record keeping standards met in most cases. Actions: • Results shared with team at the Trust Quality Improvement Audit Meeting • Emails sent to all staff and discussed in safety huddles to remind clinicians of all the key record keeping standards
STHK - Paediatric Record Keeping Q2 2023-24	24/30 standards met Improvement across all documentation since last quarter Actions: • Reminder of the criteria for making corrections and other key record keeping standards where gaps were noted • Suggestion to obtain name stamps • Paediatrics label request made to ED to provide more labels at source to aid compliance
STHK - Prescription / Kardex audit	Some good results were noted from the Audit. Actions: recommendations were disseminated to relevant staff as appropriate and discussed in the clinical governance meeting, including appropriate recording of weight, discontinued medication and ensuring oxygen and sodium chloride are signed.
STHK - Audit of Completion of Child Exploitation (CE) Screening Tools October 2022	Actions completed: • Paeds ED now complete their own internal audit to provide assurance of the completion/quality of CE tools. This is completed via Tendable • All findings from the 2022 CE tool audit have been shared with the appropriate professionals during Safeguarding Assurance Group meetings • Training is delivered on a continual basis from the Safeguarding Children's Team to both Adult and Paediatric EDs
STHK - Neonatal cranial ultrasound scanning in Whiston Hospital	The audit found some standards met 100%, including if periventricular flare is found, ultrasound scan should be repeated in 2 weeks or prior to discharge and ultrasounds appropriately requested for babies with congenital abnormalities. Further improvements needed. Actions: • To adopt local tertiary guideline – Liverpool Women's Hospital cranial ultrasound policy • Disseminate this new cranial ultrasound policy to Radiology colleagues • Re-audit in 2024
S&O –14 hour consultant	We are very proud to have this project accepted as a poster at a

Audit Title	Outcome/actions
review project	national clinical audit conference due to the improvement in practice which has been made. The audit is undertaken regularly to monitor improvement against the national standard of ensuring all patients are reviewed by a consultant within 14 hours of admission to hospital.
S&O – regular casualty card audit	Every month 10 ED casualty card are audited to measure compliance with documentation. The results are then fed back to the paediatric team and via the paediatric clinical audit meeting where areas for improvement are highlighted. By undertaken regular audits we have been able to monitor performance and give timely feedback which has resulted in improved documentation.
S&O – audit of documentation of support for parents during neonatal resuscitation	This audit measured against national standards and demonstrated an improvement from 53.7% to 91% of families being updated in delivery suite and discussion documented around resuscitation. Going forward we will reaudit and emphasise the importance of documenting the communication with patients in the delivery room.
Pharmacy	
STHK - To what extend is the new Trust 'safe dosing of paracetamol in adults' being followed on Acute Medical Ward?	The audit showed some good adherence to the guidelines, further improvements needed: Actions: • Provide teaching on prescribing paracetamol in patients weighing <50kg, CrCl≤30ml/min and risk factors for hepatotoxicity to all doctors and non-medical prescribers on AMU • Educate nurses and HCAs to weigh patient upon admission and ensure it is priority like other clinical measures, to allow correct dose adjustments to be made • Cascade the audit findings to AMU pharmacist • Repeated audit after 6 months
S&O – will add the controlled drugs audit	This audit is undertaken regularly and looks at the safe and secure handling of medicines on Southport and Ormskirk inpatient wards. A number of standards are measured including keys being held by an authorised nurse and stock being in date. The audit demonstrated full compliance and the results were discussed at the Medicines Safety Group and the Controlled Drugs Oversight Group. Ward compliance is now sent to each area to ensure local review of the results. Training on controlled drugs is also provided by pharmacy for all clinical staff within the medicines management training which is now mandatory for any new starters within the Trust.
S&O – critical medications audit	Audit was undertaken to provide an update on the Trust's position in terms of missed prescribing and administration for critical medications. Critical medications are those that should not be omitted or delayed including anticoagulants, insulin, opioids and antiepileptics.

Audit Title	Outcome/actions
	A working group was established to review the results of this audit to ensure any improvements identified were made. Actions include undertaking regular audits to ensure continued focus on critical medications along with immediate feedback to clinical staff from the pharmacy team when any issues with prescribing or administration of critical medications where identified.
S&O – pharmacy in-patient satisfaction survey	This project sought the opinions of patients regarding the inpatient pharmacy service to improve the service using feedback given by patients. 90% of patients questioned reporting seeing a pharmacist within the first 24 hours of their admission. At the end of the questionnaire individuals were asked to rate pharmacy services and 100% of feedback stated the pharmacy team were friendly and polite. The actions from this project to improve the pharmacy service include staff from the team introducing themselves clearly stating their name and job role and explaining the difference between a pharmacist and a pharmacy technician.
Quality Improvement & Clinical Audit	
STHK - Delegated consent snapshot audit	Snapshot audit to assess if each department maintains a departmental consent register to ensure that the delegation of authorisation to take consent is kept up to date (as per the Trust's Consent Policy). The audit found of the 10 specialties contacted: 1 had a Delegated Consent register/database 'in progress' in their Specialty. Actions: • Report circulated to Clinical Directors/QI-Audit Facilitators with a copy of the Clinical Consent Policy for review and action • Medical Director discussed the issue with the Surgical Groups in the clinical areas • Chair recommended a re-audit to be undertaken in 12 months' time
A STHK - annual Trust Record Keeping programme 2022-23	Overall improvement from the previous audit year Actions completed: • Disseminated findings to Record Keeping Leads for them to share with staff in order to encourage improvement of standards • Continuing with the roll out of the annual record keeping programme for the 2023-24 speciality including 3 new specialities (Newton, Duffy and Seddon Suites) • Due to the expansion of the record keeping programme results will now be provided as a one-page quarterly overview summary and two full presentations per year per specialty. This has been well received and is working successfully.
Quality & Risk	
STHK - Mental Capacity Act (MCA) & Deprivation of Liberty (DoLS) Review	Increase in number of DoLS submitted and the number of Mental Capacity assessments submitted since Service Evaluation– indicates improved awareness from ward staff

Audit Title	Outcome/actions
	Actions: • 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 • Further audit to be completed in Q4 2023-24
Radiology	
STHK - Audit on retrieval rates for temporary IVC Filters at Whiston Hospital between 2012-2022	Audit results discussed and circulated to endure staff are aware of updated recommendations on retrieval aims. Plan: That there is a standardised way of generating a retrieval appointment to ensure we are aligning with the Food and Drug Administration (FDA) recommendations. To create a code on the radiology information system (CRIS) that will generate an appointment for filter retrieval within 29-54 day approved period, which will then be vetted by the IR consultants.
STHK - Audit of Giant Cell Arteritis Pathway in Radiology	The audit noted improvements needed in compliance with the Pathway. Actions: • Implement a specific electronic request form with yes or no answers to each risk factor and specified steroid use • Booking staff trained and flow chart implemented • Scanning and reporting protocol recirculated and standard conclusions recommended
Safeguarding	
STHK - Special Care Baby Unit (SCBU) liaison form compliance: Audit of SCBU Discharge Paediatric Liaison Forms SAG= Safeguarding Assurance Group	Actions Completed: • Audit findings shared within the Safeguarding and Liaison team and SAG meeting May 23 • Daily scrutiny of forms by liaison staff • Education sessions with SCBU staff delivered- Ongoing and joint sessions with safeguarding nurses booked with SCBU staff • Meet held with SCBU manager to identify any barriers to adequate completion and ways to improve form completion • New form has been created
S&O - restrictive practices for patients with learning disabilities	The aim of this audit was to gather evidence as to whether the guidelines in relation to restrictive practice for patients with a learning disability are being followed. The audit achieved significant assurance and the areas for improvement were highlighted. An action plan has been developed and is being monitored by the Safeguarding Team. One action which has been completed was to launch the Abbey Pain Scale within the organisation and continue to develop the use of it.
S&O –MCA and DoLS compliance	The project reported significant assurance when measuring compliance with patients on the Southport site against care and treatment for patients who lack capacity. This audit demonstrated improvement from a previous audit

Audit Title	Outcome/actions
	project and demonstrated staff were implementing and utilising DoLS appropriately.
Urology	
STHK - Urology record keeping quarterly audit 2022-23	The audit found some good standards of record keeping with compliance being met is several areas. Actions: • Further meetings held with urology registrars, nurses and ward sisters to discuss the audit findings with reminders about accurate record keeping including particular emphasis on key areas not meeting targets
STHK - Urology record keeping Q2 23/24	Noticeable improvement compared to Q1. Continue to emphasise the importance of accurate record keeping and the standards that need to be adhered to. • Consultant to flag at junior doctor surgical induction that all alterations should be crossed out with single lines, dates, timed and signed • Email to be distributed to current junior doctor cohort regarding the importance of documenting social and medical history for elective patients. • Email to be distributed to current junior doctor cohort and nursing staff recording the importance of completing the discharge checklist
STHK - An audit of patients who had a Trans Urethral Resection Bladder Tumour (TURBT) (May-Jul 2022)	Actions: • In line with Get It Right First Time (GIRFT) guidance all patients should be listed as day case for TURBT procedure • Work required to improve day case rate including patient and staff education
STHK - Exploring the perceived impact of postgraduate urology education in the workforce	Staff survey. This postgraduate course has made a positive impact on all the domains explored. Contributed to career progression, demonstrating a key role in facilitating postgraduate nurse training and development of nurse-led urology services.
STHK - Consent for elective urological procedures - what is the current state of play?	To further improve consenting practice the following actions were planned: • Disseminate Trust and Good Surgical Guidelines to all urology clinicians • Laminated flyer posted in all urology clinic rooms at St Helens and Whiston • TURBT/bladder biopsy consent training organised for nurses • A consent video is to be provided for use in the nurse led teaching • Re-audit planned
STHK - (Review of) Unnecessary admission out of hours in Urology	Improvements needed: Actions: • Urology Registrar to liaise with the surgical junior doctor before leaving the hospital at 5:00pm to ensure they are aware of where to locate guidelines and relevant pathways on trust intranet • Pathway development and published on Trust intranet
STHK - Audit of diagnostic and treatment	Significant number of patients referred through the stone pathway

Audit Title	Outcome/actions
pathway in suspected ureteric colic in adults	Increased utilisation of CT scan of kidney, ureter and bladder as the initial diagnostic modality for suspected stone patients Increased performance of serum urate and calcium for stone patients Actions: • Increase theatre space and make theatre 9 laser safe for primary ureteroscopy • Increase use of non-steroidal anti-inflammatory drugs as first line analgesic for suitable patients • Acute Stone Care pathway poster to be placed in relevant areas in ED • Imaging before clinic for patients on conservative care to speed up efficiency and the patient's pathway. • Implementation of a primary ureteroscopy pathway for hot renal stones
STHK - Urology: The timed prostate cancer pathway	Meeting national standards for prostate Faster Diagnosis Standard (FDS). Delays in histology occasionally impacting ability to meet FDS Actions: • Work with histology department on how the turnaround of tissue analysis can be improved
S&O –urology documentation audit	Project was undertaken to measure the quality of documentation within the Urology Team against national best practice guidance. The audit was presented at a urology clinical audit meeting and achieved significant assurance. The areas of good practice were discussed and the areas requiring improvement were highlighted with suggested actions being put in place. The plan is to audit regularly to monitor improvement.
S&O –audit of transurethral resection of the prostate (TURP) operation notes	This audit aimed to look at the documentation of TURP. As a result of the audit a dedicated pro forma for TURP operations was developed which is available either as a printed copy or via our electronic theatre. The pro forma contains all the information which should be documented when undertaking the procedure.

2.4.3. Participation in clinical research

In July 2023, St Helens and Knowsley Teaching Hospitals and Southport and Ormskirk NHS Trusts came together to form Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). Jointly we serve a population of over 600,000. By extending our population reach we aim to offer as many patients and staff as possible the opportunity to take part in research.

Our joint MWL Research Team:

Encouraging a research-positive culture in health and care organisations is important to give patients wider access to clinical research, improving patient care and treatment options[1]. MWL is committed to providing the best possible care to patients and acknowledges that research has been widely recognised as being an important factor in providing high quality care for healthcare organisations. Not only does organisational involvement in research improve clinical outcomes and service user satisfaction, but research-active organisations attract higher quality employees and have a better organisational culture.

The Lord O'Shaughnessy report[2], published in May 2023 was commissioned to offer recommendations on how commercial clinical trials can help the life sciences sector unlock UK health, growth and investment opportunities. At MWL we have worked hard to increase our Life Sciences (commercial) activity.

MWL Commercial study successes:

- 1st Global patient randomised to the RADIANT study:

The Paediatric Diabetes Team at Ormskirk Hospital with collaboration and support from the Whiston Paediatric Team were successful in recruiting the first global patient to the RADIANT Study, supporting treatment of type 1 diabetes. We have now recruited 6 children to the study and have met our contracted target.

Professor May Ng OBE stated, "I am immensely proud of our MWL team's exceptional efforts in recruiting the first global participant for the RADIANT international trial. The importance of research impact on patients' lives cannot be overstated, as it directly translates scientific advancements into tangible improvements in healthcare outcomes."

- Screened the 1st UK patient for the Anthem study:

The Gastroenterology team at Whiston Hospital screened the first patient to an important study looking at treatments for patients with moderately to severely active ulcerative colitis.

Dr Rajiv Chandy stated that, "MWL is widely known as a top tier commercial research unit in the IBD world. This in turn translates into good clinical care for all our patients. Recruitment has never been an issue thanks to our highly engaged patients."

- Dr Ascanio Tridente, Clinical Director for Research, at Whiston Hospital forged links with commercial companies which has led to an increase in the number of commercial studies open to recruitment. We are extremely pleased to have exceeded the recruitment target for the Tozorakimab in Patients Hospitalised for Viral Lung Infection Requiring Supplemental Oxygen (TILIA) study. The purpose of this international clinical study is to evaluate the effect of tozorakimab as an add-on to standard of care treatments in patients with viral lung infection requiring supplemental oxygen to prevent death or progression to Invasive Mechanical Ventilation or Extracorporeal Membrane Oxygenation

- The whole research team opened commercial studies swiftly and efficiently and received praise from the sponsors. During 2023-2024 we had 12 commercial studies open, compared to 9 last year.

- **Harmonie study**: This is a research study that looked at how strongly babies can be protected from serious illness due to Respiratory Syncytial Virus (RSV) infection by giving them a single dose of antibodies. The results were published in the New England Medical Journal 2023. Dr Rosaline Garr, Consultant in Paediatrics & Neonatal Medicine & Honorary Clinical Senior Lecturer, and colleagues from Whiston Hospital were one of 110 sites in the UK to run the Harmonie study, which involved vaccinating babies up to 12 months of age with a single dose of Nirsevimab and were acknowledged as one of the top recruiting sites in the North West. The results of the study, supported by the National Institute for Health and Care Research, showed a reduction in RSV-related hospitalisation by 83%, which is a fantastic result.

Dr Garr said, "We're very proud to say that we have been involved in a vital research study, with such great results. We see many babies admitted with RSV through the winter period, so this new vaccine is very much welcomed."

All our commercial studies were supported by our outstanding Chief and Principal Investigators, Research Nurses and support staff. This is a huge achievement for the research staff at MWL and has put us on the map both in the UK and internationally as a site with an excellent reputation for setting up and delivering commercial research.

Key Achievements in 2023-24

In October 2023 we were notified that we had been successful in securing National Institute for Health Research (NIHR) Infrastructure funding to further expand our dedicated clinic space at both the Whiston and Southport sites. Throughout 2023 we also secured Life Sciences funding to improve the delivery of NIHR commercially sponsored studies and capital funding for equipment to help with the delivery of research. Securing this additional funding will allow us to expand our research portfolio and ensure that our patients benefit from a welcoming and friendly dedicated research environment.

In total MWL staff have recruited over 4380 patients to research studies since the 1st April 2023, the highest recruitment in 5 years, which has placed us as the third top recruiter on the Clinical Research Network, North West Coast (CRN NWC) dashboard. This is an excellent achievement as we normally sit between 8th and 11th position. This is the result of a huge effort from all the staff within the Research, Development and Innovation (RDI) Department; it also demonstrates our commitment to offering patients and public the opportunity to take part in research.

The number of research studies open to recruitment at the Whiston and St Helens sites during 2023-24 was 76 compared to 90 in 2022-23. Although this is a decrease since last year there has been an increase in the proportion of commercial studies, which are complex and more labour intensive. Also, several studies that have been open for a long period of time closed to recruitment in 2023-2024. For the Southport and Ormskirk sites there was an increase in the number of studies open to recruitment, 49 in 2023-24 compared to 43 in the previous year.

MWL took part in the iGBS study which aims to help develop a vaccine against Group B Streptococcus infection in newborn babies. This is important because if effective this could be offered to pregnant women to protect their babies from this devastating disease. So far MWL have recruited over 2817 women to this study and the Whiston site have been recognised as the top recruiting Trust in the UK.

MWL were also the top recruiters in the UK to several other important research studies. This highlights all the hard work by our staff to ensure our patients are

offered access to the latest cutting-edge research.

Top Recruiting studies at MWL during 2023-24

Study	Speciality
Oxford Cognitive Screen - Visual Impairment adaptation	Ophthalmology
Visual scanning training for hemianopia (SEARCH)	Ophthalmology
Melanoma Wide Excision Trial - MelMarT-II	Cancer
Molecular Genetics of Adverse Drug Reactions (MOLGEN)	Genetics

It has been recognised that although the number of patients recruited to research studies is important, there is a shift towards ensuring that the Recruiting to Time and Target (RTT) metric is met. This is the number of clinical trials that meet the target recruitment before the closure of the study. In 2023-24, 96% (n23/24) for the Whiston and St Helens sites and 46% (n6/13) for the Southport and Ormskirk sites met the RTT.

The Whiston site have continued to work with Marshall Cross Medical Centre, for the first time we have also worked with the team to recruit patients into two important hypertension commercial studies. This allows patients in the community setting access to research trials that would normally be out of their reach. The collaboration between primary and secondary care has been acknowledged as a real positive by Astra Zeneca who are the sponsors of the studies.

We are extremely pleased that the CRN NWC successfully appointed Dr Ravish Katira, a Cardiology Consultant at Whiston, as CRN Cardiovascular Speciality Lead. This is a key role that works in partnership with the research network locally and nationally (UK) level, providing a forum to share good practice, successes, opportunities and challenges, and helping influence and shape the clinical research environment.

In December 2023 MWL also became a member of the Applied Research Collaboration, North West Coast (ARC NWC), which aims to work in collaboration by bringing together academics, health and social care providers, members of the public, universities and local authorities to improve the quality, delivery and efficiency of health and care services; reduce health inequalities and increase the sustainability of the health and care system both locally and nationally. Dr Ascanio Tridente is the main link for this collaboration from MWL.

We have strengthened partnerships with local academic organisations, including Manchester Metropolitan, Edge Hill and Liverpool Universities. Dr Greg Irving, Director of the Health Research Institute and Director of the Edge Hill Primary and Integrated Care, has promoted research to academic and Trust researchers to produce good quality research that will benefit our patients in the future.

2024 Journal of Wound Care (JWC) Awards
The 2024 (best clinical research award gold) was presented in London to Professor Kayvan Shokrollahi (MWL/University of Liverpool), Alistair Hampden-Martin

(University of Liverpool) & Professor Kathryn Whitehead (Manchester Metropolitan University) in recognition of Innovation and Excellence in Research Practice.

Our excellent Burns team also took part in a study “A Randomised Trial of Enteral Glutamine for Treatment of Burn Injuries”. The results were published in the New England Journal, one of highest ranking journals.

2023 British Society for Paediatric Endocrinology and Diabetes (BSPED) Research and Innovation Award - The 2023 BSPED Research and Innovation Award was presented at the British Society of Paediatric Endocrinologists’ annual conference to Professor Lucy Bray (Edge Hill University), Dr Jaarod Wong (Glasgow University) and Professor May Ng (MWL) for a joint research collaboration working with patient groups on development of national educational standards and patient resources for emergency management of adrenal insufficiency.

Cancer Research – The recruitment of patients into cancer studies at MWL has remained stable with 126 patients taking part in cancer studies, the same as 2022-2023.

Our Cancer Research Team are the highest recruiting Trust in the country to the Melmart 2 study (Melanoma Wide Excision Trial). This is an important study that aims to further medical knowledge and may improve future treatment of melanoma.

The Cancer Research team is still the only research team to be Macmillan adopted. This is an exceptional achievement and demonstrates our commitment to delivering the best support and treatment for our cancer patients.

At MWL we believe that cancer research is crucial to improving the prevention, detection and treatment of cancers. We are passionate about informing our patients of research opportunities that could improve or prolong their quality of life. The July 2023 skin cancer survey monkey results revealed that 90% of patients at MWL were aware that we are a research active Trust.

The number of patients receiving relevant health services provided or sub-contracted

by Mersey and West Lancashire Teaching Hospitals NHS Trust in 2023-24 that were recruited during that period to participate in research approved by a research ethics committee/Health Research Authority was 4384.

Patient Research Experience Survey (PRES)

The PRES is conducted annually by NIHR. In 2023-2024, the Trust received the highest number of responses across the CRN NWC. The PRES continues to be a priority, as participant experience is at the heart of research delivery by providing an opportunity for as many research participants as possible to share their experience of taking part in research. It was encouraging to note the following feedback:

“Research can only be a good thing; research informs from facts; so therefore, helps influence future plans/changes/to help people now and future generations. The Specialist Nurse who enrolled me was informative, knowledgeable, friendly but respectfully professional and efficient. I left the room feeling ‘better’ and more uplifted than before I went in! Knowing, albeit only small…I was doing my bit to help”.

“From the moment I agreed to take part, I have always felt I made the right decision. The care and professionalism I have received has been amazing”.

“I feel grateful to take part in this study because if people don't do this, I may not be here to see my family and grandchildren. These tests are needed to move on with medicine”.

Feedback from research participants can help us to understand both what they are doing well and where there are opportunities to improve. The PRES has already been instrumental in how we shape our services and feedback has led to the MWL expansion of research facilities at Whiston Hospital, with planned expansion at Southport.

International Clinical Trials Day 2023

International Clinical Trials Day is an annual event that takes place on 20th May to raise awareness of clinical trials to encourage patients, carers and the public to get involved in research.

Promoting Clinical Trials Day 2023

These achievements are only made possible because of the continued support from

the committed clinicians/health professionals, who take on the role of chief and principal investigators, the research nurses/midwives, research administrative teams, support services and, most importantly the patients, who give up their time to take part in research.

'Kitty' The Mobile Research Bus

During 2023 the Clinical Research Network (CRN) North West Coast commissioned a Mobile Research Bus called 'Kitty'.

The mobile research bus is called 'Kitty' after Catherine Wilkinson, who became "Saint of the Slums", saving many lives from Cholera by opening the first public washhouse in Liverpool in 1832.

Partner organisations can request the use of Kitty to help both promote research and undertake research onboard as it consists of a single consultation room and separate waiting area. A key aim for using Kitty it to enable us to access hard to reach communities.

The CRN have recently acquired a further three mobile research units for the region.

Some of our staff and CRN colleagues with Kitty when she visited the Trust.

On the 8th February 2024 the MWL Gastroenterology team held an educational event to highlight the importance of managing patients with inflammatory bowel disease (IBD). The event was attended by consultant gastroenterologists from across the Trust, gastroenterology trainees, dietitians and IBD nurse specialists and members of the MWL Research Department. This was a great opportunity to share and discuss the latest developments in Gastroenterology Research.

2.4.3.1. Research aims for 2024-25

Our aims for 2024-2025 are to:

- Release a 2-year interim Research Development and Innovation Strategy
- Continue to increase the number of commercially sponsored studies
- Collaborate with other NHS organisations and universities. These partnerships will allow us to seek out the best academic expertise to work with our staff and patients wherever possible to ensure that our patients benefit from world-class research
- Review options to expand our workforce to support the successful delivery of both commercial and non-commercial trials, including paediatrics/maternity
- Increase our patient recruitment into NIHR adopted clinical trials
- Explore research options in specialities which are not research active
- Perform thorough feasibility so that studies reach the NIHR high level objectives i.e. setting up studies quickly, recruiting to time and target. The money generated from meeting targets will be reinvested to develop capacity/resources for research within the Trust
- Further develop our Research Hubs, we will submit business cases to the Research Network for additional income when opportunities arise
- Maintain and expand robust procedures to initiate, deliver and manage research, thus increasing opportunities for patients to participate in high quality clinical research
- Engage and communicate with patients and service users. We will ensure that the NIHR Patient Research Experience Survey is embedded into the patients' research journey. We will also feed back both positive and negative experiences, so that we can put action plans in place if necessary
- Continue and update our social media and website platforms to help promote research

In summary, this year has seen the merger of two Trusts with positive outcomes for the RDI Department at MWL. We have worked hard to align our systems and processes and are working on a 2-year interim RDI Strategy. With recruitment at its highest since 2018-2019, more commercial activity and excellent feedback from our patients and research partners we are feeling extremely positive about the future of research at MWL.

1. https://www.nihr.ac.uk/health-and-care-professionals/engagement-and-participation-in-research/embedding-a-research-culture.htm

2. https://www.gov.uk/government/publications/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review-final-report

2.4.4. Clinical goals agreed with commissioners

A proportion of Mersey and West Lancashire Teaching Hospitals NHS Trust income in 2023-24 was conditional on achieving quality improvement and innovation goals agreed between Mersey and West Lancashire Teaching Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for

the provision of relevant health services, through the Commissioning for Quality and Innovation. The full list is shown in the table below:

Reference	Contract Type	Title	Year end position
CQuIN 01	Acute & Community	Flu vaccinations for frontline healthcare workers	[DN: update when information available]
CQuIN 02	Acute	Supporting patients to drink, eat and mobilise (DrEaM) after surgery	
CQuIN 03	Acute	Prompt switching of intravenous to oral antibiotic	
CQuIN 04	Acute	Compliance with timed diagnostic pathways for cancer services	
CQuIN 05	Acute	Identification and response to frailty in emergency departments	
CQuIN 06	Acute	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	
CQuIN 07	Acute	Recording of and response to NEWS2 score for unplanned critical care admissions	
CQuIN 10	Specialised Commissioning	Treatment of non small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	
CQuIN 12	Acute & Community	Assessment and documentation of pressure ulcer risk	
CQuIN 13	Community	Assessment, diagnosis and treatment of lower leg wounds	
CQuIN 14	Community	Malnutrition screening for community hospital inpatients	

2.4.4.1. CQuIN proposals 2024-25

The mandatory CQuIN scheme will not operate in 2024-25. NHS England has produced a list of optional indicators that can be used by any systems that have agreed to operate a local quality scheme during the pause, which is entirely optional and a matter for local agreement between providers and commissioners.

2.4.5. Statements from the Care Quality Commission (CQC)

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

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

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

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

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

A further inspection of Marshalls Cross Medical Centre took place in October 2022 and was rated good for each of the five key questions, with an overall rating of good, improving from the previous requires improvement rating.

The latest comprehensive CQC inspection of legacy Southport and Ormskirk Hospital Trust took place in July and August 2019 and the final report was published on 29 November 2019 with an overall Trust rating of requires improvement.

The current rating for Mersey and West Lancashire Teaching Hospitals NHS Trust is based on legacy STHK's rating as part of the transaction rules when the new Trust came into being on 1st July 2023.

Mersey and West Lancashire Teaching Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Mersey and West Lancashire Teaching Hospitals NHS Trust during 2023-24.

Mersey and West Lancashire Teaching Hospitals NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The following inspections have been undertaken in 2023-24:
- Maternity services at Ormskirk and Whiston Hospitals on 7th and 8th December 2023
- Southport Hospital's medicine and the Spinal Unit on 24th January 2024
- Southport Hospital urgent and emergency care on 4th March 2024
- Whiston Hospital urgent and emergency care on 25th March 2024

The final reports have not yet been received for urgent and emergency care.

The CQC's assessment of Maternity Services at Whiston was rated as good overall. Maternity services overall at Ormskirk and Medicine/Spinal Injuries at Southport were not rated, following the formation of MWL. The outcomes of the further assessments are awaited.

2.4.5.1. CQC ratings table for Mersey and West Lancashire Teaching Hospitals NHS Trust, March 2019

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

Whiston's Emergency Department was rated as requires improvement for the responsive and safety domains in 2019, with action plans implemented to address the recommendations.

Mersey and West Lancashire Teaching Hospitals NHS Trust has made the following progress by 31st March 2023 in taking such action:
- Delivery of action plans to address areas where the Trust requires improvement in the ED, including clarifying and monitoring the quality and completion of ligature and clinical risk assessments to ensure they are completed as appropriate for all patients requiring them in ED

The Trust's maternity service at Ormskirk was rated as requires improvement for safety and an improvement plan has been developed to address the areas outlined, including:
- Development of a maternity specific vision and strategy that incorporates recommendations from the Ockenden report
- Continued monitoring to ensure obstetric modified early waring scores, Cardiotocography (CTG) assessments/fresh eyes, newborn baby risk assessments and baby observations are completed in line with national and Trust guidance
- Strengthened processes for discarding unused epidural infusions
- Ensuring appropriate staffing levels are maintained and all staff are up to date with mandatory training and appraisals
- Ensuring incidents are reviewed in a timely manner

Areas for improvement highlighted in the comprehensive inspection of Southport and Ormskirk Hospital NHS Trust in 2019 have been incorporated into ongoing

improvement workstreams, including nutrition and hydration and medicines management.

2.4.6. Learning from deaths

2.4.6.1. Number of deaths

During Quarters 1-4 2023-24, 2,667 of Mersey and West Lancashire Teaching Hospitals NHS Trust's patients died (in hospital). This comprised the following number of deaths which occurred in each quarter of that reporting period:
657 in the first quarter
649 in the second quarter
657 in the third quarter
704 in the fourth quarter

By the end of Q4, 246 case record reviews and 4 investigations (reds and ambers) have been carried out in relation to the 2,667 deaths included in item 2.4.6.1.
In 4 cases (reds and ambers), a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
2 in the first quarter
1 in the second quarter
1 in the third quarter
0 in the fourth quarter

0 representing 0.00% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient (red rated).
In relation to each quarter, this consisted of:
0 representing 0% for the first quarter
0 representing 0% for the second quarter
0 representing 0% for the third quarter
0 representing 0% for the fourth quarter

These numbers have been estimated using Mersey and West Lancashire Teaching Hospitals NHS Trust's Royal College of Physicians Structured Judgement Review (SJR).

126 case record reviews and 0 (reds and ambers) investigations completed during 2023-24 which related to deaths which took place before the start of the reporting period.

0 representing 0% (reds) of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Mersey and West Lancashire Teaching Hospitals NHS Trust's Structured Judgement Review (SJR) (which uses NCEPOD quality score and red, amber, green (RAG) rating similar to Royal College of Physicians SJR and consistent with Royal College of Physicians and NHS Improvement guidance. This represents the final position for Quarter 4 of 2022-23.

0 representing 0% (reds) of the patient deaths during 2022-23 are judged to be more likely than not to have been due to problems in the care provided to the patient. This represents all four quarters of 2022-23.

2.4.6.2. Summary of learning from case record reviews and investigations

The STHK legacy sites have focussed on one or two key learning priorities for each report to the Trust Board. The key lessons shared in 2023-24 are listed below:

- 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. If frail patients have 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.

- Neurological assessment in the confused patient

Patients presenting with acute confusion should have a neurological assessment carried out and documented in their medical notes at the time of their initial assessment. This will result in earlier identification of those with a focal neurological deficit and prompt earlier stroke team involvement where appropriate. It also provides a baseline assessment that can be used for comparison later in the hospital admission.

- Assessment of Pain

Patients who are confused cannot reliably indicate whether they are in pain. The Abbey Pain Scale is a tool that is validated for use in patients who cannot verbalise their level of pain. It is available via the Trust intranet and should be used as an alternative to the standard 1-10 scoring system used in other patient groups.

The S&O legacy sites have focussed on the following learning priorities reported to the Trust Board:

- End of Life Care

Access to nutrition has been raised as an issue, particularly in the frail and in those lacking capacity. It is important that this issue is considered and the clinical rationale for intervening or not intervening documented. It is important to recognise that a natural reduction in appetite occurs as part of the dying process. The individual care and communication document prompts consideration of nutrition and hydration.

Improving end of life care, primarily by raising awareness of its inevitability, normalising its discussion and developing processes and tools to put the goals of

patients at the forefront of care are key. Good communication when end of life is predictable is essential. Training is available and uptake of this is promoted and monitored.

We continue to support the ongoing staff education programmes designed to improve the quality of end of life care, recognition of patients being sick enough to die and decision making at the end of life.

There have been issues with timely verification of death. This can lead to anger and distress amongst relatives when this is delayed as the date of death is taken as the date of verification. When this delay crosses midnight, the date of death will be different from the date the family witnessed the death of their loved one. Medically it is hard to prioritise this responsibility over the responsibility to living patients, for this reason we are looking at ways of reintroducing nurse verification of death for expected deaths. Unexpected deaths will in some cases be attended by the cardiac arrest team and it is the team's responsibility to verify death and document this.

Some faiths require expedited burial processes as part of their religion. The Medical Examiners' Office is able to help with planning for faith issues to ensure that processes are robust yet expedited. If a patient is thought likely to be dying and has faith requirements please contact the Medical Examiners' Office.

- Do not attempt cardio-pulmonary resuscitation (DNACPR)

It has been raised again that 'learning disability' should not be used on a DNACPR form. This is never a reason to withhold intervention. It is either the condition which makes CPR ineffective or the element of frailty which makes CPR overly burdensome as a treatment which should be documented as the reason.

- Queenscourt

There has been a reduction in length of stay and readmission rates due to the implementation of the Queenscourt virtual ward. This has had a great impact on the quality of care received by those in the last days and weeks of life. In the first 3 months, 100 patients have been admitted, which equates to a saving of 354 bed days.

2.4.6.3. Actions taken resulting from learning

The STHK legacy sites have a robust and embedded Learning from Deaths Policy, which includes the principles laid down in the National Quality Board document "Learning from Death: Guidance for NHS trusts on working with bereaved families and carers".

Following the creation of Mersey and West Lancashire Teaching Hospitals NHS Trust, work is underway to align the two learning from deaths processes into one process. Once created and approved this will be reflected in a new MWL Learning from Deaths Policy. It is hoped that this will be complete by quarter 2 2024-25.

Lessons identified from the structured judgement reviews have been shared with the Trust Board, Quality Committee, Finance & Performance Committee, Clinical Effectiveness Council, Patient Safety Council, Patient Experience Council, Grand

Rounds, Team Brief, intranet home page, global email, local governance and directorate meetings.

The following key actions have been taken following the learning identified:

- In recognition of the increased challenges with assisted nutrition, a business case for a nutritional support team has been prepared by the gastroenterology service to improve the support to clinical teams with assisted nutrition
- The Trust has developed, with Queenscourt Hospice, a suite of educational sessions for various staff groups to improve the knowledge and confidence in the use of anticipatory clinical management plans and treatment escalation pro forma, to improve the care of deteriorating patients and those at the end of life
- The Trust has recognised the impact of incivility and poor interpersonal communication on the welfare of colleagues and the safety of patients. Departmental educational leads and departmental leaders have been asked to include this in local training and in the conduct of departmental interactions. A dedicated session on this was delivered to the foundation programme doctors
- The Medical Examiners' Office, the Trust and Queenscourt Hospice are designing a process to identify expected faith deaths so that processes of care after death can be managed efficiently, respecting faith considerations. This will include community deaths
- The Trust is evaluating the possibility of nurse verification of expected deaths to relieve pressure on on-call medical teams and provide a more responsive process for the family after death
- The ability to prescribe long-term home ventilation via ePMA to act as a prompt for nursing staff to assist patients to use their own machine whilst in hospital. These patients are usually independent with their machines at home, but may require assistance when unwell and there is the potential for significant harm should they not receive this treatment whilst in hospital

2.4.6.4. Impact of actions taken

The effectiveness of learning is assessed by audit of Datix, serious incidents, complaints, Patient Advice and Liaison Service (PALS) contacts, litigation and mortality reviews for evidence of failure to deliver these priorities. Systematic assessment of effectiveness is necessarily two quarters behind priorities, allowing time for sharing and then time to establish that learning has become embedded.

The learning from deaths process has supported the case for the ongoing construction of a second CT scanner at Southport Hospital to reduce delays for inpatients and to reduce the impact of required maintenance on the current single CT scanner in Southport on the emergency care pathway.

2.4.7. Priority clinical standards for seven-day hospital services

There are 10 standards for seven day clinical services, of which four were highlighted as a priority for trusts to deliver. These priority standards are outlined in the list below:

- Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission to an inpatient area.

For high volume specialties (eg. acute medicine) consultant presence into the evening is likely to be needed every day

- Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests should be available every day. Relevant diagnostic tests include computerised tomography (CT), magnetic resonance imaging (MRI) and ultrasound imaging, endoscopy and echocardiography
- Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions and typically should include emergency theatre, intensive care, interventional endoscopy, percutaneous coronary intervention (PCI) for acute myocardial infarction, emergency cardiac pacing and thrombolysis for stroke
- Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway

Consultant job plans in acute specialities are organised to deliver these standards, including on call arrangements. Acute assessment areas (eg. Acute Medical Unit, Frailty Unit, Surgical Assessment Unit) have once or twice daily ward rounds. There are arrangements in place to provide access to consultant delivered diagnostic tests and the majority of interventions onsite, with the remaining available via regional networks ie. interventional radiology, stroke thrombectomy and PCI for myocardial infarctions.

The job planned consultant presence is available to deliver the four priority seven-day clinical standards for the majority of patients admitted to hospital. Specialities which do not currently have job planned consultant time to deliver consistent early review, that is less than 14 hours from admission, (haematology and urology) are responsible for a small proportion of the patients admitted to hospital non-electively.

2.4.8. Information governance and toolkit attainment levels

Information Governance (IG) is the way in which the Trust manages its information and ensures that all information, particularly personal and confidential data, is handled legally, securely, efficiently and effectively. It provides both a framework and a consistent way for employees to deal with the many different information handling requirements in line with Data Protection legislation.

The Trust uses the Data Security and Protection Toolkit (DSPT) to benchmark its IG and IT security controls, also known as the IG Assessment Report. The DSPT is an annual online self-assessment tool that allows health and social care organisations to measure their performance against the National Data Guardian's 10 Data Security Standards (covering topics such as staff responsibilities, training and continuity planning) and reflects legal rules relevant to IG. The Trust must address all mandatory requirements within the DSPT in order to publish a successful assessment.

The 2023-24 DSPT is on course to be submitted for the June 2024 deadline. The

two legacy organisations, St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust were required to demonstrate their IG and IT security controls via the DSPT:

- St Helens and Knowsley Teaching Hospitals NHS Trust Information Governance Assessment Report overall submission position for 2022-23 was published in June 2023. To provide assurance that St Helens and Knowsley Teaching Hospitals NHS Trust 's DSPT for 2022-23 was of a good standard, it was audited by Mersey Internal Audit Agency and achieved substantial assurance.
- Southport and Ormskirk Hospital NHS Trust Information Governance Assessment Report overall submission position for 2022-23 was published in June 2023. To provide assurance that Southport and Ormskirk Hospital NHS Trust's DSPT for 2022-23 was of a good standard, it was also audited by Mersey Internal Audit Agency and achieved substantial assurance.

The two former Trusts each had a Data Breach Management Procedure in place which were adhered to when a personal data breach/incident occurred. All incidents were risk assessed and scored; it is a requirement that any incidents scoring highly are reported to the Information Commissioner's Office (ICO). The incidents that were reported throughout the year did not score highly and, therefore, no further escalation was required and these incidents were managed locally.

The Trust has assigned specific roles to ensure the IG framework is adhered to and is fully embedded:

• Malcolm Gandy, Director of Informatics – Senior Information Risk Owner (SIRO)
• Mr Alex Benson, Assistant Medical Director - Caldicott Guardian
• Camilla Bhondoo – Head of Risk Assurance and Data Protection Officer

All three staff are appropriately trained.

2.4.9. Clinical coding

Clinical coding is the translation of medical terminology that describes a patient's complaint, problem, diagnosis, treatment, or other reason for seeking medical attention into codes that can then be used to record morbidity data for operational, clinical, financial and research purposes. It is carried out using International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) for diagnosis capture and Office of Population, Census and Statistics Classification of Interventions and Procedures Version 4.9 (OPCS 4.9) for procedural capture.

Mersey and West Lancashire Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2023-24 by the Audit Commission.
The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Data Security and Protection Toolkit (DSPT) 2023-24.

It is widely known throughout the NHS that there is a national and local shortage of qualified and experienced Clinical Coders, which unfortunately does create recruitment challenges for all Clinical Coding departments across the country. Despite vacancy challenges faced by the team, the Trust and wider community

should be reassured that the data reported at Mersey and West Lancashire Teaching Hospitals NHS Trust is accurate and reflects the activity that is taking place, and in order to demonstrate this, the 2023-24 DSPT clinical coding audit submission achieved a high standard of accuracy.

These results demonstrate that the department continues to maintain the excellent quality of clinical coding.

Mersey and West Lancashire Teaching Hospitals NHS Trust			
	%	Audited	Errors
Primary Diagnosis	92.00	200	16
Secondary Diagnosis	96.81	973	31
Primary Procedure	96.32	163	6
Secondary Procedure	92.14	280	22

Mersey and West Lancashire Teaching Hospitals NHS Trust will be taking the following actions to improve data:

- Continuing to promote clinical engagement to ensure that clinical coding accurately reflects the patient journey
- Ensuring staff are working towards achieving the national clinical coding qualification (NCCQ)
- Ensuring staff attend regular refresher workshops to ensure coding skills are kept up to date
- Continuing to provide a robust audit service to highlight areas for improvement

2.4.10. Data quality

The Trust continues to be committed to ensuring accurate and up-to-date information is available to communicate effectively with GPs and others involved in delivering care to patients. Good quality information underpins effective delivery of patient care and supports better decision-making, which is essential for delivering improvements.

Data quality is fully embedded across the organisation, with robust governance arrangements in place to ensure the effective management of this process. Audit outcomes are monitored to ensure that the Trust continues to maintain performance in line with national standards. The data quality work plan is reviewed on an annual basis ensuring any new requirements are reflected in the plan.

There are a number of standard national data quality items, which are routinely monitored, including:

- Blank/invalid NHS numbers
- Unknown or dummy practice codes
- Blank or invalid registered GP practices
- Patient postcodes

The Trust implemented a new Patient Administration System (PAS), Careflow, in 2018 which has the functionality to allow for National Spine integration, giving users the ability to update patient details from national records using the NHS number as a unique identifier.

The Careflow configuration restricts the options available to users. Validation of this work is on-going and forms part of the annual data quality work plan.

2.4.10.1. NHS number and general medical practice code validity

Mersey and West Lancashire Teaching Hospitals NHS Trust submitted records during 2023-24 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and the patient's valid registered GP practice code contributes to the overall Data Quality Maturity Index (DQMI) scores. The DQMI score for the most recent 12 months is shown in the table below; please note before July 2023 the data reported was for St Helens & Knowsley Teaching Hospitals NHS Trust sites only and from July 2023 onwards, the data is reported as Mersey and West Lancashire Teaching Hospitals.

DQMI	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Trust Score	93.4	93.1	93.3	93.6	93.1	92.4	92.3	92.3	92.7	92.3	92.8	92.8	92.7
National Average	82.8	83.1	81.1	81.7	82.0	81.1	80.8	81.5	81.5	80.0	82.4	81.2	81.8

(Source: DQMI)

The Trust performed better than the national average, demonstrating the importance the Trust places on data quality.

The Trust takes the following actions to improve data quality:

- Data Quality team monitors the nationally mandated submissions via the NHS digital toolkit and a formal report is presented at the Information Steering Group meeting. Any elements requiring action are agreed at this meeting
- Data Quality Team will continue to monitor data quality throughout the Trust via the regular suite of reports
- Providing data quality awareness sessions about the importance of good quality patient data and the impact of inaccurate data recording
- Data Quality Forum has been established to provide oversight to ensure the timely completion of data quality checks across departments in the Trust

2.4.11. Benchmarking information

The Department of Health specifies that the Quality Account includes information on a core set of outcome indicators, where the NHS is aiming to improve. All trusts are required to report against these indicators using a standard format. NHS Digital makes the following data available to NHS trusts. The Trust has more up-to-date information for some measures; however, in the main only data with specified national benchmarks from the central data sources is reported, therefore, some information included in this report is from the previous year or earlier and the timeframes are included in the report. It is not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

2.4.11.1. Benchmarking Information

Please note the information below is based on the latest nationally reported data with specified benchmarks from the central data sources. Any internal figures included are displayed in purple font, noting there is no national data for this time period.

Indicator	Source	Reporting Period	MWL	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Summary Hospital-level Mortality Indicator (SHMI)	NHS Digital	Oct-22 – Sept-23	1.063	1	0.677	1.229	
SHMI	NHS Digital	Sept-22 – Aug-23	1.045	1	0.713	1.222	
SHMI	NHS Digital	Aug-22 – Jul-23	1.03	1	0.71	1.207	
SHMI	NHS Digital	Jul-22 – Jun-23	1.02	1	0.71	1.213	
SHMI Banding	NHS Digital	Oct-22 – Sept-23	2	2	3	1	
SHMI Banding	NHS Digital	Sept-22 – Aug-23	2	2	3	1	
SHMI Banding	NHS Digital	Aug-22 – Jul-23	2	2	3	1	
SHMI Banding	NHS Digital	Jul-22 – Jun-23	2	2	3	1	
% of patient deaths having palliative care coded	NHS Digital	Oct-22 – Sept-23	50%	41%	15%	66%	
% of patient deaths having palliative care coded	NHS Digital	Sept-22 – Aug-23	50%	41%	15%	66%	

Indicator	Source	Reporting Period	MWL	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
% of patient deaths having palliative care coded	NHS Digital	Aug-22 – Jul-23	50%	41%	14%	66%	
% of patient deaths having palliative care coded	NHS Digital	Jul-22 – Jun-23	49%	40%	14%	66%	
Mersey and West Lancashire Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Information relating to mortality is monitored monthly and used to drive improvements. The mortality data is provided by an external source (NHS Digital). Mersey and West Lancashire Teaching Hospitals NHS Trust has taken the following actions to improve the indicator and percentage, and so the quality of its services, by: Monthly monitoring of available measures of mortality. Learning from Deaths Policy implemented with continued focus on reviewing deaths to identify required actions for improvement and effective dissemination of lessons learned as noted in section 2.4.6.							
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-22 to Mar-23 (provisional)	S&O *	STHK *	0.468	0.378	0.531	The mandatory varicose vein surgery and groin-hernia surgery national PROMs collections have ended
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-21 to Mar-22 (final)	S&O *	STHK 0.396	0.462	0.393	0.534	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-20 to Mar-21 (final)	S&O *	STHK 0.430	0.472	0.393	0.574	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-22 to Mar-23 (provisional)	S&O *	STHK *	0.354	0.233	0.410	
EQ-5D adjusted health	NHS Digital	Apr-21 to	S&O	STHK	0.324	0.181	0.417	

Indicator	Source	Reporting Period	MWL		National Performance			Comments
					Average	Lowest Trust	Highest Trust	
gain: Knee Replacement Primary		Mar-22 (final)	*	0.256				
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-20 to Mar-21 (final)	S&O *	STHK 0.314	0.315	0.181	0.403	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-18 to Mar-19 (final)	N/A		N/A	N/A	N/A	
Mersey and West Lancashire Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation (IQVIA). Mersey and West Lancashire Teaching Hospitals NHS Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by: Appointing a Consultant lead to oversee and support PROMs. Explaining PROMs to patients at Joint School and requesting that they complete Part 1 of the form to increase participation rates, manage patient expectations post-surgery and increase knowledge of what to expect following surgery and the support offered if required. Developing plans for an opt in (post discharge) telephone service for follow up with patients to enhance the patient care and quality further. PROMs data was monitored at the Trauma and Orthopaedic bi-monthly clinical effectiveness meeting.								
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2021-22	-		-	-	-	Following the merger of NHS Digital and NHS England on 1st February 2023 they are reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was

Indicator	Source	Reporting Period	MWL	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2020-21	76.0	74.5	67.3	85.4	due to be released in March 2023 has been delayed. As of the 2020-21 survey, changes have been made to the wording of the 5 questions, as well as the corresponding score regime, which underpin the indicator. As a result, 2020-21 results are not comparable with those of previous years
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2019-20	66.2	67.1	59.5	84.2	
Mersey and West Lancashire Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust's vision and drive to provide 5-star patient care ensures that patients are at the centre of all the Trust does. The Trust was rated outstanding overall for caring by the CQC following their latest inspection undertaken in 2018. The survey was conducted by an independent and approved survey provider (Quality Health), with scores taken from the CQC website. Mersey and West Lancashire Teaching Hospitals NHS Trust has taken the following actions to improve this data, and so the quality of its services, by: Promoting a culture of patient-centred care. Responding to patient feedback received through national and local surveys, Friends and Family Test results, complaints and Patient Advice and Liaison Service (PALS). Working closely with Healthwatch colleagues to address priorities identified by patients, including improving discharge planning.							
If a friend or relative needed treatment, I would be happy with the standard of care	NHS staff surveys	2023	71.18%	63.32%	44.31%	88.82%	

Indicator	Source	Reporting Period	MWL		National Performance			Comments
					Average	Lowest Trust	Highest Trust	
provided by this organisation.								
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	NHS staff surveys	2022	S&O 51.2%	STHK 77.6%	61.9%	39.2%	86.4%	Data for 2020 onwards is for acute and acute & community providers
If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2021	S&O 52.6%	STHK 79.4%	66.9%	43.6%	89.5%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2023	14.92%		19.25%	26.09%	12.30%	Low scores are better performing trusts
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2022	S&O 22.7%	STHK 15.1%	20.0%	25.9%	12.3%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2021	S&O 21.1%	STHK 15.1%	19.5%	27.2%	12.3%	
% believing there are opportunities to develop their career in this organisation	NHS staff surveys	2023	54.44%		55.07%	46.92%	64.38%	

Indicator	Source	Reporting Period	MWL		National Performance			Comments
					Average	Lowest Trust	Highest Trust	
% believing there are opportunities to develop their career in this organisation	NHS staff surveys	2022	S&O 42.9%	STHK 58.2%	53.4%	42.9%	63.6%	
% believing there are opportunities to develop their career in this organisation	NHS staff surveys	2021	S&O 44.5%	STHK 52.5%	52.1%	38.8%	64.6%	
Mersey and West Lancashire Teaching Hospitals NHS Trust considers that this data is as described for the following reasons; The Trust provides a positive working environment for staff with a proactive Health, Work and Wellbeing Service. An independent provider (Quality Health) provides the data. Mersey and West Lancashire Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff. Engagement of staff at all levels in the development of the vision and values of the Trust. Honest and open culture, with staff supported to raise concerns via Speak Out Safely, Freedom to Speak Up champions and anonymous Speak in Confidence website.								
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Jan-24	84%		78%	48%	98%	
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Dec-23	86%		78%	54%	100%	
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Nov-23	85%		79%	57%	100%	
Friends and Family Test - % That Rate the	NHS England	Oct-23	84%		79%	52%	97%	

Indicator	Source	Reporting Period	MWL	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
service as Very Good or Good - A&E							
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Sept-23	86%	79%	11%	100%	
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Aug-23	86%	82%	56%	100%	
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Jul-23	87%	82%	0%	99%	
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Jan-24	94%	94%	74%	100%	
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Dec-23	94%	94%	73%	100%	
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Nov-23	94%	95%	75%	100%	
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Oct-23	95%	94%	70%	100%	
Friends and Family	NHS England	Sept-23	94%	94%	78%	100%	

Indicator	Source	Reporting Period	MWL		National Performance			Comments
					Average	Lowest Trust	Highest Trust	
Test - % That Rate the service as Very Good or Good - Inpatients								
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Aug-23	95%		94%	67%	100%	
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Jul-23	96%		95%	79%	100%	
Mersey and West Lancashire Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust actively promotes the Friends and Family Test across all areas. The data was submitted monthly to NHS England. Mersey and West Lancashire Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and technology, supported by volunteers in key areas. Actively working with ward staff to improve levels of engagement with the system, to ensure the latest results are shared at local level and actions are delivered to respond to the feedback.								
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 3 2019-20	S&O 98.0%	STHK 96.2%	95.3%	71.6%	100%	All data is for Acute Providers only
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2019-20	S&O 98.0%	STHK 95.2%	95.4%	71.7%	100%	All data is for Acute Providers only
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2019-20	S&O 97.8%	STHK 95.2%	95.6%	69.8%	100%	Data for Q4 2019-20 onwards is suspended
Mersey and West Lancashire Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:								

Indicator	Source	Reporting Period	MWL	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Adult admitted patients with a stay over 24 hours have a venous thromboembolism (VTE) risk assessment undertaken to ensure that they receive the most appropriate treatment. NHS England data collection was suspended nationally in 2020 due to the impact of the pandemic. This is due to recommence in April 2024. Reviews are carried out for all patients who develop a hospital acquired thrombosis (HAT). A hospital-acquired venous thromboembolism (VTE), also known as hospital-acquired or hospital-associated thrombosis (HAT), covers all VTEs that occur in hospital and within 90 days after a hospital admission. Of the 137 reviews completed to date (for the period April 2023 – December 2023) it was found that 22 required a Patient Safety Investigation. Of these 22 it was determined that 14 cases needed escalation to the Incident Review Group as patients did not receive appropriate treatment in relation to VTE prevention. Patient Safety Investigations undertaken on VTEs are recorded on Datix to ensure best practice is followed. COVID-19 related VTE has been identified nationally and internationally as a complication of the virus and, therefore, the Trust developed and implemented appropriate guidance for clinicians to consider in planning VTE prophylaxis. Mersey and West Lancashire Teaching Hospitals NHS Trust is taking the following actions to improve this percentage, and so the quality of its services, by: Utilising IT systems and pathways to facilitate VTE risk assessment and prescribing of thromboprophylaxis. Undertaking audits on the administration of appropriate medications to prevent blood clots. Completing investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed. Sharing any learning from these reviews and providing ongoing training for clinical staff.								
C. Difficile rates per 100,000 bed- days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	April-22 to Mar-23	S&O 62.7	STHK 38.0	43.9	0	133.6	
C. Difficile rates per 100,000 bed- days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	April-21 to Mar-22	S&O 54.4	STHK 42.8	43.7	0	138.4	
C. Difficile rates per 100,000 bed- days for	GOV.UK	Apr-20 to	S&O 45.1	STHK 39.8	41.1	0	161.3	

Indicator	Source	Reporting Period	MWL		National Performance			Comments
					Average	Lowest Trust	Highest Trust	
specimens taken from patients aged 2 years and over (Total cases)		Mar-21						
C. Difficile rates per 100,000 bed- days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-19 to Mar-20	S&O 41.0	STHK 43.2	34.7	0	136	
Mersey and West Lancashire Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Infection prevention remains a priority for the Trust. All new cases of C. difficile infection are identified by the laboratory and reported to the Infection Prevention Team, who co-ordinate mandatory external reporting. The Trust is maintaining compliance with the national guidance on testing stool specimens in patients with diarrhoea. Cases are thoroughly investigated, which is reported back to a multidisciplinary panel to ensure appropriate care was provided and lessons learned are disseminated across the Trust. Mersey and West Lancashire Teaching Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by: Focussing on ensuring staff compliance with mandatory training for infection prevention. Actively promoting the use of hand washing and hand gels to those visiting the hospital. Providing a proactive and responsive infection prevention service to increase levels of compliance. Ensuring comprehensive guidance is in place on antibiotic prescribing.								
Incidents per 1,000 bed days	Internal	Apr-23 to Mar-24	S&O 48.73	STHK 62.13	-	-	-	
Incidents per 1,000 bed days	Internal	Apr-22 to Mar-23	S&O 68.48	STHK 52.39	-	-	-	
Incidents per 1,000 bed days	NHS Improvement	Apr-21 to Mar-22	S&O 47.37	STHK 60.56	55.96	30.18	120.59	
Incidents per 1,000 bed days	NHS Improvement	Apr-20 to Mar-21	S&O 55.00	STHK 37.20	57.63	27.20	118.70	Nationally published data is suspended with the launch of Learn From Patient Safety

Indicator	Source	Reporting Period	MWL		National Performance			Comments
					Average	Lowest Trust	Highest Trust	
Incidents per 1,000 bed days	NHS Improvement	Oct-19 to Mar-20	S&O 62.35	STHK 35.31	49.70	27.52	110.21	Events (LFPSE) framework in 2023. Publications will be reinstated when all trusts have transitioned from National Reporting and Learning System (NRLS) to LFPSE framework. Data for Apr-21 to Mar-22 and Apr-20 to Mar-21 is based on acute (non-specialist) trusts with complete data (12 months data) Data for Oct-19 to Mar-20 is based on acute (non-specialist) trusts with complete data (6 months data)
Number of incidents	Internal	Apr-23 to Mar-24	S&O 8372	STHK 17469	-	-	-	
Number of incidents	Internal	Apr-22 to Mar-23	S&O 10674	STHK 14530	-	-	-	
Number of incidents	NHS Improvement	Apr-21 to Mar-22	S&O 9512	STHK 16557	14808	4577	49603	
Number of incidents	NHS Improvement	Apr-20 to Mar-21	S&O 6222	STHK 8124	12644	3169	37572	
Number of incidents	NHS Improvement	Oct-19 to Mar-20	S&O 4205	STHK 4370	6607	1758	22340	
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Apr-23 to Mar-24	S&O 0.08	STHK 0.137	-	-	-	
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Apr-22 to Mar-23	S&O 0.11	STHK 0.28	-	-	-	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Apr-21 to Mar-22	S&O 0.14	STHK 0.18	0.22	0.02	0.63	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Apr-20 to Mar-21	S&O 0.13	STHK 0.14	0.25	0.03	1.08	

Indicator	Source	Reporting Period	MWL		National Performance			Comments
					Average	Lowest Trust	Highest Trust	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Oct-19 to Mar-20	S&O 0.19	STHK 0.04	0.15	0.00	0.52	
Number of incidents resulting in severe harm or death	Internal	Apr-23 to Mar-24	S&O 13	STHK 39	-	-	-	
Number of incidents resulting in severe harm or death	Internal	Apr-22 to Mar-23	S&O 17	STHK 78	-	-	-	
Number of incidents resulting in severe harm or death	NHS Improvement	Apr-21 to Mar-22	S&O 28	STHK 50	58	5	216	
Number of incidents resulting in severe harm or death	NHS Improvement	Apr-20 to Mar-21	S&O 15	STHK 31	54	4	261	
Number of incidents resulting in severe harm or death	NHS Improvement	Oct-19 to Mar-20	S&O 6	STHK 5	19	0	93	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-23 to Mar-24	S&O 0.16%	STHK 0.22%	-	-	-	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-22 to Mar-23	S&O 0.16%	STHK 0.54%	-	-	-	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Apr-21 to Mar-22	S&O 0.3%	STHK 0.3%	0.4%	0.0%	1.3%	

Indicator	Source	Reporting Period	MWL		National Performance			Comments
					Average	Lowest Trust	Highest Trust	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Apr-20 to Mar-21	S&O 0.2%	STHK 0.4%	0.4%	0.0%	2.8%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Oct-19 to Mar-20	S&O 0.1%	STHK 0.1%	0.3%	0.0%	0.9%	

Mersey and West Lancashire Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
The Trust actively promotes a culture of open and honest reporting within a just culture framework.
The data was validated against National Reporting and Learning System (NRLS) and NHS Digital figures until March 2022 when publications were paused for the implementation of Learn From Patient Safety Events (LFPSE) framework in 2023. This framework was launched nationally by NHS England and future publications will run from LFPSE data. Data from April 2022 to March 2024 has been taken from the internal data held on Datix and used to report to NHS England. The number of patient safety incidents at the Trust per 1000 bed days for 2023-24 was 62.13. The Trust's overall percentage of incidents that resulted in severe harm or death was 0.22%.

Mersey and West Lancashire Teaching Hospitals NHS Trust has taken the following actions to improve this number and rate, and so the quality of its services, by:
Undertaking comprehensive investigations of incidents resulting in moderate or severe harm.
Delivering simulation training to enhance team working in clinical areas.
Providing staff training in incident reporting and risk management.
Monitoring key performance indicators at the Patient Safety Council, Quality Committee and the Trust Board.
Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported.

2.4.11.2. Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2023-24 is shown in the table below:

Performance Indicator	2022-23 Target for STHK & S&O combined	2022-23 Performance for STHK & S&O combined	2023-24 Target	2023-24 Performance	Latest data
Cancelled operations (% of patients treated within 28 days following cancellation)	100%	86%	100%	92.40%	April 23 – Feb 24
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	92%	62.5%	92%	60.80%	April 23 – Mar 24
Cancer: 31-day wait from diagnosis to first treatment	96%	93.50%	96%	91.70%	April – Feb 23
Cancer: 62-day wait for first treatment from urgent GP referral	85%	76.90%	85%	78.1%	April – Feb 23
Cancer: 28 day wait from GP referral to Diagnosis informed	75%	69.10%	75%	69.50%	April – Feb 23
Emergency Department waiting times within 4 hours – all types (mapped performance)	95%	73.70%	76%	74.90%	April 23 – Mar 24
Percentage of patients admitted with stroke spending at least 90% of their stay on a stroke unit	80%	79.20%	80%	85.30%	April – Sept 23
Clostridium Difficile	105	104	85	114	April 23 – Mar 24
MRSA bacteraemia	0	1	0	6	April 23 – Mar 24
Maximum 6-week wait for diagnostic procedures: % of diagnostic waits waited <6 weeks	99%	72.40%	95%	87.80%	April 23 – Mar 24

3. Additional information

3.1. Equality, Diversity and Inclusion (EDI)

The Trust remains committed to ensuring that its staff and service users enjoy the benefits of a healthcare organisation that respects and upholds individuals' rights and freedoms. Equality and human rights are at the core of our beliefs and the Trust strives to ensure that people with protected characteristics, as defined by the Equality Act 2010, and those individuals from traditionally underserved groups are not disadvantaged when accessing the services that the Trust provides.

The Trust's EDI Steering Group meets regularly to ensure compliance with all external standards, including those statutory requirements conferred on the Trust by the Equality Act 2010. The membership of the group is drawn from a wide range of staff from all disciplines, clinical, non-clinical, trade union representatives, Healthwatch representatives and members of the Trust staff networks.

The Trust is a member of the following external charter marks, accreditations and commitments, which are used to further our equality strategy:

- Armed Forces Covenant (re-signed 2023)
- Defence Employer Recognition Scheme (Armed Forces, gold accreditation 2020)
- Disability Confident Scheme, Leader (Level 3, reaccredited 2023)
- Dying to Work Charter (member, 2023)
- NHS Rainbow Badge Accreditation (LGBT) (Bronze, accredited 2022)
- NHS Sexual Safety Charter (member, 2023)
- Veterans Aware (Armed Forces, reaccredited 2023)
- North West region Stroke Voices

The Trust is a member of the North West black, Asian and minority ethnic (BAME) Assembly and is working towards applying for the North West Anti-Racism Framework accreditation.

3.1.1. Human Resources Equality, Diversity & Inclusion Operational Plan

The Human Resources EDI Team has continued to implement the Trust's Equality, Diversity & Inclusion Operational Plan 2022-2025. The Trust's three key priority areas are:

- Inclusive and compassionate leadership
- Culture of inclusion
- Diverse workforce

The plan builds on and complements the activities in response to the Staff Survey results, the Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES) and the Equality Delivery System (EDS).

An informal information, advice and guidance service for line managers and disabled employees was implemented providing advice on the workplace disability reasonable adjustments process and passport. The Trust was recognised for its commitment to

supporting disabled staff, winning the Browne Jacobson Award for Excellence in Employee Engagement at the HPMA Awards. A suite of training courses was delivered for staff, line managers and decision makers, on the following topics

- Lunch and learn: reasonable adjustments
- Designing bias out of recruitment, appraisal, promotion and progression
- Disability awareness & reasonable adjustments for line managers
- Equality & diversity in recruitment and selection (for recruiters)
- Equality impact assessments for decision makers (bitesize & full)
- Harassment and discrimination for managers
- Organising an inclusive event or activity
- Unconscious bias (generic & key recruiters)

The Trust continued to meet is legal and regulatory obligatory obligations, completing the annual:

- EDS assessment,
- Gender Pay Gap
- Workforce Disability Equality Standard,
- WRES, Medical WRES and Bank WRES

A new Carers' Toolkit was launched for staff with caring responsibilities, along with guidance documents on topics including bullying, harassment, sexual misconduct, cultural awareness and cultural competence, common disabilities and adjustments. The Trust has continued to support six staff networks:

- Armed Forces Community
- Abilities @ MWL (disability)
- Building a Multicultural Environment (black, Asian and minority ethnic)
- Carers
- Menopause
- Proud@MWL (LGBTQIA+)

EDI awareness events organised throughout the year included participation at St Helens, Southport and Liverpool LGBTQIA+ Prides, Black History Month and Wear Red Day, Disability History Month and the first EDI festival/week of events.

3.1.2. Patient Experience and Inclusion Strategy

The Patient Experience and Inclusion Team launched the new three year Patient Experience and Inclusion Strategy in 2022 following consultation with internal and external stakeholders. The strategy brings together objectives for equality, diversity, inclusion and engagement for the first time, rather than having separate strategies

The strategy comprises of three commitments with a total of 30 actions, which are on track to be delivered:

- Commitment 1

Inclusion and engagement - to be inclusive in our engagement with patients, carers and the public

- Commitment 2

Care and treatment accessible to all - We will endeavour to ensure that the care and treatment we provide is accessible to all

- Commitment 3

Capture, listen, learn - We will capture, listen and learn from the experiences of patients, carers and the public

3.1.3. Equality Delivery System

In 2023 the Trust transitioned to the new version of the Equality Delivery System (EDS22) and our approved grades are shown on the right hand side of the table below, with the previous year's grades on the left hand side of the table.

In January and February 2024, the Trust held its Equality Delivery System (EDS) panel assessments, which were attended by senior leaders in the Trust, representatives from local Healthwatch groups, St Helens Council, Unison and the Senior Governance Manager from the Integrated Care Board (ICB). Progress on EDS goals and the Equality Objectives 2019-23 action plan were presented and the approved grades are outlined in the table below.

Goal	Outcome	2023	Goal	Domain	2024
Better health outcomes	1.1	Achieving	Commissioned and provided services	Merged/removed	
	1.2	Achieving		1B	Achieving
	1.3	Achieving		Merged/removed	
	1.4	Achieving		1C	Achieving
	1.5	Excelling		Merged/removed	
Improved Patient access and experience	2.1	Achieving		1A	Achieving
	2.2	Achieving		Merged/removed	
	2.3	Achieving		1D	Achieving
	2.4	Excelling		Merged/removed	
A representative and supported workforce	3.1	Achieving	Workforce Health & Wellbeing	2A	Achieving
	3.2	Excelling		2C	Achieving
	3.3	Achieving		Merged/removed	
	3.4	Developing		2B	Achieving
	3.5	Achieving		Merged/removed	
	3.6	Excelling		2D	Achieving
Inclusive leadership	4.1	Developing	Inclusive Leadership	3A	Achieving
	4.2	Developing		3B	Achieving
	4.3	Achieving		3C	Achieving

The EDS22 is split into domains rather than goals. The patient element in the new EDS22 is Domain 1, which involves a deep dive into three services per year to see how inclusive and accessible they are and to identify any gaps as a tool for improvement.

Following the assessments an action plan/improvement plan is developed and progressed by the services, with an update on any improvements made at the

following year's assessment.

The Trust reviewed the following three services, with their scores indicated below:
- Sexual health – excelling
- Faster diagnosis pathway – developing/achieving
- Palliative and end of life care – undeveloped

Overall domain 1 score = Achieving

The parties present at the assessment approved the Trust's self-assessment of the grades.

3.1.4. Equality objectives 2019-23

3.1.4.1. Improving access and outcomes for patients and communities who experience disadvantage

Communication support for those with disabilities
We have further increased the number of patients who told us they had additional communication needs due to their disability (in line with the Accessible Information Standard (AIS)) by:
- Additional training for appointments/admissions staff to 'ask'
- Publicity via social media, posters, GPs and Healthwatch
- Regularly audit alerts on patients' records
- Training with team from Deafness Resource Centre (DRC) for our doctors in training
- Webform on communication needs for patients to tell us if they have additional communication needs due to disability
- Ongoing awareness training delivered by St Helens DRC to multiple groups of 25 staff, with over 400 staff completing this training to date. Staff from all groups across the organisation have accessed the training, including our medical workforce who have found the training very good in expanding their knowledge of the issues a D/deaf patient has when accessing our services

Increasing accessibility
- Additional virtual wards launched
- Cancer symptoms advice line set up originally set up in 2020 due to COVID has been reintroduced
- Virtual British Sign Language (BSL) interpreting available through DRC
- Work completed in ED focussing on their access to interpreting services when they are needed at short notice
- Looking at an application (app) for BSL interpreters for ED and out of hours/short notice requests
- Learning Disability Nurse Specialists increased in the Trust therefore additional capacity to assist with reasonable adjustments and completion of health passports
- Internal and external review of all polices and departments as part of the Rainbow Badge Accreditation (scored bronze)
- Patient information leaflets have content checked to ensure they are inclusive (both language and content)

Collaborative working

- Working in collaboration with Cheshire and Merseyside ICB and the accessibility lead from Sefton Council to look at accessibility and also to seek to improve the information given to us by GPs services when referring patients to the Trust
- Leading on a Transgender task and finish group established to identify issues affecting trans patients and staff; this group developed a workforce policy for use in all trusts in Cheshire and Merseyside, working on this with clinicians from this Trust, Cheshire and Merseyside ICB, Sefton Council and local transgender specialists with the potential to roll the work and guidance out nationally once complete
- Reaccredited for the Veterans Aware and now a member of Lancashire Armed Forces Covenant meetings to work collaboratively with them to improve what we can offer our patients moving forward.

3.1.4.2. Engagement and consultation

- Patient Participation Group is held each quarter, with a face to face meeting and virtual access for those who cannot travel
- Regular updates are given regarding changes to the estate in the Trust, new services and service development. The group helped to develop our Trust values and priorities for the next year and were actively involved in our EDS22 assessment
- We continue to engage regularly with our community stakeholders to understand any barriers that they may face when trying to access our services and also to show them what changes we have made, some of which will be based on their feedback
- Carers groups to explain our carers passport and the benefits for carers detailed in the passport
- Access audits and PLACE inspections restarted following the pandemic and patient representatives from our local communities and local Healthwatch groups participated alongside Trust staff
- Engaged and consulted on policies and standard operating procedures (SOPs) from specialist groups eg trans polices with Lesbian and Gay Foundation (Rainbow Badge) and our Proud staff network
- Engaged with patient groups regarding the formation of the new Trust

3.1.4.3. Patient equality objectives 2023-27

The following objectives will be the focus for the coming years looking at all areas of the Trust, and not only how accessible the estate is, but also how accessible and inclusive are our services which will include:

- Patient app
- Patient letters and alternative to letters and phone calls for patients who are unable to use these formats
- Accessible formats and what more we can offer
- Alternative ways to contact patients eg emails
- Information in alternative formats
- Review accessibility of Trust areas/services across all sites
- Lay out/estate
- Accessibility
- Patient call systems

- Booking systems
- Change the way interpreting services are delivered in the Trust
  - 20% face to face
  - 40% telephone
  - 40% video

The use of interpreters had the following split in 2023:
- Face to face – 65.1%
- Telephone – 34.3%
- Video – 0.6%

3.1.5. Freedom to speak up

The Trust has an established system to encourage and support staff to have the freedom to raise concerns. Staff are encouraged not only to speak up about anything that gets in the way of delivering great care and treatment but also about areas of good practice that could be replicated elsewhere.

- Freedom to speak up (FTSU)

The Trust has six freedom to speak up guardians, two of whom undertake a dedicated role to both support staff and the development of a speak up, listen up and follow up culture, within the organisation. The team is supported by a FTSU Specialist Administrator and a developing network of FTSU champions, who come from different professional groups and are working at various levels and roles within the Trust. Whilst champions primarily support the culture within the teams in which they are embedded, they may also offer support and signposting to any staff member within the Trust. Guardians and champions come together once a month to share information and develop ideas for further developing the culture.

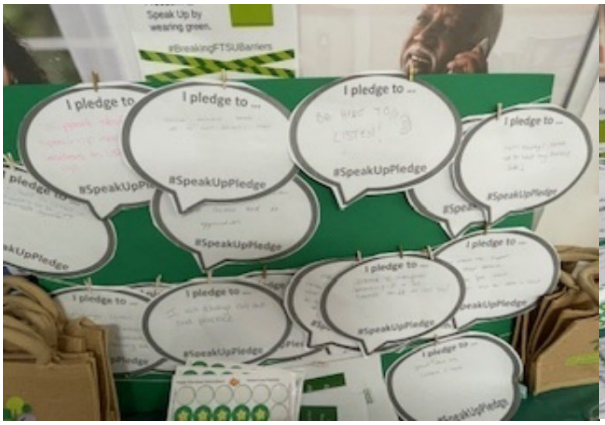
Following the formation of the Trust in July work has been completed to align processes and further enhance the service offered. Staff are encouraged to speak up and raise any concerns, within their own teams, however they can also access support via the FTSU guardians and champions. They can raise concerns via the web based, Speak in Confidence system, by email to a dedicated inbox, via a hotline to the Medical Director or by contacting the Chief Executive, who is also a FTSU Guardian. FTSU guardians participate in corporate staff inductions and offer an array of sessions to individual departments or as part of a training programme. The FTSU guardians meet on a regular basis to discuss any emerging trends, whilst maintaining confidentiality regarding individual cases.

The Trust Board completed a self-assessment of the FTSU arrangements within the Trust in January 2024, using the National Guardian's office and NHS England's Reflection and Planning Tool. The outcome of this has been used to develop an action plan for continuous improvement and an updated merged FTSU Strategy.

Each year, October is freedom to speak up month and the theme for 2023 was breaking barriers, with several activities undertaken to raise awareness of speaking up including:
- FTSU guardian and champions walk arounds on each site
- Information stands on each site and encouragement to staff to make a FTSU

pledge

- Distribution of quizzes and word search relating to speaking up
- Wear green Wednesdays
- Discussion at Trust Brief Live throughout the month
- Launch of a campaign to recruit FTSU champions across all Trust sites
- Launch of Speak in Confidence system at the Southport and Ormskirk sites



The FTSU system is complementary to the just and learning culture adopted by the organisation.

In 2023-24, whilst no Trust themes have emerged following analysis of FTSU cases, there has been appropriate actions taken to address all cases where action was required following review of the issues raised. When a FTSU guardian has supported a member of staff to raise concerns, feedback is requested before a case is closed. There is consistent positive feedback from staff in relation to the support offered by guardians, with examples below:

I would speak up again. I found the FTSU Guardian helpful in resolving my concerns. They kept me fully updated and was supportive.

I found myself in a situation recently, where I needed advice quickly and impartially. I felt that I was listened to and given advice on what to say which enabled me to address the issues I was facing.

The Team was involved quickly to address the concerns and acted properly with involving proper managers for investigation and satisfactory outcome.

Staff are also asked if they feel they have suffered detriment as a result of speaking up and, whilst there have been no reports of detriment in 2023-24, one member of staff was supported to consider applying and signposted to the NHS England FTSU Support Scheme.

The Trust continues to work in partnership with the National Guardian's Office and Northwest Regional Network of Freedom to Speak Up Guardians to enhance staff experience with raising concerns.

The range of other routes to raise concerns and receive support are listed below:

- Health, work and wellbeing hotline

Staff members have access to a dedicated helpline, to provide advice and support regarding health and wellbeing aspects relating to work or impacting on the individual. Bespoke support can be offered depending on the needs and circumstances. Concerns about the workplace can be raised through the hotline.

- Hate crime reporting

A hate crime is when someone commits a crime against a person because of their disability, gender identity, race, sexual orientation, religion, or any other perceived difference. The Trust, in partnership with Merseyside Police, continues to support staff members with the first ever Hate Crime Reporting Scheme based at an NHS Trust. This is a confidential online reporting service that enables anyone from across our organisation and local communities to report, in complete confidence, any incidents or concerns around hate crime to Merseyside Police.

- Policies and procedures

There are a number of Trust policies and procedures that facilitate the raising of staff concerns, including Grievance Policy and Procedure, Respect and Dignity at Work Policy and Being Open Policy. Staff are also encouraged to informally raise any concerns to their manager, nominated HR lead or their staff-side representative, as well as considering the routes listed above.

All concerns are taken seriously and changes made where appropriate, including making changes to the working environment, providing individual support and information available to staff and reviewing staffing levels in key areas. The Trust has made available nationally recommended FTSU training to all staff members on its e-learning platform.

3.1.6. Staff survey key questions

The national staff survey provides a key measure of the experiences of the Trust's staff, with the findings used to reinforce good practice and to identify any areas for improvement. For the 2023 survey, reported in 2024, the Trust conducted a full census staff survey. There were 3924 completed questionnaires returned giving a 38% response rate for the first MWL NHS Staff Survey.

For the second year, eligibility to participate in the NHS Staff Survey was extended to bank only workers in NHS organisations, using a tailored version of an online questionnaire. Eligibility was based on Bank workers who had worked in the six months between 1st March 2023 and 1st September 2023 and who did not have a

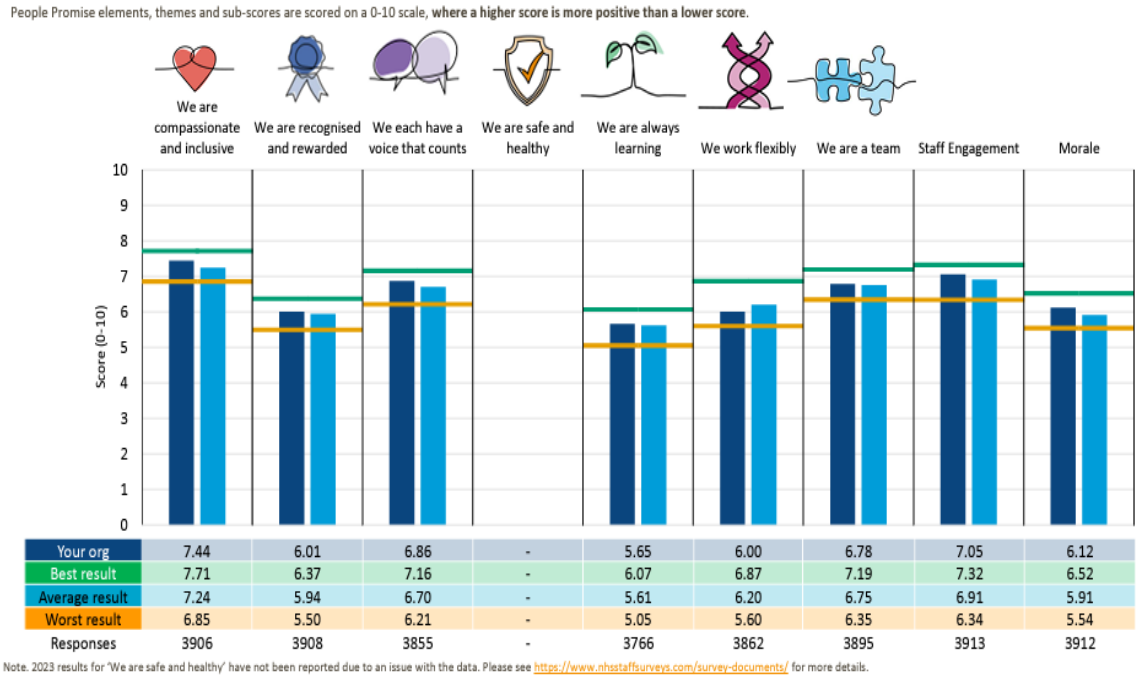
substantive or fixed term contract. Out of the 1453 people the survey was sent to, 217 people responded providing a response rate of 14.9%

We are able to make comparisons with the Trust's benchmarking group, which comprises the data for 'like' organisations, weighted to account for variations in individual organisational structure. The Trust's benchmarking group comprises 122 organisations.

The survey questions are still related to the themes and sub-themes of the NHS People Promise with additional themes of staff engagement and morale retained from earlier surveys. The results give a wide picture of satisfaction across the whole organisation.

Results are reported both as individual question responses and as themes, aligned to the NHS People Promise which are:
• We are a team
• We are always learning
• We are compassionate and inclusive
• We are recognised and rewarded
• We are safe and healthy
• We each have a voice that counts
• We work flexibly
Plus the two recurring themes:
• Morale
• Staff engagement

These results are shown in the chart below:

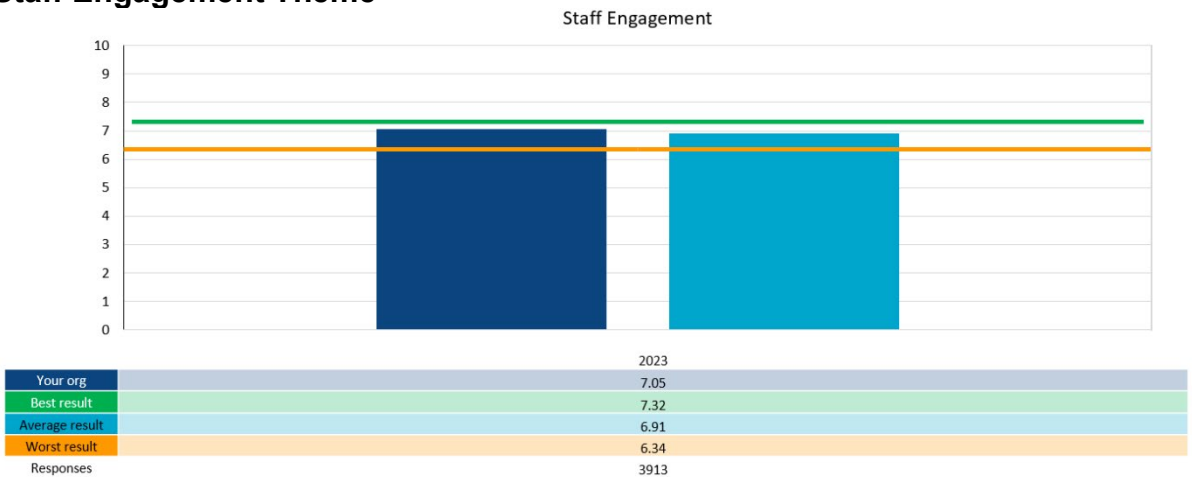


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.44	6.01	6.86	-	5.65	6.00	6.78	7.05	6.12
Best result	7.71	6.37	7.16	-	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	-	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	-	5.05	5.60	6.35	6.34	5.54
Responses	3906	3908	3855	-	3766	3862	3895	3913	3912

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Note: Some data from the survey relating to the PP theme of 'We are safe and healthy' has not been included in the report due to a national issue with data quality. Further details have been sent to HR Directors.

Staff Engagement Theme



Staff Engagement is calculated as an average from the scores of the following three sub-themes: motivation, involvement and advocacy. MWL preformed above the national average for all but one sub theme within this sector, involvement.

The Trust achieved the best scores for an acute trust in the North-West for sub-theme compassionate culture and advocacy, which include responses about recommending the Trust as a place to work, receive treatment, feeling that care is the organisation's top priority and that their roles make a difference to patients/service users.

Action plans are being developed for areas identified for improvement at Trust and local level.

3.2. Patient safety

One of the Trust's continuing priorities in 2023-24 was to embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience. There was a particular focus on reducing avoidable harm by preventing falls.

3.2.1. Falls

The Falls Team continues to develop strategies to minimise the occurrence of inpatient falls and in 2023-24 legacy STHK reported 2.71% reduction in inpatient falls per 1000 bed days, decreasing from 7.297 falls per 1000 bed days in 2022-23 to 7.099 in 2023-24.

The Trust continued to implement its Falls Prevention Strategy 2022-25 with a focus on 5 key areas for improvement:

- Embedding a culture of safety improvement that reduces harm caused by falls
- Improvement in communication of patient risk factors between wards/areas and the Falls Team
- Providing assurance of improvements and learning
- Education and development
- Equipment and environment

The Hospital Falls Team have provided staff with various methods of support, education and guidance to ensure the action plan associated with our strategy is completed within the specified timeframes. Some examples of this work include daily falls walk rounds by Falls Nurse Specialist, daily snapshot audits of falls care and ward based training.

Falls prevention training is provided to newly qualified nursing staff, junior doctors and healthcare assistants new to the Trust as part of the induction programmes. The Team also host a North West regional falls nurse forum. The group now meets bi-monthly and is a valuable opportunity for all members to share practice and news on national and local initiatives. Falls nurses, therapists and patient safety colleagues across the region attend and the membership has grown from 9 to 13 trusts during 2022-23. The forum has also been asked by the NHS England Cheshire and Merseyside Falls Prevention Steering Group chair to support as an operational group where decisions made or suggested by the Steering Group can be discussed with staff who work operationally in falls prevention roles across the region.

3.2.2. Pressure ulcers

The Trust has continued to focus on reducing the risk of patients developing hospital acquired pressure ulcers due to any lapses in care. A Trust-wide strategic action plan was developed and implemented in 2023, with compliance and actions monitored. There has been a decrease in 2023 in cases of category 2 - 3 pressure ulcers with lapses in care, from April to December there was 27 category 2 compared to 36 in 2022 and 3 category 3 cases compared to 1 in 2022. However, the number of total hospital admissions has increased by 9.2% in year to date. In addition, the team have reported significant higher acuity in referrals and an increase in complexity and co morbidities since COVID, as well as extended stays in ED.

In-depth investigations were commissioned to identify the causes of category 3 and 4 pressure ulcers, with improvement actions taken, including education for staff members to improve risk identification and appropriate care planning to prevent the development of a pressure ulcer. In one of the cases the patient had significant vascular insufficiency and vessel occlusion to lower legs.

The Trust-wide action plan highlights the main activities implemented in year to improve performance and is showing some improvements in several areas, including, documentation, compliance with policy and engagement in education and training, which the team offer bespoke at ward level.

Several new strategies have seen improvements including, all patients admitted through ED are placed on a bed frame and nursed on bed frames when possible. Further the pressure ulcer CQuIN has enabled the team to raise the profile of risk assessments and care planning, with achievement of a pass rate for April to December 2023.

3.2.3. Venous thromboembolism (VTE)

VTE covers both deep vein thrombosis (DVT) and its possible consequence, pulmonary

embolism (PE). A DVT is a blood clot that develops in the deep veins of the leg. However, if the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a blockage (PE) that could lead to death.

The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients on admission to hospital and taking appropriate action. This might include prescribing and administration of appropriate medication to prevent blood clots and application of specialised stockings.

National reporting for VTE risk assessment compliance has been suspended since April 2020, however the Trust has continued to maintain appropriate prevention interventions by:

- Electronic VTE risk assessments live on narrative system
- Paper document integrated into ED acute assessment pro forma making a documented VTE risk assessment available for ED patients
- VTE risk assessment recorded on patient flow boards with distinct purple circle assisting ward staff to identify status at a glance
- Sharing risk assessment compliance through daily dashboards
- Undertaking an investigation of all cases of hospital acquired thrombosis in order to reduce the risk of it happening again
- On-going VTE training including Moodle based online learning for all clinical staff
- Face to face training for new starters to the Trust

3.2.4. Medicine safety

The Pharmacy Department has continued to focus on medicine safety, with a number of actions taken as outlined below.

Electronic Prescribing and Medicines Administration (ePMA)
There has been an ongoing programme of ePMA system development and rollout overseen by the project board. In 2023-24 the Spinal Unit at Southport went live with ePMA, with further roll out to the rest of Southport and Ormskirk sites anticipated to be in the second half of 2024-25. Other priorities for 2024-25 include integrating the discharge prescriptions with ePMA to eliminate transcription and a progressive reduction in the use of paper prescriptions for specialist prescribing, including palliative care, paediatrics and anticoagulation.

Electronic inpatient non-stock drug ordering has been rolled out to all wards that are on ePMA, which saves nursing time but also ensures the order is received immediately in the pharmacy department and ensure patients receive their medicines in a timely manner.

Chemocare electronic prescribing system was upgraded in early 2023 and is now a Trust wide system for MWL.

Pharmacy dashboard
During 2023-24 the pharmacy dashboard continued to be developed. This is an invaluable ‘live’ resource which enables clinical pharmacy staff to review the medicines status of patients on each ward at a glance and prioritise their workload.

This takes feeds from multiple systems including ePMA, laboratory results, alerts and the dispensary systems.

Emergency Department developments
The Whiston ED pharmacy team was expanded at the end of 2022-23 and is now well established in the department. The Team focusses on patients being admitted as inpatients and performing medicines reconciliation to ensure an accurate drug history is obtained and that all prescribed medicines are appropriate on an individual patient basis. During the intense pressure on inpatient beds and patient flows during winter 2023-24, the input of this pharmacy team in ED has been especially important to support the prompt, safe treatment of patients with medicines in ED, especially for those whose onward transfer to wards was delayed. A critical medicines bleep is now in place which ensures patients receive these without delay and there is also a system to ensure any medicines dispensed follow the patient when they are transferred to an inpatient bed.

Targeted education on the management of controlled drugs has been provided to the ED nursing staff.

The storage of individual patients' medicines in ED has also been reviewed and a business case has been submitted to support the storage of medicines. At Southport and Ormskirk hospitals, bedside lockers are in place in ED, Ambulatory Care Unit and Clinical Decision Unit. There is a business case in development to increase the pharmacy team in ED.

Medicines audits
Medicines storage and security audits remain ongoing and continued improvement in performance has been reported from the previous year when Tendable was introduced. Targeted improvement work has been provided to areas identified as requiring support in the audits. Ward based pharmacy technicians now also perform weekly audits on safety and security of medicines on wards. Feedback is given to the ward manager and escalated to the matrons and an action plan put in place if improvement is not made.

The audit pro forma for controlled drugs (CD) in clinical areas is now within Tendable. This will enable faster analysis of results and subsequent feedback and support for areas which require this. A capital bid has been submitted for Careflow CD Manager, an electronic system to replace paper CD registers. In the meantime the pharmacy technical team is about to trial new pre-printed CD book indexes which will help address some shortfalls in CD audits. High level reporting and assurance for management of CDs will be combined with the general medicines storage and security audit reports from Tendable and presented to Quality Committee in future. Work has started to align STHK and S&O Safe and Secure Handling of medicines audits.

Additional developments
During the year, notable work has been completed to update and implement guidance for valproate prescribing and administration in female patients. We have continued a campaign to alert clinical staff of the importance of obtaining up to date

weights for patients on weight-sensitive medicines doses such as both IV and oral paracetamol.

Experienced hospital clinical pharmacists have been required to review clinically vulnerable patients' current medicines for harmful interactions with the first-choice oral antiviral for COVID, Paxlovid. Additionally, our dispensary team ensure the prompt supply of COVID antivirals for community patients, making arrangements for collection or delivery as the demand for these treatments continued.

Other medicines safety and quality-related work has included:

- Regular input into the Trust's safety huddles and quality & risk newsletters
- Cross site medicines safety bulletins, with MWL branding to inform on modified release and non-modified release preparations, and reminder that vigilance required with gabapentin/pregabalin prescribing and administration. Further bulletins for Emollients and Penicillin Allergy being drafted
- Critical medicines guidance cards supplied for attachment to lanyards at STHK, with plans to roll out to S&O
- Adverse drug reaction (ADR) event with stands in foyers at both Whiston and St Helens hospitals to promote ADR reporting
- Discharge medicines service to prompt follow up of patients by community pharmacists after discharge, which now includes targeting for smoking cessation support
- Adrenaline storage in community - creating standard operating procedures for safe storage for community nurses
- Worked with Urgent Treatment Centre (UTC) to help with their patient group directives (PGDs), safe storage and out of hours
- Medicine safety communication board in the department and updated on the intranet with reports and alerts
- IPads in the department for medication error reporting and Yellow card app installed
- Established drug library (Smart Infusion Pumps) for adults in place at S&O, with a view to expanding to paediatrics
- Falls reviews of patients by clinical pharmacists
- Contribution to investigation of serious incidents
- Extended safe and secure audits to reach community clinics
- Medicines Safety Officer in place for MWL, who attends Serious Incident Review Group, to advise on medicines related issues. Plans to review NHS England's (NHSE) enduring standards to benchmark and align processes across MWL
- Relaunch of the nurses' link group (STHK)
- Initiatives to maximise recruitment and retention of pharmacists and pharmacy technicians such as over-recruitment, redesign of posts
- Increased number of trainee pharmacy technicians in 2023-24
- Approval for additional trainee pharmacists to start in 2024-25
- Implementation of the Yellow card team within the department
- Business case approved for additional staff to support increased workload in outpatients; at S&O this is outsourced to Rowlands Pharmacy
- Additional Omnicell in Paediatric ED installed (STHK). Omnicells at S&O sites are situated in ED, ITU, and Paediatric ED
- Expansion continuing of ward-based dispensing with a new dispensary on the 5th floor at Whiston Hospital to be launched in spring 2024

- Aseptic dispensing unit establishment of additional funding stream to enable recruitment of extra staff

3.2.5. Theatre safety

The Trust Operating Theatre Department continues to develop and refine patient safety initiatives in keeping with the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs), to reduce the number of patient safety incidents related to invasive procedures. The key performance indicators are reviewed and monitored through Datix.

The department had one never event in November 2023 within Ophthalmology Theatres, with immediate actions taken to reduce the risk of further incidents.

As the World Health Organisation (WHO) surgical safety checklists continue to evolve in response to learning from incidents and other improvement work, the department has focused upon initiating several actions within the patient pathways. These will incorporate the new NatSIPPs 8 sequential steps that will provide clearer and more specific space for additional checks. In particular regarding surgical implant verification, consent, site and procedural verification and the reconciliation of items in prevention of retained foreign objects.

3.2.6. Being open – duty of candour

The Trust is committed to ensuring that we tell our patients and their families/carers if there has been an error or omission resulting in harm. This duty of candour is a legal duty on trusts to inform and apologise to patients if there have been mistakes in their care that have, or could have, led to significant harm (categorised as moderate harm or greater in severity).

The Trust promotes a culture of openness, honesty and transparency. Our statutory duty of candour is delivered under the Trust's Being Open - A Duty of Candour Policy, which sets out our commitment to being open when communicating with patients, their relatives and carers about any failure in care or treatment. This includes an apology and a full explanation of what happened with all the available facts. The Trust operates a learning culture, within which all staff feel confident to raise concerns when risks are identified and then to contribute fully to the investigation process in the knowledge that learning from harm and the prevention of future harm are the organisation's key priorities.

The Trust's incident reporting system has a mandatory section to record duty of candour. Weekly incident review meetings are held, where duty of candour requirements are reviewed on a case-by-case basis allowing timely action and monitoring. This ensures the Trust meets its legal obligations. The Trust has continued to raise the profile of duty of candour through the lessons learned processes and incident review meetings. In addition, duty of candour training is included as part of mandatory training and investigation training for staff.

3.2.7. Never events

Never events are described by NHS England in its framework published in 2018 as serious incidents that are wholly preventable. Each never event has a potential to cause serious harm or death. However, serious harm or death is not required for the incident to be categorised as a never event. Never events include incidents such as, wrong site surgery, retained foreign object post-surgical procedure and chest or neck entrapment in bedrails.

The Trust remains committed to understanding the cause of these incidents through comprehensive investigation. This approach is underpinned by the Trust's commitment to ensuring an open and honest culture in which staff are encouraged to report any errors or incidents and to feed back in the knowledge that the issues will be fairly investigated and any learning and improvement opportunities implemented.

The Trust reported one never event in 2023-24, which met the criteria of wrong implant/prosthesis. A number of actions were identified and implemented, including revision of the storage of the implants, review and update of the policy for the Local Safety Standards for Invasive Procedures (LocSSip) and local safety checklists and embedding pause/stop moment during the handling of implants in theatre as recommended by the centre of perioperative care (CPC) and NatSSIPs. Training was updated and delivered locally.

3.2.8. Infection prevention

The Health and Social Care Act 2008 requires trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infections (HCAI). The Director of Nursing, Midwifery and Governance is the Trust's Director of Infection Prevention and Control (DIPC), with Board level responsibility for infection control.

The Trust's infection prevention priorities are to:

- Reduce the incidence of healthcare associated infections.
- Adopt and promote evidence-based infection prevention and control practice across the Trust
- Identify, monitor and prevent the spread of pathogenic organisms, including multi-drug resistant organisms throughout the Trust
- Reduce the incidence of HCAI by working collaboratively across the whole health economy

The Infection Prevention and Control Team provides expert advice to the organisation regarding all aspects of IPC, including national policy initiatives and the development and implementation of the HCAI Annual Plan with key stakeholders.

The NHS Standard Contract 2023-24 includes quality requirements for NHS trusts to minimise rates of both Clostridioides difficile (C. difficile) and of Gram-negative bloodstream infections to threshold levels set by NHS England. The MWL combined objectives have not yet been established, with the legacy Trusts reporting separately until the end of the financial year.

STHK (Whiston, St Helens and Newton hospital sites) reported:

- Four hospital-associated MRSA bacteraemia cases; of these, three were associated with peripheral venous cannulae and were deemed avoidable, with the fourth case being linked to a urinary catheter. Improvements were identified in consistency of aseptic non-touch technique (ANTT) competency assessment and reliability of compliance with ANTT during care of invasive devices
- The Trust threshold is no more than 46 cases of hospital associated C. difficile in 2023-24, with 75 hospital-associated cases which is above target and an increase on last year

Southport and Ormskirk sites reported:

- Two hospital-associated MRSA bacteraemia cases. The first case was deemed as unavoidable in a complex patient who was colonised with MRSA on admission to hospital. The second case was an avoidable peripheral venous cannula infection, which resulted in Trust-wide learning and improvement by way of a Trust improvement plan given that this was the fourth cannula-associated bacteraemia
- The Trust threshold for hospital associated C. difficile is no more than 39 cases in 2023-24 with 40 cases reported, a decrease of 9 from last year

All cases of hospital-associated C. difficile undergo post infection reviews (PIR). Themes in these cases are largely unchanged, with the most common lessons identified in the timely isolation and stool testing of patients and antimicrobial stewardship in some cases. Lessons learned from the PIRs are shared with Trust colleagues via a monthly infection prevention report.

The Infection Prevention and Control Team undertakes a programme of clinical practice and environmental audits, to provide assurance on compliance with key standards and to identify areas where improvements can be made.

Key achievements for 2023-24 were:

- The Infection Prevention Teams working collaboratively across the new MWL Trust, with a focus on harmonising policies and guidance, to ensure standardised and reliable IPC practice
- The development of an E. coli bloodstream infection (BSI) improvement plan, with a focus on hydration and urinary catheter care.
- The development of a cannula care improvement plan to address lessons from the MRSA BSI, to improve care and ongoing maintenance of these devices
- Alignment of ANTT system and process across MWL
- Improved engagement with ward leaders to optimise the clinical environment for patients, with a programme of estates walkarounds, with estates and the IPC Team Matron
- Support from the IPC Team on capital estates projects, to improve the built environment for patients and staff

3.2.9. Safeguarding

The Trust is committed to ensuring safeguarding responsibilities are carried out in line with legislation and national and local policy. There are dedicated Safeguarding Teams situated on both the legacy S&O and STHK sites. Within the teams there are Named Nurses and Named Midwifes for both children and adults supported by

specialist safeguarding practitioners. There are two Assistant Directors who support the Director of Nursing. Midwifery and Governance to ensure that the Trust is fulfilling its statutory safeguarding responsibilities.

There is a suite of safeguarding policies which have been harmonised following the transaction of the two legacy Trusts, along with associated robust processes to protect unborn infants, children and young people and adults at risk (including those with a diagnosis of a learning disability and/or autism) from harm or abuse. In addition, there is a specific Safeguarding Training Needs Analysis which identifies the level of training every staff member within the organisation must complete, including safeguarding adult and children training, mental capacity, prevent and learning disability awareness. The Safeguarding Team also ensure there are processes in place to support patients who are unable to consent to care and treatment and require a formal capacity assessment and completion of an urgent deprivation of liberty safeguard (DoLS) authorisation; these are quality assured and processed by the Safeguarding Teams.

The Safeguarding Teams maintain a visible presence across sites and are available to offer advice, support and supervision to all Trust staff. The Trust safeguarding key performance indicators (KPIs) are submitted on a quarterly basis and quality assured by the Integrated Care Board (ICB) Designated Nursing Team (St Helens and Sefton Places). During 2023-24, a red/amber/green (RAG) rating of green was given in all areas except safeguarding training compliance and completion of Looked After Children (LAC) initial health assessments within the St Helens based Developmental Paediatric Service. There has been a steady increase in training compliance with the 90% required compliance achieved in the majority of all levels.

The expectation in relation to initial health assessments for LAC is that 100% of children will receive their assessment within 20 days of entering the care system; this continues to prove challenging due to both internal and external pressures, including late notifications from the Local Authority, children not being brought to appointments and an increase in the numbers of children requiring assessments. The Developmental Paediatric Team has taken steps to increase appointment capacity and provide weekend appointments to support attendance, as well as working with community partners to review processes and consider any potential barriers.

The ICB continue to confirm assurance in relation to safeguarding activity which has risen consistently across all areas, particularly numbers of referrals and evidence of good multi-agency working. Quarterly safeguarding reports and an annual report are presented to the Quality Committee and the Safeguarding Assurance Group meets quarterly to provide safeguarding updates in all areas of safeguarding activity and process, with external stakeholder representation provided by the Designated Nurses and Healthwatch partners for the purpose of additional scrutiny and information sharing.

The Trust provides representation at five local safeguarding partnership boards for adults and children and to associated subgroups. When required, there is additional representation and contribution to adult and children multi-agency reviews, domestic abuse related death reviews (previously known as Domestic Homicide Reviews) and theme specific multi-agency audits.

There has been further external scrutiny by way of a Mersey Internal Audit Agency (MIAA) safeguarding audit. This was a positive report with a rating of substantial assurance with elements of high assurance. The medium/low level recommendations will be implemented as per the Safeguarding Action Plan.

3.2.10. Clinical harm reviews

There continue to be high numbers of patients awaiting elective procedures. Each patient is listed with a clinical priority code (Priority 2 (P2) – Priority 4 (P4)) which guides the timing of the procedure according to the level of clinical need. P2 indicate procedures to be undertaken in less than a month, P3 within three months and P4 being the most routine.

Ongoing operational challenges mean there are a significant number of patients waiting beyond the target timescale. Individual specialties are tasked with validating their waiting lists and reviewing those patients at highest risk of deterioration whilst waiting.

To support this process and ensure we are identifying the patients at the highest risk of clinical deterioration on the waiting list we are utilising artificial intelligence (AI) software (C2AI), which can provide patient level risk data. The system is also able to validate the priority code assigned to each patient. Those patients who have had related non-elective admissions whilst waiting for elective surgery are also identifiable and can be reviewed for harm and reprioritised by the speciality team. Where significant risk of clinical harm due to surgical delay is identified by AI, a formal review of the case is requested by the clinical team to validate and action a new priority if indicated.

A system is also in place for retrospectively reporting any evidence of clinical harm due to prolonged waiting times identified at the time of treatment.

Work is underway to standardise these processes across MWL.

3.3. Clinical effectiveness

The Clinical Effectiveness Council meets monthly, is attended by representatives from all care groups and is chaired by the Medical Director. It monitors key outcome and effectiveness indicators, such as mortality, nationally bench-marked cardiac arrest data, critical care performance, hip fracture performance, readmissions, clinical audit performance, departmental performance and application of National Institute for Health and Care Excellence (NICE) guidance. The Clinical Effectiveness Council reports monthly to the Quality Committee through its chair.

3.3.1. Clinical Speciality Presentations

Each speciality in the Trust is invited to give a presentation to the Clinical Effectiveness Council outlining their achievements, challenges, research/audit activity and patient feedback from the previous year. This gives them an opportunity to showcase the good work that they have been doing in their speciality and to raise

with the Council any challenges they have, which may require Executive or Board support.

3.3.2. Research, Development and Innovation Group

Clinical research is vital to the NHS as it means we can continually improve the healthcare we provide to our patients and develop new and improved treatments and medications. MWL has a successful and busy research department which supports clinical staff to carry out research projects in the Trust to help improve patient care. The Research, Development and Innovation Group (RDIG) presents regular reports to the Clinical Effectiveness Council on the annual plans for clinical research within the Trust, provides assurance that research projects are being successfully completed and gives updates from RDIG meetings.

3.3.3. Quality Improvement and Clinical Audit

Clinical audit is a key process in the Trust's cycle of continuous quality improvement, through the review of care provided against evidence based standards. In order to assist this process, the Quality Improvement & Clinical Audit (QICA) Department provides a wide range of support and advice to Trust staff, both clinical and non-clinical, who are involved with audit projects at national, regional or local/Trust level. QICA present regular updates on compliance with mandatory national audits, the progress of ongoing audit projects within the Trust and compliance with action plans

3.3.4. National Emergency Laparotomy Audit (NELA)

This is a national audit which is carried out to monitor the outcomes of emergency abdominal surgery. The results are presented to the Clinical Effectiveness Council by the Clinical Director for Surgery to provide assurance that safe care is being provided to patients undergoing emergency laparotomy and to identify any areas where improvements could be made.

3.3.5. National Institute for Health and Care Excellence (NICE) guidance

Mersey and West Lancashire Teaching Hospitals NHS Trust has a responsibility for implementing NICE guidance to ensure that:

- Patients receive the best and most appropriate treatment
- NHS resources are not wasted by inappropriate treatment
- There is equity through consistent application of NICE guidance/quality standards

During 2023-24, as a newly merged organisation, we have been working towards a harmonised process for managing NICE publications to ensure we demonstrate to stakeholders that NICE guidance/quality standards are being implemented within the Trust and across the health community. This is a regulatory requirement that is subject to scrutiny by the Care Quality Commission. The Quality Improvement and Clinical Audit (QICA) Team are responsible for supporting the implementation and monitoring of NICE guidance compliance activity. The Trust has a robust NICE compliance policy and during 2024-25 we will continue to develop our processes

throughout the footprint of the new organisation.

A total of 205 pieces of new or updated NICE guidance were published during 2023-2024. 106 of these were identified as applicable to the Trust and there are systems in place to ensure all relevant guidance is distributed to the appropriate clinical lead to assess the guidelines relevance and, if applicable to the service, to complete a gap analysis of compliance with the requirements. Action plans are produced for any shortfalls to ensure compliance is achieved. Compliance is rigorously assessed by mandatory departmental compliance audits reportable through the Trust audit meetings.

NICE compliance position at end of financial year 2023-24

	Legacy STHK	Legacy S&O
Awaiting response	13%	4%
Fully compliant	65%	83%
Partially compliant	14%	13%

3.3.6. Promoting health

The Trust continues to actively promote the health and wellbeing of patients by undertaking a holistic assessment on admission that looks at physical, social, emotional and spiritual needs. Patients are referred or signposted to relevant services, for example, the Spiritual Care Team, dieticians, stop smoking services and substance misuse. In addition, the Maternity Service actively promotes infant feeding and treatment and support for those with tobacco dependency.

The initial review of patients includes a number of risk assessments that are used to highlight specific concerns that are acted upon, including nutrition, hydration and falls. The Trust has a Smokefree Policy in place that promotes a healthy environment for staff, patients and visitors, with measures in place to support staff and patients to give up smoking. Patients are asked on admission about smoking and alcohol intake and then provided with support and guidance as required. In 2023-24 the Trust employed a dedicated team of Tobacco Dependency Treatment Advisors in preparation for the launch of the inhouse Tobacco Dependency Treatment Service in April 2024.

The Trust works in partnership with other agencies to provide holistic services throughout the patient's journey to ensure a seamless service, supported by integrated pathways across the hospital and community settings. Examples of this include the work of our Community Falls Team, who work collaboratively with the local council, primary and community care and our Infection Prevention Team who liaise closely with community teams and GP services.

In addition, the Trust's volunteer survey from 2022-23 showed that 35.75% of volunteers felt that their general health and wellbeing had increased, with comments received such as, "When I was made redundant I honestly believe if I had not become a volunteer my life would not be so fulfilled and I have a sense of purpose" and "It's been life changing, really helped with my confidence". The satisfaction of helping others is not the only advantage of the volunteer experience as the gift of helping others may actually benefit health and wellbeing. Volunteering can broaden

social networks, enhance mental wellbeing and increase activity levels. Research has shown that volunteering can decrease the risk of depression, it increases social interaction and builds confidence. Our volunteer exit questionnaires highlight a reoccurring theme that volunteering has increased confidence.

3.4. Patient experience

The Trust acknowledges that patient experience is fundamental to the quality of healthcare and that a positive experience leads to better outcomes for patients, as well as improved morale for staff. Patient experience is at the heart of the Trust's vision to provide 5- star patient care.

The Southport and Ormskirk Hospital NHS Trust patient experience strategy 2020 - 24 was launched in 2020 and identified four key areas for improvement:

- Listening to our patients, carers and families and responding to their feedback
- We will provide a safe environment for our patients
- We will meet the physical and comfort needs of our patients
- We will provide a safe discharge for our patients

At St Helens and Knowsley Teaching Hospitals NHS Trust, the Patient Experience and Inclusion Team launched the new Patient Experience and Inclusion Strategy in 2022 following consultation with internal and external stakeholders. The strategy brings together objectives for equality, diversity, inclusion and engagement for the first time, rather than having separate strategies. The strategy sets out the Trust's commitment to improving patient experience by meaningfully engaging with our patients, key stakeholders and local communities to remove any barriers to access, by building on our current engagement activities and ensuring people from all our local communities are included and able to help. There are three commitments and associated objectives laid out in the strategy that will support a continuous cycle of engagement throughout every step of the patient journey and embodies the Trust 5 Star patient care and Trust values. The strategy is re-enforced with a detailed implementation plan which is monitored the Patient Experience Council.

Patient stories have continued to be shared in multiple formats such as written, digital and filmed. Stories have been collected from a wide variety of areas and featured end of life care, hyperacute stroke pathway and dementia and delirium care. They are shared at the Patient Experience Council and bi-monthly at Trust Board. Stories have been presented that have demonstrated both positive experiences and those where learning and improvements are required, for example, the introduction of butterfly volunteers to support families whose loved ones are receiving end of life care as featured in case study 4 below.

The Tendable patient experience audit provides a quality assessment enabling direct contact with the patients and provides an opportunity for real time experiences to be shared. It is about actively listening and if a concern is raised of a serious nature this is acted upon immediately. It also provides the opportunity to inform patients of services and campaigns and gain specific feedback about different areas within the Trust. A number of changes have been made throughout the year as a result of this direct patient feedback, including, successful reimbursement of monies made for bedside television, provision of employment sick notes for patients on discharge,

improvement to WIFI connectivity within paediatric wards and the Radiology Department, use of prevention of delirium volunteers for a patient on our assessment ward and safety netting a diabetic patient on discharge using interpreter services.

The Trust-wide Patient Participation Group, which consists of patients, carers and members of the public has continued to meet quarterly as planned. The group welcome guest speakers to provide updates on current and planned improvement works, with presentations from Staff Engagement Lead, Merseyside Police Hate Crime Coordinator, Macmillan End of Life Care facilitator and People Protection and Asset Manager. The group have been specifically involved in various service improvements, including naming psychology support bags, “unwind the mind kits”, (provided to inpatients to support with coping strategies for tolerating distress in response to physical health adversity), contributing to the organisational review of the new Trust values and reviewing the Trust clinical strategy 2023-2025. Colleagues and patient representatives from S&O sites have been added to the group membership.

Additional feedback is gained in many ways, through everyday interactions, local and national surveys, social media platforms, independent statutory bodies and regulators, Patient Advice and Liaison Services (PALS) and complaints. Fundamental to feedback is that we gather, analyse, share and demonstrate learning. To increase the number of comments, the Trust has welcomed external partners such as Healthwatch and the Deafness Resource Centre back into the hospital premises following the removal of social distancing to undertake regular outreach visits. This allows the additional collection of comments from patients and visitors and enables a quick resolution to queries.

Following previous years’ success, the Patient Experience and Inclusion Team repeated the appeal for school aged children to send in seasonal pictures and messages to cheer up our patients who were unfortunately in hospital during the Christmas period. The team received nearly 1167 pictures and messages, which were added to the Christmas packs for our inpatients, which also included a festive message from the Trust and quizzes for patients across all sites at MWL. Members of the team have written to every school and child who sent pictures/messages with a thank you from the Trust. CEO Ann Marr also met with some of the children who had made cards and were very happy to tell her all about them.

The festive fun that took place across all hospital sites included delivery of gifts from our local community, charity organisations and rugby and football celebrities, Christmas choir presentations, events to thank our dedicated teams of Trust volunteers and Christmas parties and markets.

3.4.1. What our patients said about us in 2023-24

Emergency Department – Southport site
My father was rushed to A+E with a bad infection and the doctors advised he had hours to live. The care and attention from the doctors and nurses was fantastic, we couldn't fault the service. It was like private healthcare, they even arranged Chaplain services for prayers. We were given regular updates and they were so caring with my dad. NHS at its absolute best.

Childrens Ward - Ormskirk site
My little boy was looked after amazingly. He had great interactions with the play specialists which he absolutely loved whilst recovering. Thank you.

Delivery Suite – Ormskirk site
The midwives I had during my delivery were fantastic and very supportive. Everything was explained well and we were guided through the process whilst keeping us motivated and reassured.

Maternity Whiston
We had an amazing experience today. We didn't wait long. Staff were all lovely and Nikki was so bubbly, made our scan experience fabulous. We would definitely recommend Whiston to all our friends; it is such a clean, friendly, lovely place to have a baby.

Dermatology Department – Ormskirk site

Although I had to wait 30 minutes beyond my appointment time I was treated with smiles, chirpiness and professionalism. Most importantly I felt I was not on a conveyer belt and staff took time not to rush me out.

Facilities Department - Ormskirk site
I visited with my daughter for an outpatients appointment and arrived early as I know parking can be tricky. As I drove round the back of the hospital I was directed by a series of fantastically helpful and cheery parking marshals. They directed me to a space in no time and each one had a smile and a wave for us! I suspect dealing with parking can be a thankless task so just wanted to share this positive feedback.

Ward 3A-Orthopaedics - Whiston

I would like to thank all the hospital staff that handled my treatment during my stay from the surgery that I had through to my discharge from the hospital. The staff were friendly, caring, helpful with a sense of humour when appropriate. We know that times are difficult in hospitals and the staff have to deal with a variety of issues with limited time, but nothing appears to have phased them. As it is said, teamwork is key.

Intensive Care Unit - Southport site

We just wanted to thank everyone involved in the care of our mother. We really couldn't have wished for a better team that showed so much care and compassion. It really was a help to both of us and we can't thank you enough. Thanks again

Physiotherapy – Ormskirk site

The assessment I received was excellent and I completely understood my symptoms after it which made me feel relieved. Was given exercises to complete and very happy with the appointment. I felt that the physio really knew what she was talking about and I was very happy with her explanation.

Ward 2A- Haematology

I would just like to say a huge thank you to all the staff who were involved with my son's care at Whiston this year.
Every person that was involved in his care demonstrated the Trust values are being practised across all the teams, from the medical staff and nurses involved in his direct clinical care and the Macmillan nurses who supported him throughout, providing reassurance on the stressful, frightening days and a lot of humour to keep his spirits up and relieve the boredom on the long days as an inpatient. Also, to the friendly staff who came in to offer him drinks or to keep his room spotless, they all referred to him by name, chatted to him and made him feel that he was being well looked after. Thank you to all.

Whiston ED

I just wanted to write to express mine and my families sincere gratitude for the kindness compassion and support you showed us when my father in law recently was admitted following a stroke, from all the A and E staff to the ward and therapists, social work team arranging the discharge you treated us all with the utmost respect making a very stressful situation less daunting

Radiology

I have been having a number of tests done in the Radiology Department and it has been quite a worrying time for me whilst those investigations have been taking place. I am providing feedback as I have been so impressed by the care, compassion and friendliness of all the staff in that Department. Each time I have been, I have been greeted with a smile and a manner that really puts me at ease. The nurses in particular have been nothing but outstanding in their care. The hospital have got amazing staff and I just want to say a huge thank you.

Patient feedback received by Healthwatch Knowsley about the Trust is generally positive and particularly so around treatment and care (83%) and staff (100%). Areas where comments have been less positive include access to services (60%) and communication (60%), reported for quarter 3 2023-24.

3.4.2. Patient case studies

At Mersey and West Lancashire Teaching Hospitals NHS Trust, we know that patient experience is more than just meeting our patient's physical needs, but also about treating each patient as an individual with dignity, compassion and respect. We do not want to just meet expectations, we want to exceed them. This means we are committed to working in partnership with our patients to improve the quality of care that we provide and we commit to actively seek, listen and act on feedback received from our patients. The following four case studies described below provide anonymised examples of changes made as a direct result of patient feedback.

1.Carer Support Southport Hospital site.
As COVID restrictions were lifted and following on from the introduction of the carer passport and the ongoing commitment to John's Campaign it was recognised that further investment was needed to support carers to stay overnight if they wished to support loved ones who have enhanced care needs.

In response to this x5 foldaway beds were purchased via the Charitable Funds which are held centrally and provided to wards on request. This has allowed those carers to be present if they wish to contribute to a loved one's care and allows them to be fully involved in any decisions regarding care and treatment. Most importantly it gives the patient a sense of familiarity when spending time in the unfamiliar hospital environment.

> 'I have attended A & E and as an inpatient a number of times. The hospital is very supportive of carers as my husband has dementia. You are allowed to stay with the person you care for 24 hours a day if you want.' (Sefton Healthwatch Website)

2. Meal Delivery on the Acute Medical Admissions Unit (AMU) Southport Hospital site.
Patient feedback was received expressing concern over the ability to access a hot meal on the Acute Medical Unit (AMU). On further investigation it was noted that the ward only provided soup and sandwiches and a limited choice of hot meals in the evening. This was due to the expected short length of stay of patients on the unit. However, due to the increase in hospital admissions patients were experiencing an extended length of stay. In response to this, improvements were made ensuring that all patients were supported to order a hot meal if required at lunch and in the evening. Once this had been embedded, further improvements were made to ensure that patients received their meal in a timely manner. As an additional outcome of this regular audits are now completed across other inpatient areas to ensure that patients experience an effective meal delivery service.

3.The difference that the patient experience questionnaire can make to a patient
The Patient Experience Team met a patient admitted to Seddon Suite, our Specialist

Regional Rehabilitation Unit in St Helens Hospital, during a routine survey of the in-patient experience in the Department. For this individual patient it became apparent through questioning, listening and the sharing of personal photographs before admission that her hair was an important physical feature for her and her body image. Unfortunately her hair had been cut quickly prior to brain surgery and the patient described it as a "shadow of its former glory". We were able to help the patient feel and look a bit more like herself through an appointment with the hospital hairdressing team to cut and colour her hair. The patient also showed the team the protective helmet that must be worn when she goes outside. The helmet in her words was really "ugly and embarrassing". Following a conversation with the physiotherapy team, therapy sessions were arranged to incorporate decoration of the helmet as part of fine motor therapy.

Other changes have been made to capture and use more patient feedback to enable service improvements that will positively impact the experience of future patients. These include refreshing the Tendable audit questions to reflect the areas of improvement highlighted within the most recent national in-patient survey results, recruitment of other non-clinical members of staff who can support the completion of surveys with patients, including volunteers to enable the experiences of more patients to be captured and actioned and the development of patient experience champions to undertake ward audits as part of their role.

In addition, the Patient Experience Matron is working with the volunteer service to develop a database of young volunteers who are happy to be available to provide some young person distractions for our long-term younger patients at the Whiston, St Helens and Newton sites.

This case study demonstrates that questionnaires stimulate meaningful conversations to yield valuable information that allows staff to make a real difference to the patient, families and friends at point of care and for future patients also.

4.One opportunity to get end of life care right, Whiston, St Helens and Newton Hospital sites.

In the acute setting on average 30% of all current hospital in-patients are in the last year of life. The legacy STHK Trust Bereavement Guiding Principles and Palliative and End-of-Life Care Strategy advocates that bereavement support and end-of-life care is everyone's responsibility. Healthcare professionals have one chance to provide excellent care for the dying, the deceased and those who are grieving. Grief and loss do not start at the time of death**.**

A patient's wife worked with the Patient Experience Team to create a digital story, recounting in her own words the end-of-life care received by her and her late husband during an inpatient stay within the Medical Care Group at Whiston Hospital. On occasion, their experience fell short of the 5 Star patient care vision and Trust values, in particular in relation to communication and care.

Listening to and working with the patient's wife following the death of her husband, many service improvements have been developed, including a patient experience focussed re-launch of Trust bereavement champions, the purchase of thirty-fold up beds for overnight use by loved ones and reconfiguration of our existing family

overnight accommodation. The Patient Experience Team remain in contact with the family and have invited them to the next development day for our Butterfly champions, who are being introduced across all the MWL sites where end of life care is delivered.

3.4.3. Friends and Family Test

The Friends and Family Test allows patients to rate their overall experience of care. It is an important feedback tool that support the fundamental principle that people who use NHS services are able to offer real-time feedback at any point in their care. Feedback that is gathered is used to identify trends and themes to direct local improvements to patients, families and carers. Positive feedback is often shared with staff to ensure that they feel valued.

The opportunity to give feedback is provided via multiple methods such as postcards, online surveys, automated SMS text messaging and interactive voice messaging.

The Trust's inpatient positive rating recommended care rate for 2023-24 was in line with NHS England's average of 94%.

Wards and departments across the Trust monitor the patient feedback and display 'you said, we did' improvement posters to highlight the actions being taken to continuously improve the care we provide, as well as maintaining staff motivation and influencing change. The table below highlights some examples of feedback and actions taken:

You Said	We Did
Ward noisy at night disturbing rest Southport and Ormskirk Hospitals inpatient areas	The Silent Night campaign was re-launched across Southport and Ormskirk sites in December 2023. Headphone sets were acquired from Hospedia and shared across all inpatient settings. Sleep well kits are available in both the inpatient and the ED setting.
Parents attending Paediatric ED felt that children with additional needs are not taken into full consideration. Paediatric ED Ormskirk Hospital	A new behavioural pain scale has been introduced for use in the department for these children.
Delivery beds are broken and uncomfortable. Delivery Suite - Ormskirk Hospital	Differing delivery beds were piloted. Feedback was sought from service users and staff. Based on this feedback new delivery beds were ordered for all delivery rooms.
Long wait in reception before procedure and long wait in ward after waiting discharge. Would like to have been told long waits possible, this would have made the waiting easier.	Thank you for your feedback, waiting times have unfortunately increased recently due to extra theatre activity. We will be creating a poster to advise patients of potential long waits during busy periods and will endeavour to keep patients up to date on how long they can be expected to wait in the future.

Plastic Surgery Day Unit Whiston Hospital	
Feedback on my end of treatment pack which was useful containing lots of information. It would be helpful within the pack to perhaps have some guidance about benefit and household support, etc. I could not find this kind of info out easily from the Macmillan desk previously as no one was there at the time to ask about this. Lilac Centre, St Helens Hospital	Thank you for your comments about our end of treatment information packs. We have now included two new Macmillan booklets with guidance on managing your energy costs and claiming benefits when you have cancer. We hope these will help to cover some of the difficulties patients and families may face. The Macmillan desk at St. Helens hospital is now also staffed daily following some recent recruitment.
Patient not eating food as feeling over faced. Daughter expressed concerned to nursing staff. Newton Hospital inpatients	Discussed with catering staff who agreed smaller portions and little and often options. List of favourite foods given to catering. Family encouraged to bring in snacks and alternative food options. Continue to monitor patients' food intake and weight.
More contact with patient. Ward 4F Whiston Hospital	Firstly, we apologise that you feel contact with our patients was limited, as a team we set out to implement set times to provide engaging physical/mental games to interact with our patients more.

3.4.4. Our Chaplains

All the hospital sites are covered by the Spiritual Care and Chaplaincy teams, with the aim of supporting the Trust's Five Star vision by meeting spiritual, religious and pastoral needs. Not everyone has a religious dimension, but everyone has a spiritual dimension and, therefore, spiritual needs.

The service has a good network of multi-faith colleagues who provide specific religious and faith support when requested. The service receives referrals from various sources, including:

- Ward staff
- Hospital systems (Careflow etc)
- Direct from patients, their relatives or faith communities
- Specific teams (for example, Palliative Care)
- Meeting patients on wards

The Spiritual Care Teams work closely with many other teams and also are involved in training, including induction to the Trust, breaking bad news and bereavement support. As well as routine visiting there is a 24 hour on call service available for urgent life changing situations. The aim is to be at a patient's bedside within an hour of an urgent call, although often it is much sooner than that.

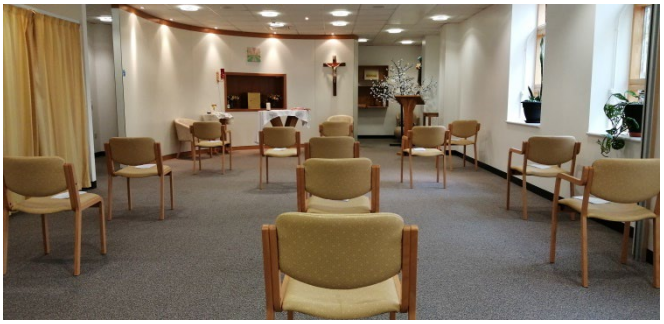
There are regular events including annual adult and baby memorial services and other one-off occasions. In the last year the Ormskirk Baby Garden was renamed the "Evergreen Garden" and the memorial wall was dedicated, in a very moving ceremony in which a number of the hospital leadership team took part.

The Southport and Ormskirk team lead (Martin Abrams) is one of the authors on two papers about to be published in partnership with Edge Hill University on spiritual care in a pandemic. In addition, the Southport and Ormskirk team was very proud to be nominated for the People's award at this year's MWL staff awards.

The teams receive many compliments, including:

> Just a very brief email to express again my heartfelt thanks for all you love, help, support, and direction these past few months following the passing of my mum and dad. You helped me and them greatly and I am forever grateful for you being there.

> My 87 year old father was rushed to (Southport) A&E at 2am with a bad infection. The 2 doctors on shift advised he had hours to live and we were given a side room. The care and attention the nurses and doctors was fantastic, we couldn't fault the service. It was like private health care. They even arranged Chaplain services for prayers which called an out of hours Chaplain within 20 mins. We were given regular updates and they were so caring with my dad in his final days. NHS at its absolute best.



The team are available to respond to needs in whatever shape they come including just sitting with patients if that is required.

In addition, the team offer a daily opportunity for staff to take time out by 'dropping in' to the Sanctuary at Whiston. This gives staff the option of just sitting on their own, talking to one of the duty chaplains or to partake in a guided reflection.

3.4.5. Our volunteers

Whiston and St Helens Hospitals
Our volunteers play a key role in providing 5 star patient care and we are incredibly grateful to them for the time they give. We have a well-established and embedded volunteer team of over 290 volunteers who carry out 19 different roles, including new roles for therapy volunteers on our stroke ward, Discharge Lounge volunteers and re-instated volunteers on our Delivery Suite.

We hold volunteer recruitment events bi-monthly and recruited 160 new volunteers in 2023-24. Our recruitment events are supported by staff who take time to present volunteer opportunities in their areas. In addition, we offer a number of training courses to equip our volunteers with the skills required for their role and during 2023-24 we trained the following:

- 138 volunteers received wheelchair training
- 165 volunteers had infection prevention training
- 109 volunteers received disability & autism awareness
- 34 volunteers had refresher safeguarding training
- 35 volunteers attended dementia awareness courses
- 31 volunteers were trained as dining companions

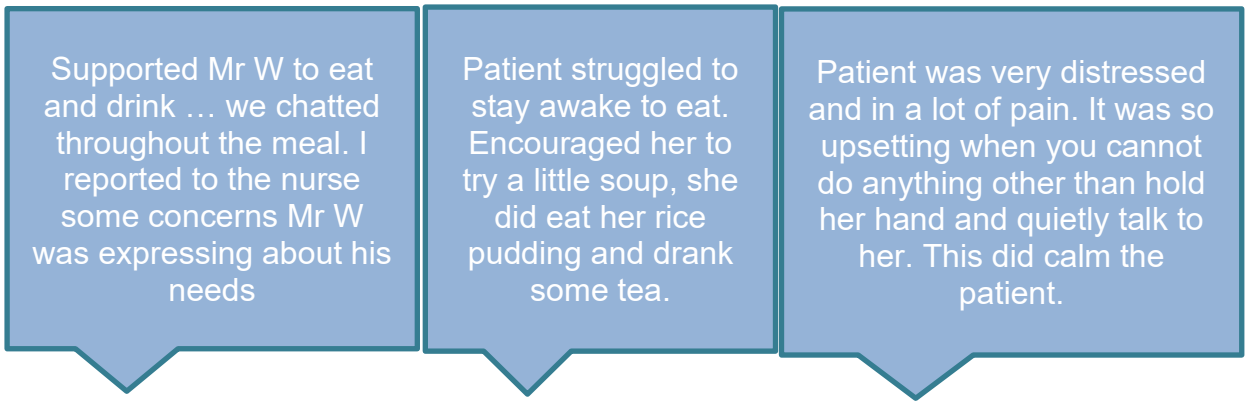
We currently have 15 dining companions across Whiston site based on our care of the elderly wards. Feedback forms have allowed us to measure the impact of this service, which highlighted that volunteers love interacting with the patients and staff are very supportive and appreciate the help offered by the dining companions. Staff have made the following comments:

> Such an amazing lady really helped having her assist the patients …. I can only say thanks a lot for this service you provide as it really helps both patients and staff. The companion we had has been a diamond and the patients she assisted really enjoyed her company. A job well done!

> Lovely communication with patient, very friendly and provided lots of help with feeding.

> Volunteer comforted patient and patient became settled because volunteer was gentle and polite with her. Great service as always

Volunteers gain a sense of satisfaction when assisting our patients during mealtimes and make a real difference to them as shown by the comments below:



We continue to provide a Volunteer Responder service which delivers urgent medications from the pharmacy department to the wards. During the year volunteers delivered a total of 600 urgent medications to our wards. As a direct result of this service nursing staff are no longer required to leave the ward area to collect the medication, thus enabling them to continue to provide essential care to our patients.

We continue to provide a reactive volunteer service and responded to many requests for volunteer assistance. Volunteers have acted as patients and supported staff with their clinical exams. We have received many befriending requests from nursing staff to support patients who are feeling lonely, upset or are in need of a chat.

The Volunteer's Service is pleased to be launching a new 2-year pilot in collaboration with the Anne Robson Trust which aims to offer palliative patients and their loved ones meaningful support in the last days and hours of their life. This will embed the Bereavement Guidelines and Principles and highlights the importance of excellent care at this critical time. It is called the Butterfly project and will be led by a Butterfly Co-Ordinator who joined the team in January. They will recruit and train volunteers and promote awareness of the service by linking in with wards and liaising with clinical staff on the referral process as this is developed. The benefits of patients being supported at this highly sensitive time is evident in reduced anxiety and stress levels for all involved, reduced risk of complex grief for relatives and, therefore, improved outcomes for the trust and its staff.

Whilst the Butterfly Project is still in its infancy within Whiston, we are linking in with the Anne Robson Trust with the aim of rolling out the project initially as a pilot scheme with the support of the Palliative Team and Bereavement Service. We then hope to extend our volunteer support to other wards in addition to Southport and Ormskirk Hospitals.

When volunteers leave the Trust we collect feedback on their experience through our exit questionnaires, which shows that **100%** of leavers would recommend the Trust to other people who are interested in volunteering.

Dining Companion/Infant Feeding/Ward Volunteer
No two days were the same and I loved just being able to have the opportunity to help make a difference to someone's day.

Gained university place to study Midwifery.

Maternity Volunteer
Learning new things along the way and being treated amazingly by staff.

Left due to full time college.

Meet & Greet Volunteer
I gained confidence in helping and supporting the community.

Gained university place at Northampton to study Bio Chemistry.

Southport and Ormskirk Hospital
The Southport and Ormskirk sites volunteer service has continued to support the patient and family experience over the last twelve months. The service has continued to grow allowing volunteer opportunities for those aged 16 years and above. Currently the service has 106 active volunteers within 19 roles such as pharmacy volunteers, ED volunteers and dining companions. Volunteers have provided approximately 18,000 hours of support over the last year.

The reintroduction of volunteers to support nutrition and hydration within the ED and Ambulatory Care Unit has been invaluable particularly over the winter months and is acknowledged positively by both patients and staff.

'I felt compelled to get in touch with you about one of your volunteers. A lovely gentleman is going round with the tea trolley, giving out drinks and sandwiches. He has such a gentle, caring way about him and nothing seems to be too much trouble for him. Thank you all for providing such a valuable service, the simple things like a cup of tea and a friendly face make such a difference when you are in a stressful environment.'

The ED volunteer service was highly commended in the volunteer of the year category in the 2023 Time to Shine awards.

The volunteer dining companion role has been relaunched recently with seven volunteers completing dietetic training to assist patients with eating and drinking on the inpatient wards.

The discharge support volunteer service aims to contact patients 48 hours following discharge and has a positive impact not only with answering queries but ongoing referrals to the local community voluntary sector. Since the service began in 2021 approximately 7000 calls have been made with 88 referrals made to local community services. The service works closely with the community services and patients have benefited from the support offered such as financial advice, befriending and support with shopping.

The volunteer service has also been very fortunate to recruit a volunteer with lived experience of learning disabilities and autism. This has greatly benefited the quality improvements of the learning disability service and has enabled the volunteer themselves to improve their own confidence.

"The job makes me feel like I matter, and to be somebody. I have always wanted to help others but never given that opportunity until this role. This role has made me feel better because it has given me more confidence to talk to doctors and nurses. In this role, I help the Learning Disability Nurse, do all sorts of activities to improve services and raise awareness for Learning Disability and Autism. Thank you for giving me this opportunity."

The volunteer service continues to have a positive impact on the patient experience in many different ways as shown by the quotes below.

I was helped by one of your fabulous volunteers to find the pre op assessment area and check in.

Lovely experience from the welcome of the volunteers at the front of the hospital

Such a thoughtful gesture to have a volunteer serving drinks and biscuits to those waiting.

3.4.6. Complaints

The Trust takes patient and carer complaints extremely seriously. Staff work hard to ensure that any concerns are acted on as soon as they are identified and that there is a timely response to rectify any issues that are raised either at a local level, through the Trust's two PALS Teams, or through the Chief Executive AskAnn process where anyone with concerns or feedback can make contact with Ann Marr directly via the dedicated email address, askann@sthk.nhs.uk, by letter or by telephone to the executive offices. Matrons, ward and departmental managers are available for patients and their carers to discuss any concerns and to provide timely resolution to ensure patients receive the highest standards of care. Each area has a patient experience notice board to highlight how patients and carers can raise a concern and this is also included on the information table placemats available for patients in some areas. At times, however, patients and their carers may wish to raise a formal complaint, which is thoroughly investigated so that complainants are

provided with a comprehensive written response. Complaints leaflets are available across the Trust and information on how to make a complaint is also available on the Trust internet. Since 1 July 2023 the Trust has moved to an agreed target to respond to formal complaints within 60 working days, where appropriate.

For simplicity, and where possible, figures are provided for the legacy Trusts for quarter 1 and for the entirety of MWL for the rest of 2023-24. In quarter 1 2023-24, S&O received 39 new first stage complaints that were opened for investigation and STHK received 54. For the remaining three quarters MWL received 327 1st stage complaints, leading to a total of 430 for the financial year.

The previous annual numbers of first stage complaints received for the 2 Trusts are set out below:

	2019-20	2020-21	% change	2021-22	% change	2022-23	% change	2023-/24	% change
STHK	325	251	22% decrease	269	7% increase	211	22% decrease	246	17% increase
S&O	254	213	16% decrease	272	28% increase	243	11% decrease	174	28% decrease
Combined total	579	464	20% decrease	541	17% increase	454	16% decrease	420	8% decrease

Therefore MWL has received 8% fewer first stage complaints than in 2022-23, with a significant reduction in S&O complaints and an increase in the number for STHK.

In Q1 2023-24, there were six complainants at STHK who were dissatisfied with the initial response and raised a stage two complaint. In the same period S&O had 3 reopened complaints. Since 1 July 2023 MWL have received 36 second stage complaints, which is an increase on the previous year. In response to the increased number of second stage complaints received, the Trust undertook a review in August 2023 to identify if there were any common themes. The clearest theme was delayed responses to 1st stage complaints, with just under 50% of 2nd stage complaints having breached the original 1st stage timescale. In response to this the Trust now sends out a letter at day 55 indicating that the response may be delayed, where it is anticipated the deadline may breach.

In total, STHK received 65 complaints in total (including second stages, out of time complaints, complaints primarily against other organisations) in Q1. S&O received 42 formal complaints (including reopened complaints). Since 1 July 2023, MWL has received a total of 397 complaints including 2nd stage/reopened, out of time and joint complaints.

On 1 July 2023, MWL standardised the time limit for responding to complaints to 60 working days across the entire Trust. Previously S&O had operated a target of 40 working days, whereas STHK had been operating a target of 100 working days since 1 August 2022, as part of the post COVID complaints recovery plan. There have been challenges in harmonising the time limits, not least for STHK, who had 2 sets of complaints (100 day and 60 day) falling due at the same time going into last winter. The Trust has also decided to take a firmer approach to extensions; these are only granted in very exceptional circumstances (only 2 complaints this year have been

granted extended timescales due to their length and complexity).

MWL has achieved total compliance of 52.7% against the timescale of 60 working days from quarter 2 to quarter 4 2023-24. The Trust is working hard to reduce the time taken to respond to complaints, including the appointment of a dedicated Head of Complaints, recirculation of the guidance on drafting and quality checking of statements and complaint responses, offer of training on statement writing to new divisions and discussions with divisions about appropriate resources for complaints within their new structures.

Complaint satisfaction survey
The Trust trialled a new style complaints satisfaction survey from October 2023, due to low responses rates in recent months. This was sent to each complainant who received a response for legacy STHK cases, including all stages and out of time responses.

This report covers the completed satisfaction survey questionnaires received 1 October 2023 to 31 March 2024. During this period the Trust signed off 142 complaints for STHK and nine completed questionnaires were received giving a response rate of **6.34%**.

The survey highlighted areas where improvements could be made, including making the complaints leaflet more informative, ensuring complainants were aware that making a complaint would not negatively affect their ongoing care and providing regular communication about progress with the complaint.

The Trust will look at updating the satisfaction survey before rolling out across all sites, as well as reviewing if it could be completed using alternative technology. We will also be reviewing the leaflet in order to ensure it better meets the needs of complainants, providing regular updates on progress with the complaint and ensuring patients and carers are confident when complaining that their care will not be adversely affected.

Lessons Learned
The Trust is committed to learning the lessons from complaints and ensuring robust actions are put in place. This is to offer assurance to the complainant and to prevent a similar issue from occurring again. Below are some of the key lessons and changes from the last financial year:

- **Nutrition and Hydration** - Omission in fluid balance chart completion will be shared with wider ward team. Staff will be reminded of the requirements surrounding the completion of fluid balance charts so that an accurate record can be maintained of all fluid input and output. Ward undertook weekly fluid balance compliance audits and these results were shared with the ward team at the daily safety huddles and ward meetings
- **Nutrition and Hydration** – Ensuring all staff are trained in the use of eating and drinking needs assessment and patients to have this completed on admission to AMU. This tool identifies if patients require assistance - e.g. opening packets/removing lids or additional assistance

- **Support to new mothers** - Introduced a specific referral form for staff to fill out and send to the community office when a woman is identified out of hours as requiring a visit. This formalises the process and will avoid missed visits for women in the future
- **Incorrect information regarding medication** - Department manager reviewed and amended the current advice leaflets. The new paperwork was shared with wider endoscopy team to ensure it was implemented
- **Poor documentation** - undertaking monthly audits (10 sets of notes) to ensure high standard of records are being maintained. This specific audit looked at post procedure instructions being clearly documented and communicated to patients
- **Missed/delayed investigations** – Implementation of a weekly tracking list to flag any outstanding inpatient fluoroscopy examinations and expedite appointments
- **Discharge of vulnerable patients** – Ensuring the involvement of family in discharge process e.g. dementia advocate and ensuring the Dementia Passport is completed

3.5. Operational summary

During 2023-24 four divisions were developed as part of the leadership structure for services in the new organisation. These divisions span the entire organisation and cover the Trust geographically. They are based on the principles of:

- Taking best practice from legacy organisations and services
- Maintaining Place-based care provision whilst standardising the way in which we deliver care
- Making the most efficient use of our capacity and resources to deliver 5 star patient care

The four divisions are:

- Medicine and Urgent Care
- Surgery
- Women and Children
- Clinical Support and Community Services

Each division is led by a triumvirate to ensure a robust focus on operational delivery and safe, effective care comprising of:

- Divisional Director of Operations
- Divisional Medical Director
- Divisional Director of Midwifery/Nursing/AHP

The appointment process has progressed to near completion and the rest of the divisional leadership team is currently in development.

Fragile services and areas of greatest opportunity for improvement will be the focus for 2024-25, with a number of services and areas already identified; and building on areas where progress has already been made.

Haematology services at Southport were originally identified as fragile and have now joined forces with the legacy Whiston team and a single service has been designed

and launched which has maintained Place-base care and restored the ability to deliver all aspects of care required.

In surgery, we successfully moved a proportion of trauma and orthopaedic work from Whiston Hospital to Ormskirk Hospital to make best use of available capacity during the winter months. This ensured we could do everything possible to protect and continue with our elective recovery work. These principles will feature in the forthcoming work across many other specialities.

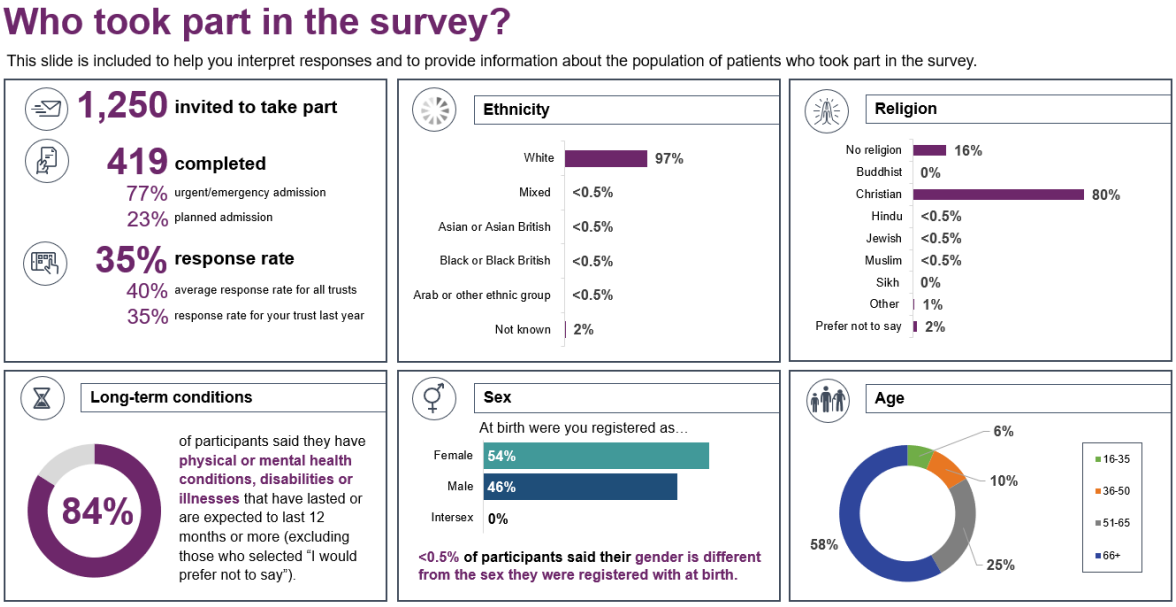
3.6. Summary of national patient surveys reported in 2023-24

The full results for all the latest Care Quality Commission's national patient surveys can be found on their website at www.cqc.org.uk

3.6.1. National inpatient survey

The National Inpatient Survey 2022 is coordinated by the Care Quality Commission. The results from the survey are used in the regulation, monitoring and inspection of NHS Trusts in England and were published in September 2023

Whiston, St Helens and Newton Hospitals



Whiston, St Helens and Newton Hospitals received extremely positive results, which generated a special message of recognition from the Regional Director of NHS England. The Trust scored the 2nd highest score for the overall in-patient experience and when specialist trusts are removed, 57.7% questions are within the top 10 performing trusts.

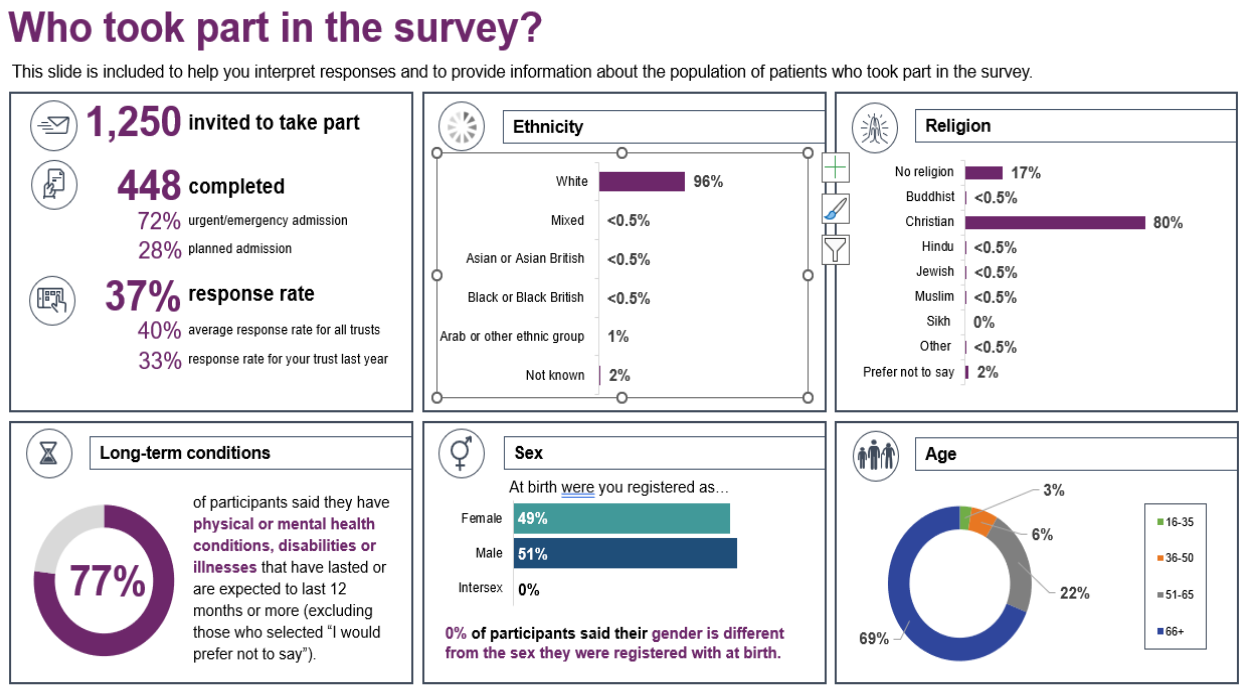
Patients scored the hospitals particularly highly for having confidence and trust in our clinical staff, being treated with respect and dignity by all and the cleanliness of rooms and wards. Results show a year-on-year improvement in scores, which is proof of our continued commitment to delivering the highest standard of patient care, despite the national challenges facing the NHS.

Result highlights:

- Much better than most trusts for 1 question (0 in 2021)
- Better than most trusts for 8 questions (7 in 2021)
- Somewhat better than most trusts for 8 questions (3 in 2021)
- Not banded much worse, worse, somewhat worse than most trusts for any questions (1 in 2021)
- About the same as other trusts for 28 questions (36 in 2021)
- The whole section scores for doctors were banded as better than most Trusts.
- The whole section scores for hospital and ward and overall experience were banded as somewhat better than most Trusts
- No scores have statistically significantly increased or decreased, however scores have increased for 25/45 questions and decreased for 13/45 questions, with reductions of 0.1-0.2 in most of those questions
- Scores have neither increased nor decreased for 7/45 questions
- Six whole section scores have increased from the 2021survey

Themes for improvement have been identified including communication, involvement in decision making and discharge information, which are included in the action plan. Progress towards all actions is underway and monitored quarterly through the Patient Experience Council.

Southport and Ormskirk Hospitals



Southport and Ormskirk sites were:

- Better than most trusts for 0 questions
- Same as other trusts for 44 questions
- Somewhat worse than most trusts for 1 question – relating to information about what you should or should not do after leaving hospital

An action plan has been developed and is monitored by the Patient Experience Council.

3.6.2. National maternity survey 2023

CQC National Maternity Patient Surveys were undertaken in 2023 looking into women's experiences of maternity care. There was a 41% response rate for the Whiston maternity site and a 37% response rate for the Ormskirk maternity site compared to the national response rate of 41%.

The Whiston site survey findings indicated that they scored:
- Much better than most trusts for **0** questions
- Better than most trusts for **1** question
- Somewhat better than most trusts for **1** question
- About the same as other trusts for **46** questions.
- Somewhat worse than most trusts for **5** questions
- Worse than most trusts for **1** question
- Much worse than most trusts for **0** questions.
- 10 questions had a statistically significant increase compared to the 2022 survey

Key areas of focus for improvement related to antenatal care which included staff being aware of the service user's medical history, having enough time to ask questions or discuss their pregnancy during antenatal check-ups, taking concerns seriously and enabling partners to be involved or stay as much as they wanted during their stay in the hospital.

Areas where service users experience were rated the best were appropriate advice and support provided when they contacted a midwife or the hospital at the start of their labour, being able to get a member of staff to help when they needed it whilst in hospital after the birth, cleanliness of the environment during their stay at the hospital and that they felt that midwives and other health professionals gave them adequate support and encouragement about feeding their baby.

The Ormskirk site survey findings indicated that they scored:
- Much better than most trusts for **0** questions
- Better than most trusts for **1** question
- Somewhat better than most trusts for **0** questions
- About the same as other trusts for **49** questions
- Somewhat worse than most trusts for **0** questions
- Worse than most trusts for **4** questions
- Much worse than most trusts for **0** questions
- 1 question had a statistically significant increase and 1 question showed a significant decrease compared to the 2022 survey

Key areas of focus for improvement were identified as providing more information to help decide where to have their baby, awareness of medical history and having enough time to ask questions to discuss their pregnancy during antenatal check-ups, midwives listening to service users and providing relevant information about feeding their baby during pregnancy.

Areas where service users experience were rated the best were service users being given enough support for their mental health during pregnancy, not being left alone

at times when it worried during labour and birth, being able to see or speak to a midwife as much as they wanted during care after birth, being given information about any changes and who to contact with any concerns regarding mental health after birth.

The maternity service have identified key priorities following the findings of the survey and developed an action plan to address key areas of improvement, which will be monitored by the Patient Experience Council.

3.6.3. National cancer patient experience survey (NCPES)

STHK participated in the latest National Cancer Patient Experience Survey (NCPES) 2022, which was the 12th iteration of the survey that the Trust has participated in. The NCPES is overseen by the national Cancer Patient Experience Advisory Group, who set the principles and objectives of the survey programme and guide questionnaire development. The survey was commissioned and managed by NHS England.

The sample for the survey included all adult (aged 16+) NHS patients with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2022. The results were published in July 2023.

292 patients responded out of a total 603 patients, resulting in a response rate of 48%. The national response rate was slightly higher at 53%. When asked how patients rated their overall care on a scale of 1-10, patients responded giving a positive rating of 9.1 out of 10, surpassing the national average of 8.88.

All responses scored either within the expected range or above. In total, there were 9 positive outliers where the Trust exceeded the expected range:

Care Plan

- Able to have a discussion about needs or concerns prior to treatment (79%)
- The team helped the patient to create a care plan and address any needs or concerns (98%)

Hospital Care

- Patients were always involved in decisions about their care and treatment whilst in hospital (98%)

Treatment

- Patients had enough understandable information about hormone therapy (94%)

Side Effects

- Possible side effects from treatment were explained in a way the patient could understand (81%)
- The patient felt possible long-term side effects were explained in a way they could understand in advance of their treatment (66%)
- Patients were able to discuss options for managing the impact of any long term side effects (65%)

Care

- Care team gave family or someone close all the information needed to help care for the patient at home (70%)

LWBC

- Patient was given enough information about signs of cancer recurrence (72%)

Whilst the Trust either met or exceeded the national average on all questions asked there are still areas for improvement. Work for the next year will focus on delivering improvements to the below questions:

- The patient had enough understandable information about immunotherapy pre-treatment
- The patient had enough understandable information about progress with immunotherapy
- After treatment, the patient definitely could get enough emotional support at home from community or voluntary services
- Cancer research opportunities were discussed with the patient

S&O also participated in the latest National Cancer Patient Experience Survey (NCPES) in 2022, marking its 12th involvement in the survey programme. Notably, the response rate for S&O stood at 62%, surpassing the national average by 9%, with 89 out of 143 patients participating.

Patients responded favourably when asked to rate their overall care on a scale of 1-10, giving an average rating of 9.1 out of 10, which exceeded the national average of 8.88. Moreover, an impressive 97% of patients felt they were always treated with respect and dignity during their hospital stay.

Although most responses fell within or exceeded expected ranges, there were two outliers related to radiotherapy, a service not provided at the Trust. However, this will serve as an opportunity to explore how to better manage patient expectations or communicate about services offered in other organisations. The Trust showcased two positive outliers where it exceeded expected performance levels.

These results highlight the Trust's dedication to understanding and enhancing the experiences of cancer patients. Leveraging insights from the survey can further drive improvements in patient care and satisfaction levels.

The full reports can be found at www.ncpes.co.uk

3.6.4. National general practice (GP) patient survey

Marshalls Cross Medical Centre participates in the national GP patient survey each year. In 2023, 123 surveys were returned from a total of 448 resulting in a response rate of 27%.

The results showed that of the 18 questions, 10 responses were above or the same as the national average, with the remaining 8 below; this is an improvement on the previous year's survey when there were 6 above average, reflecting the hard work of staff within the practice. An action plan will be agreed to address areas of performance below the local ICB and national average, including focussing on improving the number of times patients get to see or speak to their preferred GP when they would like to and improving accessibility.

4. Statement of directors' responsibilities in respect of the Quality Account

The Trust Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012) to prepare a Quality Account for each financial year.

The Department of Health issues guidance on the form and content of the annual Quality Account, which has been included in this Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered for 2023-24
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance

The Trust Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Trust Board

Richard Fraser, Chairman

Ann Marr OBE, Chief Executive

5. Written statements by other bodies

5.1. Commissioners

5.2. Healthwatch West Lancashire

5.3. Healthwatch Sefton

5.4. Healthwatch Halton

5.5. Healthwatch Knowsley

Mersey & West Lancashire Teaching Hospitals NHS Trust
Quality Account Commentary 2023-24

Healthwatch Knowsley welcomes the opportunity to provide this commentary in response to the Mersey & West Lancashire Teaching Hospitals NHS Trust Quality Account for 2023/24.

Firstly, our congratulations to the Trust on the achievements and range of recognition it gained during 2023-24. Congratulations also on retaining the Outstanding Rating from CQC. We will watch with interest and hope this continues with the added complexities of the enlarged Trust.

We remain grateful for the opportunity to continue to work with the Trust in the various ways referenced throughout the document. This collaborative working has been a consistent theme over many years and is very much appreciated.

Comment on 2023-24 Quality Objectives
We are pleased to see a number of actions are in place to improve performance of Sepsis screening and hydration and look forward to seeing updated data on these objectives.

Comment on Quality Objectives for improvement 2024-25
Looking at the Quality Objectives identified for improvement in the coming year, we especially welcome:

- The timely and effective assessment and care of patients in the Emergency Department. This resonates with our own data from patient experiences such as those summarised in the visit and report produced with HW Halton (Dec 2023) including the recommendations around providing updates for patients waiting to be seen and addressing a lack of information about waiting times.
- Targeting improvements to the discharge process. Again a number of the specific actions the Trust has identified resonate with our own insight based on patient experiences. For example, delays to discharge due to waits for medication continue to be an issue as highlighted from patient interviews in January 2024. From the same exercise and report, there is evidence that information provided within the Whiston hospital setting about support services available to Knowsley residents upon discharge is not always accurate (Updated Discharge Report – May 2024).

Other comments

Adding to the information included in the Patient Experience section (pages 121-134), patient feedback received by HWK about the Trust is generally positive and particularly so around Treatment and Care (83%) and Staff (100%). Areas where comments have been less positive include Access to Services (60%) and Communication (60%)*

**Reported for Oct-Dec 2023*

Finally, at section 3.1.4.3 of the draft report there is reference to a change in the way interpreting services are delivered in the Trust, together with some proportions of how this will be achieved going forward. We are curious to know what were the former proportions?

David Aspin
Interim Support Team Manager
Healthwatch Knowsley

5.6. Healthwatch St Helens

5.7. Amendments made to the Quality Account following feedback and written statements from other bodies

The following amendments were made following feedback from other bodies:

Section	Amendment/addition
2.2.1	Added the following to the review of progress in achieving the quality objectives: "Commenced the roll out of an AKI risk assessment to be completed within 6 hours of admission."
3.1.4	Added the following information regarding proportions of face-to-face, telephone and video interpreting: The use of interpreters had the following split in 2023: • Face to face – 65.1% • Telephone – 34.3% • Video – 0.6%
3.4.1	Included the following statement: Patient feedback received by Healthwatch Knowsley about the Trust is generally positive and particularly so around treatment and care (83%) and staff (100%). Areas where comments have been less positive include access to services (60%) and communication (60%), reported for quarter 3 2023-24.

6. Abbreviations

ADR	Adverse drug reaction
AHPs	Allied Health Professionals
AI	Artificial intelligence
AIS	Accessible Information Standard
AKI	Acute kidney injury
AMU	Acute Medical Unit
ANC	Ante-natal Clinic
ANTT	Aseptic non-touch technique
App	Application
AQ	Advancing Quality
ARC NWC	Applied Research Collaboration North West Coast
BAME	Black, Asian and minority ethnic
BAUS	British Association of Urological Surgeons
BJP	Bence Jones Protein
BP	Blood pressure
BSI	Blood stream infection
BSL	British Sign Language
BSPED	British Society for Paediatric Endocrinology and Diabetes
BTS	British Thoracic Society
CCS	Clinical Classifications Service
CD	Controlled drugs
C. difficile	Clostridioides difficile infection
CGM	Continuous glucose monitoring
CHPPD	Care hours per patient per day
CMAST	Cheshire and Merseyside Acute and Specialist Trust provider collaborative
CMP	Case mix programme
COPD	Chronic obstructive airways disease
CPD	Continuing professional development
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQuIN	Commissioning for quality and innovation
CRAB	Copeland risk adjusted barometer
CRB	Cervical ripening balloon
CRN NWC	Clinical Research Network, North West Coast
CSP	Cervical Screening Programme
CT	Computerised tomography
CTG	Cardiotocography
CYP	Children and young people
Datix	Integrated risk management, incident reporting, complaints management system
DIEP	Deep inferior epigastric perforators
DIPC	Director of Infection Prevention and Control
DLQI	Dermatology Life Quality Index
DNA	Did not attend
DNACPR	Do not attempt cardiopulmonary resuscitation

DQMI	Data quality maturity index
DRC	Deafness Resource Centre
DrEaM	Drink, eat and mobilise
DSPT	Data Security and Protection Toolkit
DVT	Deep vein thrombosis
EASI	Eczema Area and Severity Index
ED	Emergency Department
EDI	Equality, diversity and inclusion
EDS or EDS2	Equality Delivery System
EMIS	Egton Medical Information System
ENT	Ear, nose and throat
ePMA	Electronic prescribing and medicines administration
EPR	Electronic patient record
ESR	Electronic staff record
eVTE	Electronic venous thromboembolism (recording)
FBC	Full blood count
FDA	Food and Drug Administration
FDS	Faster diagnosis standard
FFT	Friends & Family Test
FGR	Fetal Growth Restriction
FRAX	Fracture Risk Assessment Tool
FTSU	Freedom to speak up
GAP	Growth assessment protocol
GAP SCORE	Growth assessment protocol standardised case outcome review and evaluation
GI	Gastrointestinal
GIRFT	Get it right first time
GP	General Practitioner
HASU	Hyper-Acute Stroke Unit
HAT	Hospital-acquired or hospital-associated thrombosis
HbA1c	Haemoglobin A1c - average blood glucose (sugar) levels for the last two to three months
HCA	Healthcare Assistant
HCAI	Healthcare associated infections
HCSW	Healthcare Support Worker
HES	Hospital Episode Statistics
HHS	Hyperosmolar Hyperglycaemic State
HPMA	Healthcare People Management Association
HR	Human Resources
HS	Hidradenitis Suppuritiva
HWWB	Health, Work and Well-being
IBD	Inflammatory bowel disease
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner’s Office
ICB	Integrated Care Board
ICCR	Individual care and communication record
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision

ICS	Integrated Care System
IG	Information governance
IMCA	Independent mental capacity advocate
IPC	Infection prevention and control
IT	Information technology
IV	Intravenous
JAK	Janus Kinase
JSNA	Joint Strategic Needs Assessment
KPI	Key performance indicator
LAC	Looked after children
LeDeR	Learning disability mortality review
LFPSE	Learn from Patient Safety Events
LGA	Large for gestational age
LGBT	Lesbian, gay, bisexual, transgender
LGBTQIA+	Lesbian, gay, bisexual, transgender, questioning, intersex, asexual
LocSSIPs	Local safety standards for invasive procedures
MBRRACE-UK	Mothers and babies - reducing risk through audits and confidential enquiries across the UK
MDT	Multi-disciplinary team
MINAP	Myocardial infarction national audit programme
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant staphylococcus aureus
MRSAb	Methicillin-resistant staphylococcus aureus bacteraemia
MWL	Mersey and West Lancashire Teaching Hospitals NHS Trust
NACAP	National asthma and COPD audit programme
NACEL	National audit of care at the end of life
NAOGC	National audit oesophago-gastric cancer
NatSSIPs	National safety standards for invasive procedures
NBOCA	National bowel cancer audit
NCAA	National cardiac arrest audit
NCAP	National cardiac arrest programme
NCCQ	National clinical coding qualification
NCEPOD	National confidential enquiry into patient outcome and death
NCPES	National cancer patient experience survey
NDA	National diabetes audit
NELA	National emergency laparotomy audit
NEWS	National early warning score
NG	Nasogastric
NHS	National Health Service
NHSE	National Health Service England
NHSP	NHS Professionals
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National joint registry
NLCA	National lung cancer audit
NMPA	National maternity and perinatal audit
NMTR	National Major Trauma Registry (formerly TARN)

NNAP	National neonatal audit programme
NOD	National ophthalmology audit
NPCA	National prostate cancer audit
NPDA	National paediatric diabetes audit
NRLS	National Reporting & Learning System
NVR	National Vascular Registry
OBE	Order of the British Empire
ODPs	Operating Department Practitioners
OH	Occupational Health
OPCS	Office of Population, Census and Statistics Classification of Interventions and Procedures
OSCE	Objective structured clinical examination
OT	Occupational Therapist/Therapy
P2, P3, P4	Priority 2, 3, 4
PALS	Patient Advice and Liaison Service
PACS	Picture archiving and communication system
PAS	Patient administration system
PCC	Prothrombin complex concentrate
PCI	Percutaneous coronary intervention
PE	Pulmonary embolus
PIR	Post infection review
PLACE	Patient-led assessments of the care environment
PMRT	Perinatal mortality review tool
PRES	Participant in research experience survey
PROMs	Patient reported outcome measures
PSII	Patient safety incident investigation
PSIRF	Patient Safety Incident Response Framework
QI	Quality improvement
QICA	Quality Improvement and Clinical Audit
RAG	Red, amber, green
RCEM	Royal College of Emergency Medicine
RDI	Research, development and innovation
RDIG	Research, Development and Innovation Group
RCOG	Royal College of Obstetricians and Gynaecologists
RLC	Rugby League Cares
RN	Registered Nurse
RNDA	Registered Nurse Degree Apprenticeship
RTT	Recruiting to time and target
RSV	Respiratory syncytial virus
SAG	Safeguarding Assurance Group
SAMBA	Society for Acute Medicine (SAM) benchmarking audit
SAU	Surgical Assessment Unit
SBAR	Situation, background, assessment, recommendation
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SFLC	Serum free light chains
SHMI	Summary hospital-level mortality indicator
SHOT	Serious hazards of transfusion

SIRO	Senior Information Risk Owner
SJR	Structured judgement review
S&O	Southport and Ormskirk Hospital NHS Trust
SOP	Standard operating procedure
SSI	Surgical site infection
SSNAP	Sentinel stroke national audit programme
STHK	St Helens and Knowsley Teaching Hospitals NHS Trust
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
TAR	Transfusion authorisation record
TAT	Thrombin-Antithrobin Complex
TIA	Transient ischaemic attack
TILIA	Tozorakimab in Patients Hospitalised for Viral Lung Infection Requiring Supplemental Oxygen
TNA	Trainee nursing associate
TTO	To take out
TURBT	Transurethral resection of bladder tumour
TURP	Transurethral resection of prostate
uDNACPR	Unified do not attempt cardiopulmonary resuscitation
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
UK	United Kingdom
VBAC	Vaginal birth after caesarean
VIP	Visual infusion phlebitis
VTE	Venous thromboembolism
WDES	Workforce Disability Equality Standard
WHO	World Health Organisation
WRES	Workforce Race Equality Standard

7. Contact details

Additional information about the Trust is available on the website: www.merseywestlancs.nhs.uk

If you have any queries relating to this Quality Account please direct them to the following email: askann@sthk.nhs.uk.

Alternatively please contact the Executive Office on 0151 430 1371.

Title of Meeting	**Trust Board**			**Date**	29 May 2024
Agenda Item	**TB24/042**				
Report Title	Meeting Effectiveness Reviews				
Executive Lead	Nicola Bunce, Director of Corporate Services				
Presenting Officer	Nicola Bunce, Director of Corporate Services				
Action Required	X	**To Approve**		**To Note**	

Purpose

To provide the Board with a pack of revised Board and Committee ToR that reflect the outcomes of the 2023/24 meeting effectiveness review process.

Executive Summary

1. The annual effectiveness review of the Board and its Committees has been undertaken, reflecting the meetings that took place in 2023/24.
2. The detailed review of each committee has been shared with the committee chair and has or will be reported at its next scheduled meeting.
3. A summary of the findings of each review has been reported to the Audit Committee.
4. The conclusion of the reviews is that the purpose, remit and organisation of the Trust Board and its Committees remain fit for purpose and provides the assurance that the Trust is effectively and appropriately managed. This evidence supports the development of the Annual Governance Statement.
5. The final part of this review is the issuing of revised ToR incorporating any agreed changes from the reviews (in red text).

The changes ensure that as a whole, the Board governance structure remains comprehensive and there are clear lines of accountability.

Financial Implications

None directly because of this report.

Quality and/or Equality Impact

Not applicable

Recommendations

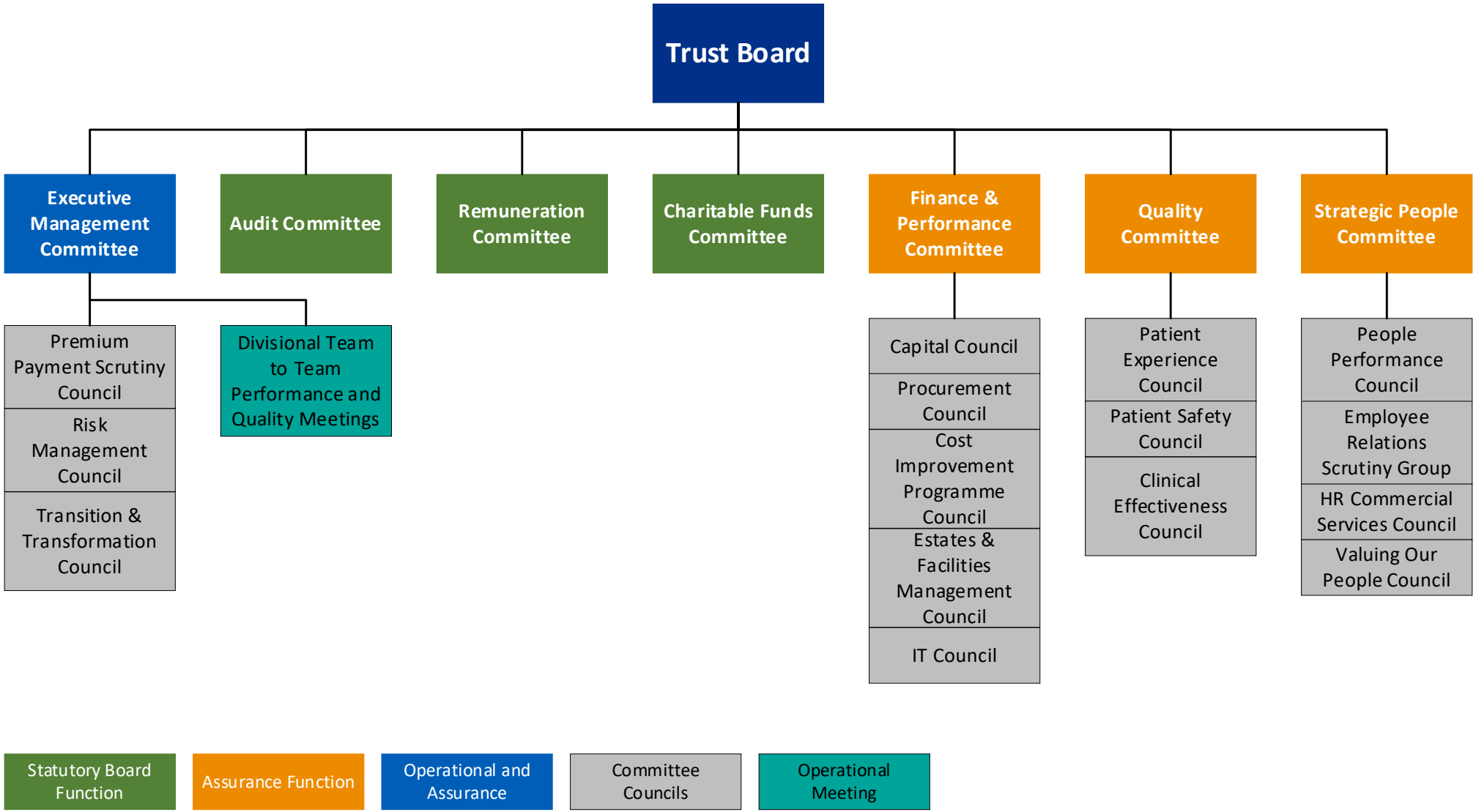
The Board is requested to approve the updated ToR.

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
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance

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

GOVERNANCE STRUCTURE 2024/25



COMMITTEE TERMS OF REFERENCE 2024/25

TRUST BOARD – Terms of Reference (2024/25) - Proposed	
Authority	Mersey and West Lancashire Teaching Hospitals NHS Trust (the Trust) is a body corporate which was established under the St Helens and Knowsley Hospital Services National Health Service Trust (Establishment) Order 1990 (SI 1990/2446) amended by SI 1999/632 and SI 2023/711(the Establishment Order). The principal place of business of the Trust is the address as per the establishment order. The terms under which the Trust Board operates are described in the Standing Orders section of the Corporate Governance Manual (section 7.3).
Delegated Authority	The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board and appended within the Corporate Governance Manual. The Board has delegated authority to the following Committees of the Board i) Audit Committee ii) Remuneration Committee iii) Quality Committee iv) Finance & Performance Committee v) ~~Workforce~~ Strategic People Committee vi) Charitable Funds Committee vii) Executive Committee
Agendas	The Board will have a forward work programme for the ensuing year that provides an outline plan for reporting throughout the year. This will include items on quality, performance, and statutory compliance as well as reports from the Trust's Committees where more in-depth scrutiny of items has occurred in the presence of both Non-Executive and Executive Directors. This does not prevent agenda items being added as required and may result in items being deferred to another month if the agenda becomes too congested. A Board member desiring a matter to be included on an agenda shall make their request to the Chairman a minimum of 10 days before the meeting. The request should state whether the item of

	business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman. Where a petition has been received by the Trust the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting.
Accountability and reporting	All ordinary meetings of the Board are open meetings which members of the public can attend to observe the decision-making process of the Trust. They are not open meetings where the public have a right to contribute to the debate, however, contributions from the public at such meetings can be considered at the discretion of the Chairman. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers. Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. Such items will be business that: i) relate to a member of staff, ii) relate to a patient, iii) would commercially disadvantage the Trust if discussed in public, iv) would be detrimental to the operation of the Trust.
Review	Each year the Board will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Terms of Reference.
Membership	**Core Members (voting)** Non-Executive Chairman (chair) 6 Non-executive Directors (one of which will be appointed Vice Chair) Chief Executive 4 Executive Directors (to include Director of Finance, Medical Director, Nursing Director plus one other. One to be the nominated Deputy Chief Executive)

	Collective Responsibility - Legally there is no distinction between the Board duties of Executive and Non-Executive Directors; both share responsibility for the direction and control of the organisation. All Directors are required to act in the best interest of the NHS. There are also statutory obligations such as quality assurance, health and safety and financial oversight that Board members need to meet. Each Board member has a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public. <u>In attendance</u> The Board shall be able to require the attendance of any other Director or member of staff.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year.
Quorum	50% of the core membership must be present including at least one Executive Director and one Non-Executive Director.
Meeting Frequency	The Trust Board will meet monthly (with the exception of August and December). All meetings will have public and private elements.
Agenda Setting and papers	Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Trust Board should be in line with the corporate standard.

AUDIT COMMITTEE – Terms of Reference (2024/25) - Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Audit Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Board may request the Committee to review specific issues where the Board requires additional scrutiny and assurance.
Role	The Committee shall review the establishment and maintenance of an effective system of integrated governance internal control and risk management across the whole of the organisations clinical and non-clinical activities that support the achievement of the Trust's objectives.
Duties	The Committee will undertake the following duties: <u>Internal Control and Risk Management</u> 1. In particular the Committee will review the adequacy of: - All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board. - The structures, processes and responsibilities for identifying and managing key risks facing the organisation. - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any other reporting and self-certification requirements. - The operational effectiveness of policies and procedures via internal audit reviews. - The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Agency (NHSCFA) 2. The Committee will: - Consider the findings of other significant assurance functions (e.g. regulators, professional bodies, external reviews); - Ensure there is a clear policy for the engagement of internal and external auditors to supply non-audit services, to ensure auditor independence and objectivity; - Review the work of other Trust Committees whose work will provide relevant assurance to the Audit Committee's own areas of responsibility; - Request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

	- Request assurance of the delivery of the annual trust objectives aligned to the Committee. <u>Internal Audit</u> 3. To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal. 4. To review the internal audit programme, consider the major findings of internal audit investigations (and management's response), and ensure coordination between the Internal and External Auditors. 5. To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. <u>External Audit</u> 6. Make recommendations to the Trust Board about the appointment and independence of the External Auditor. 7. Consider the audit fee, as far as the rules governing the appointment permit, and make recommendation to the Board when appropriate. 8. Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health community. 9. Review External Audit reports, including value for money reports and annual audit letters, together with the management response. 10. Review the adequacy and effectiveness of statements within the quality account in line with DHSC guidance. 11. Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-statutory audit work including the pre-approval by the Audit Committee's Auditor Panel for this work. <u>Financial Reporting and Governance</u> 12. Approve the Annual Report and Accounts on behalf of the Trust Board, when the audit timetable does not allow for the Annual Report and Accounts to be approved at a scheduled Trust Board meeting. When approving the Annual Report and Accounts the Audit Committee should focus particularly on: - The Annual Governance Statement. - Changes in, and compliance with, accounting policies and practices. - Unadjusted mis-statements in the Financial Statements; - Letters of representation. - Major judgemental areas, and; - Significant adjustments resulting from the audit. 13. Consider any proposed changes to Standing Orders and Standing Financial Instructions and to the Scheme of Reservation and Delegation of Powers including delegated limits and make recommendations to the Trust Board. (NB. All of these are incorporated within the Trust's Corporate Governance Manual.) 14. Consider any proposed changes to the Trust's Standards of Business Conduct Policy and Anti-Fraud, Bribery and Corruption Policy and make recommendations to the Trust Board. 15. Review responsibilities in respect of the appropriate processes and compliance with Standing Orders for the use of the seal (delegated

	from the Board), tender waivers, losses and special payments, and aged debt, gifts and declarations of interests.
Review	Terms of reference and effectiveness of the Committee will be reviewed annually and included in the report to the Board.
Membership	Core Members The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than 3 members, one of whom will be the committee chair (who will be a qualified accountant or have a finance background). In attendance The Director of Finance, the Director of Corporate Services, the Head of Internal Audit and a representative of the External Auditors shall normally attend meetings. However at least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board Director present. The Committee shall be able to require the attendance of any other Director or member of staff. Specifically, the Committee should consider inviting the Chief Executive to attend the Audit Committee to discuss the Annual Governance Statement and Internal Audit Plan.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	A quorum shall be 2 members.
Accountability & Reporting	The committee reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Audit Committee Chair.
Meeting Frequency	Meetings shall be held not less than three, but usually 4 – 5 times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Committee should be in line with the corporate standard.

REMUNERATION COMMITTEE – Terms of Reference (2024/25) - Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Remuneration Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised to make recommendations to the Trust Board on the appropriate remuneration and terms of service for the Chief Executive and Executive Directors and Associate Directors with due regard to market rates, NHS guidance, affordability, and equal value.
Duties	The Committee will undertake the following duties: 1. To receive and consider information and advice from the Chief Executive on the levels of remuneration for individual Directors taking into account internal relativities, the particular contribution and value of individual Directors and affordability. 2. To consider the level of remuneration for the Chief Executive taking into account the above factors. 3. To receive and consider external information on the wider pay scene including: - Guidance on Executive remuneration from the Department of Health or NHS England. - The levels of Executive remuneration offered by similar NHS organisations. - Consideration of the environment in which the organisation is operating. 4. To advise and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate including the approval process for: - Redundancy payments made to Chief Executives and Directors. - Redundancy payments in excess of £50,000 made to all other staff. - Special payments, i.e. any severance payments exceeding contractual obligations (or exceeding 3-months pay in lieu of notice). 5. Ratify the appointment of new Directors and approve the remuneration and terms of service if outside the parameters agreed for previous appointments to the role. 6. Approve novel or potentially contentious changes to the pay or terms and conditions of other staff working for the Trust
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	<u>Core Members</u> Membership will comprise the Chairman and all Non-Executive Directors. <u>In attendance</u> The Chief Executive (except during discussions about his /her remuneration or terms of service) shall normally attend meetings. The Director of Human Resources shall be Secretary to the Committee and shall attend to take minutes of the meeting.

	The Chairman may co-opt other members, such as the Director of Finance, as appropriate, in order to assist the Committee in meeting its objectives.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Remuneration Committee would be considered quorate when the Trust Chair or Deputy Chair plus 3 Non-Executive Directors are in attendance.
Accountability & Reporting	The Remuneration Committee is a Non-Executive function and its decisions must be agreed by a majority of the Non-Executive Directors and reported in accordance with the Trust's publication scheme, via the annual report and accounts.
Meeting Frequency	The Committee will meet at least once a year. Meetings may be convened with the agreement of all members at any time.
Agenda Setting and papers	The Director of Human Resources will be responsible for all administrative arrangements.

QUALITY COMMITTEE – Terms of Reference (2024/25) - Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Quality Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to quality of services and subsequent risk to patients. In establishing the Committee, the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered of Board level significance it is to be reported to the Board for approval before action. The Board may request the committee to review specific aspects of quality performance where the Board requires additional scrutiny and assurance. The Committee is authorised by the Board to commission independent professional or legal advice within the delegated authority of the Director of Nursing Midwifery and Governance or the Medical Director
Role	The Committee shall review all aspects of clinical quality, including patient experience, patient safety and clinical effectiveness and provide assurance to the Trust Board that the Trust is delivering high quality safe care to patients.
Duties	The Committee's role is to: 1. Provide assurance on clinical quality, including triangulating relevant information and ensuring an effective framework in place for learning lessons and acting on feedback from incidents, complaints, claims, patient, and staff feedback. 2. Provide assurance that appropriate quality governance structures, processes and controls are in place through reviewing relevant internal and external reports (including CQC recommendations and compliance, national patient surveys) and assessing the Trust's performance against each. 3. Provide assurance to the Board on the delivery of the Trust's Clinical Strategy, based on the Trust's vision for 5-star patient care. 4. Provide assurance to the Board of compliance with regulatory standards and guidelines, including compliance with NICE. 5. Monitor the Trust's performance against other internal and external quality targets via the IPR and to advise the Board of relevant actions if performance varies from agreed tolerances. 6. To recommend measures of success /targets in relation to new quality improvement initiatives so that the Board can monitor outcomes. 7. Identify areas for action to address any under-performance, initiating and monitoring quality improvement programmes, and where necessary escalating issues to the Board.

<table>
<tr><td></td><td>
8. Request assurance of the delivery of the annual trust objectives aligned to the Committee.
9. Review the final draft Annual Quality Account prior to submission to the Board for approval.
10. Gain assurance that the reporting councils are approving the policies and procedures for which they are responsible, in line with the Trust Procedural Documents development and Management Policy.
11. Approve any policies and procedures that are aligned to the Quality Committee and if necessary, make recommendation to the Board, in line with the Trust Procedural Document Development and Management Policy.
12. Agree the ToR and the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of quality is delegated appropriately.
~~13.~~ Receive assurance reports from the Council chairs following each meeting of the Councils and to request in-depth reviews where performance is below the expected levels.~~or commission independent audits where necessary.~~
14. Receive assurance that effective safeguarding arrangements are in place.
15. Receive assurance that high quality maternity services are delivered,
16. Receive annual reports on behalf of the Board, e.g., complaints, infection prevention control, safeguarding, medicines management, patient engagement strategy, the clinical audit and clinical research programmes.
17. Receive assurance that the appropriate quality and equality impact assessments of proposed service developments or service changes are being undertaken.
18. Undertake any reasonable quality related reviews as directed by the Board or initiated from work of the Committee or its Councils.
19. Escalate any issues or concern or newly identified risks relating to quality to the Board.
</td></tr>
<tr><td>Review</td><td>Terms of reference and effectiveness of the Committee will be reviewed annually and included in the report to the Board.</td></tr>
<tr><td>Membership</td><td>
Core Members
<table>
<tr><th>No</th><th>Title</th><th>Named Deputy (if app)</th></tr>
<tr><td>1.</td><td>Non-Executive Director (chair)</td><td>n/a</td></tr>
<tr><td>2.</td><td>Non-Executive Directors x 2</td><td>n/a</td></tr>
<tr><td>~~3.~~</td><td>~~Chief Executive*~~</td><td>~~n/a~~</td></tr>
<tr><td>4.</td><td>~~Director of Human Resources /~~Deputy Chief Executive</td><td>Deputy Director of HR</td></tr>
<tr><td>5.</td><td>Director of Finance</td><td>Deputy Director of</td></tr>
<tr><td>6.</td><td>Medical Director</td><td>Deputy Medical Director</td></tr>
<tr><td>7.</td><td>Director of Nursing, Midwifery and Governance</td><td>Deputy Director of Nursing and Quality</td></tr>
<tr><td>8.</td><td>Managing Director</td><td>Chief Operating Officer or Divisional</td></tr>
</table>
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</table>

			Director of Operations
	9.	Chief Operating Officer	Divisional Director of Operations
	10.	Director of Corporate Services	

*The CEO can attend any meeting of the committee, but it is recognised that responsibilities in relation to Cheshire and Merseyside ICS/CMAST do not allow regular attendance.

Core members should ensure that if they are unable to attend a meeting, a fully briefed deputy is appointed and attends in their place.

Requested attendees.
In addition to core members the committee shall be able to require the attendance of any other member of staff, to present reports, including the Chief Pharmacist, Divisional Directors of Nursing/Midwifery, Head of Safeguarding, Infection Prevention Control lead, Deputy Director of Nursing and member of the Corporate Nursing Team including Council Chairs (where this is not the Director of Nursing or Medical Director) and Corporate Governance Manager.

A log of all members and supporting staff names and titles (and where external members, email addresses) are to be recorded on the Group's membership and circulation list. This list is to be reviewed and/or updated every financial year in accordance with the terms of reference review**.**

Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress. A record of attendance will be maintained throughout each financial year
Quorum	A quorum shall be 50% of core members including at least two Non-Executive Members (including the Chair).
Accountability & Reporting	The committee reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Quality Committee Chair. The committee should undertake regular effectiveness reviews, including reviews of the terms of reference and annual workplan. Meeting effectiveness will be a standing agenda item.
Meeting Frequency	The Committee will meet monthly each year, except August and December.

Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Nursing, Midwifery and Governance. Documents submitted to the Committee should be in line with the corporate standard.

FINANCE & PERFORMANCE COMMITTEE – Terms of Reference (2024/25) - Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Finance and Performance Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to financial and operational performance and subsequent risk of the Trust. In establishing the Committee, the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is of Board level significance it is to be reported for approval before action. The Board may request the Committee to review specific aspects of financial or operational performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that the Trust has robust activity and financial plans in place to meet both short and long-term sustainability objectives and maintain the Trust as a going concern. To contribute to the overall governance framework and support the development and maintenance of effective financial and performance governance arrangements throughout the Trust to promote the efficient and effective use of resources and identify, prioritise and manage risk from Trust activities.
Duties	The Committee will undertake the following duties: - 1. To review and make recommendations to the Board on the annual financial and business/activity plan and the assumptions which underpin it and review the Trust's longer-term financial and operational strategies to be able to make recommendations to the Board. 2. To monitor ~~review~~ the performance of the Trust against all elements of the Trust finance and activity objectives via the monthly Committee ~~Integrated~~ Performance Report (C~~I~~PR) including against national and contractual waiting time and access standards. To make recommendations to the Board on key risks, and actions to ensure the Trust performs to the optimum level and operates within the resources available. 3. To oversee the Trust's commercial services activity and the decision-making underpinning service developments and market strategy, including for MMDA, Payroll, Lead Employer. 4. To review proposed Cost Improvement Programme (CIP) and to monitor implementation and report, to the Board, proposals for corrective actions ~~considered~~ if required. 5. To monitor the financial and non-financial benefits realisation from approved business cases to provide assurance of a return on investment. 6. To approve policies and procedures in respect of finance and performance and if necessary, make recommendations to the Board.

	7. To receive reports on the impact and efficacy of finance policies and controls to deliver the agreed financial plans and provide assurance to the Board. 8. Based on forecast resources available, to plan the five-year rolling capital programme and in year delivery of the agreed capital programme 9. To review and monitor progress with annual contract negotiations and the impact on Trust sustainability, escalating any concerns to the Board. 10. To consider relevant central guidance, benchmarking reports, reference costs or consultations and where appropriate make recommendations to the Board 11. To review the ToR including the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of finance and performance is delegated appropriately. 12. To receive assurance reports from the reporting Council chairs following each meeting of the Procurement, CIP, Capital Planning, Estates and Facilities Management and IT councils and to request in-depth internal reviews, ~~or~~ commission independent reports ~~audits~~ where necessary or make recommendations to the audit committee. 13. To undertake any reasonable finance and performance related reviews as directed by the Board or initiated from work of the Committee or its Councils. 14. To provide assurance that appropriate governance structures, processes and controls are in place through reviewing relevant internal and external benchmarking reports (including Model Hospital, ~~and~~ GIRFT, ERIC, Corporate services benchmarking and report recommendations) and seek assurance on the action being taken where the Trust is an outlier. ~~assessing the Trust's performance against each.~~ 15. Monitor delivery of the Trusts annual objectives where the assurance route is via the committee.
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Non-Executive Director (chair) Non-Executive Director x 2 Director of Finance & Information Deputy Chief Executive Director of HR Managing Director Medical Director or Director of Nursing Midwifery and Governance Chief Operating Officer Director of Corporate Services Director of Informatics

	The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. In attendance - In addition to core members the ~~Director of Corporate Services,~~ Deputy Director of Finance, Assistant Director(s) of Finance and nominated Divisional Directors ~~deputy to the Director~~ of Operations and Corporate Governance Manager may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff. Members are selected for their specific role or because they are representative of a professional group or Department. As a result, members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

STRATEGIC PEOPLE COMMITTEE – Terms of Reference (2024/25) Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as Strategic People Committee which will formally be constituted as a Committee of the Trust Board. The Committee shall provide assurance to the Trust Board on all matters pertaining to the quality, delivery and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, education and training, employee health and wellbeing, learning and development, employee engagement, organisational development, leadership, workforce development, workforce planning and culture, diversity, and inclusion. In establishing the Committee, the Trust Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Trust Board level significance it is to be reported to the Trust Board for approval before action. The Trust Board may request the Committee to review specific aspects of workforce performance where the Board requires additional scrutiny and assurance.
Role	The Committee will provide assurance to the Trust Board of the achievement of the Trust's strategic and operational objectives and specifically the Trust's People Strategy. To enable the Board to obtain assurance that high standards of workforce and people practices and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 1. Provide assurance to the Board on all workforce issues. 2. Identify, prioritise, and monitor risk arising from workforce and people policies and practice. 3. Ensure the effective and efficient use of resources through benchmarking and evidence-based practice. 4. Protect the health and safety and wellbeing of Trust employees. 5. Ensure compliance with legal, regulatory, and other obligations. The Committee has established a Valuing our People Council, People Performance Council and the HR Commercial Services Council and may recommend additional Councils aligned to key areas of its activity as it deems appropriate. Triangulation with other committees of the Board to ensure themes are identified and actions are progressed to support the development of the people agenda and delivery of high-quality services.
Duties	The Committee will undertake the following duties: - 1. Consider and recommend to the Board, the Trust's overarching People Strategy and associated action/implementation plans. 2. Obtain assurance of the delivery of the People Strategy through the associated action/implementation plans.

	3. Consider and recommend to the Board the key people and workforce performance metrics and improvement targets for the Trust. 4. Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case. 5. Review the people and workforce risks on the corporate risk register and the risks relating to HR/Workforce as detailed on the Board Assurance Framework, (BAF). 6. Receive reports in relation to internal and external quality and performance targets relating to people and workforce and associated activity/implementation plans. 7. Conduct reviews and analysis of strategic people and workforce issues and to recommend the Board level response. 8. Review and make recommendations to the Board in respect of regulatory and statutory workforce publications and returns, such as; Annual Gender/BAME/Disability Pay Gap, Freedom to Speak Out declarations, the annual staff survey, WDES/WRES//MWRES/Bank WRES/PSED and workforce planning.
Review	The Committee will undertake an annual meeting effectiveness review. Part of this process will include a review of the Committee Terms of Reference.
Membership	**Core Members** • Non-Executive Director (chair) • Non-Executive Directors x 2 • Director of Human Resources • Deputy CEO • Director of Nursing, Midwifery and Governance • Managing Director • Chief Operating Officer • Director of Finance & Information • Director of Corporate Services **Other Members** ~~Director of Staff Engagement and Inclusion~~ Deputy Director of HR x 2 (by invitation as per agenda) Corporate Governance Manager The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. **In Attendance** In addition to core members, other officers of the Trust may be co-opted or requested to attend as considered appropriate may be asked to attend all or part of the meetings to present on specific issues.

	Members are selected for their specific role or because they are representative of a function of service. As a result, members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and two Non-Executive Directors.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet 10 times per annum
Agenda Setting and papers	Agendas agreed by the Chair and Director of HR/Deputy CEO, will be in accordance with the annual reporting schedule of the Committee. Administration, minute production and distribution are via the PA to the Deputy Director of HR & Governance. Items for the agenda must be sent to the Chair a minimum of 5 working days prior to the meeting. Urgent items may be raised under any other business. The agenda will be sent out to the Committee members at least 3 working days prior to the meeting date together with the updated action list and other associated papers. Formal minutes shall be taken of all Committee meetings. Once approved by the Committee the Chair will produce an assurance report for the following Trust Board. Assurance reports from the People Councils reporting to the Strategic people Committee (and associated groups) will be received by the Committee along with the reports as agreed.

CHARITABLE FUNDS COMMITTEE – Terms of Reference (2024/25) - Proposed	
Delegated authority	The Trust shall establish a Committee to be known as the Charitable Funds Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee has no executive powers other than those specifically delegated in this ToR.
Purposes	The Charitable Funds Committee ('the Committee') is established to ensure that the Trust's duties as Corporate Trustee of its subsidiary charity ('the Charity') have been discharged. The formal purposes of the Charitable Funds Committee can be summarised as follows. • To agree the purpose, strategy, policies, and controls of the Charity. • To oversee the Charity's financial and treasury management processes. • To control expenditure from the funds. • To control and support fundraising and income initiatives. • To recommend an Annual Report and Accounts to the Corporate Trustee, outlining the Charity's key achievements. The Board of Directors of the Corporate Trustee maintains overall responsibility and legal obligations for these areas. However, the Charitable Funds Committee has delegated authority / responsibility, from the Corporate Trustee, within the limits set out in this ToR.
Authority	The Committee will oversee the administration of the Charity in line with statute and with Charity Commission (and other regulatory) requirements. The Committee has duties and delegated authority from the Board as follows. i) Approve the purpose, strategy, policies, and controls of the Charity, having due regard for propriety, compliance, risk, effectiveness, and efficiency. ii) Approve any significant changes in the Charity's governing document and registration with the Charity Commission, for recommendation to the Board of Directors of the Corporate Trustee. iii) Review those aspects of Standing Orders and Standing Financial Instructions that relate to the Charity and its operation, advising the Audit Committee on any such matters which need further attention. iv) Control all charitable expenditure in accordance with the Charity's Objects, Charities Act 2011/2016, *patient benefit criteria*, and best practice, through review and approval of the Charity's *Expenditure Policy*.

	v) Control income generation / handling mechanisms, including official fundraising, in accordance Charities Act 2016 and best practice, through review and approval of the Charity's *Fundraising and Incomes Policy.* vi) Approve detailed proposals for: appeals, the accumulation of funds for major purchases, delegated fundholder-ship and financial limits, fund structure, closing funds, and/or the establishment of new funds. vii) Oversee the use of investments in line with the Trustee Act 2000 and best practice, restricted to the explicit conditions or purpose of each donation, bequest or grant, through review and approval of *the Charity's Treasury Management Policy* and the *Reserves Policy.* viii) Oversee the appointment of investment advisors when required and monitor the performance of any resultant portfolio. ix) Receive and consider reports addressing the Charity's risks and risk management arrangements. x) Receive regular reports on the performance of the Charity, and steer activity with a view to maintaining acceptable levels of risk and maximising compliance and effectiveness. xi) Appoint the external auditor for the Charity and approve any change from audit to independent examination if the Charity qualifies as below-threshold. xii) Receive the Annual Report and Accounts, consistent with *Charities SoRP* and relevant legislation and accounting standards, for review and recommendation for final approval to the Board of Directors of the Corporate Trustee. The Charitable Funds Committee's duties may be discharged by any sub-committees or working groups that it seeks to establish. It would approve the Terms of Reference, workplans and duration of any such groups. The Committee must respond to any action plans referred to it by the Audit Committee. The Committee is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources. **All decisions on behalf of the Charity must be distinct from Trust decisions, must be in the best interests of the Charity, and must be in accordance with the *duty of prudence*.**
Associated documents	This ToR is to be read in conjunction with the following.

	• ***The essential trustee: what you need to know, what you need to do*** – *Charity Commission* (to be interpreted for an NHS Charity context, and a Corporate Trustee context). • **The Trust's Standing Financial Instructions.** Additionally, the following governance documents – taken as a set - describe the separate Charity entity**.** • **The Charity's 5-year Vision and Income Strategy**, as approved by this Committee. • **The Charity's Annual Report and Accounts,** which outlines the Charity's history, constitution, governance, and management arrangements, as recommended to the Trust Board for approval. • **The Charity's policies**, as approved by this Committee, including the following. ○ Treasury Management Policy; ○ Reserves Policy; ○ Fundraising and Incomes Policy; and ○ Expenditure Policy, including Mission Statement. The above documents make direct reference to the following legislation: • Charities Acts 2011 and 2016 • Trustee Act 2000 • General Data Protection Regulation (GDPR) 2018
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. This process includes review of this ToR, and the setting of the Committee's annual workplan.
Membership	**Core membership** • Nominated Non-Executive Director (Chair) • Additional Non-Executive Director • Director of Finance & Information • Head of Charity In attendance • Charitable Funds Financial Accountant • Charitable Funds Officer • Assistant Director of Communications • Fundraising Team representatives • Corporate Governance Manager All members should aim to attend all scheduled meetings. Other officers of the Trust may be invited to attend on an ad-hoc basis to present papers or to advise the Committee. Professional advisors and/or auditors may be invited to attend, when deemed necessary.

	Other members of the Board of the Corporate Trustee may attend meetings of the Committee. As mentioned under *Authority,* the Committee may establish appropriate time-limited working groups to consider specific issues on a project basis. Representation from such groups may be required at Committee meetings.
Attendance	Core Members are expected to attend a minimum of 60% (2 of the 3 meetings) of meetings per year. Members are expected to engage as follows. • Ensure that papers are read prior to meetings. • Attend as many meetings as possible. • Contribute fully to discussion and decision-making. • If not in attendance, seek a briefing from another member who was present, to ensure that they are informed about progress. Core members, and officers who engage in Charity business, are also expected, from time to time and with appropriate notice, to contribute to Charity events and promotional activities, as requested by the Head of Charity. If a decision is needed between meetings, it can be made via an ad hoc virtual meeting, or a shared email trail, with quoracy as below. It must be ratified at the next full meeting of the Committee.
Quorum	The Committee would be considered quorate with 50% attendance, to include both of the following. • At least one Non-Executive Director. • Either the Director of Finance & Information or the Head of Charity.
Accountability & reporting	The Committee will report to the Board of Directors following each meeting via a Chair's report, covering key decisions, developments and risks, and the basis of any recommendations made to the Board.
Frequency	The Committee will meet at least three times per year. Meetings may also be convened with the agreement of all members at any time.
Administration	The Director of Finance & Information will be responsible for all administrative arrangements, including the following. • Timely notice of meetings. • Agendas based on the Committee's annual workplan. • Distribution of electronic papers at least 4 working days prior to the Committee, unless there are exceptional circumstances agreed with the Chair.

	• Minutes and Action Log updates for each meeting.

EXECUTIVE COMMITTEE – Terms of Reference (2024/25) - Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Executive Committee which will formally be constituted as a Committee of the Board.
Role	The Executive Committee meeting is established as the most senior executive forum within the Trust. This forum will be the final arbiter on all operational issues. The prime role of meetings is to consider the operational issues within the Trust along with the coordination of work programmes required to deliver the annual and strategic objectives of the organisation.
Duties	Duties of the Committee will include: 1. To review and approve business cases for the appointment of consultants and key Trust staff, or the creation of such posts 2. To review and approve business cases for new service developments, material expansion or reduction of existing services including capital developments (within the approved budgets or delegated authority of the Chief Executive), arising within the year. 3. To monitor the delivery and benefits realisation of approved business cases and service developments 4. To review and approve significant tender/bid documents submitted by the Trust for new services 5. The management of issues with reputational and relationship management significance 6. The monitoring of Trust performance against all objectives, standards and targets including the development of any remedial actions 7. Receiving and considering the Chair's report from the Risk Management Council, the Premium Payment Scrutiny Council, the Transition and Transformation Council and other appropriate supporting governance or project groups 8. Governance matters including preparation and arrangements for regulatory review 9. Brief the Trust's senior managers on the business and decisions made at the Executive Committee

Review	Each year the Committee will undertake an Annual Meeting Effectiveness Review. Part of this process will include a review of the Committee Terms of Reference.
Membership	Core membership of the meeting will comprise: - Chief Executive (chair) - Deputy CEO/Director of Human Resources (vice chair) - Medical Director - Director of Nursing, Midwifery and Governance - Director of Finance and Information - Managing Director - Director of Corporate Services - Chief Operating Officer - Director of Informatics - Director of Integration - Director of Strategic Clinical Reconfiguration The attendance of deputies will not routinely be permitted, however attendance by Trust staff and stakeholders is allowable for specific agenda items.
Attendance	Members are expected to attend a minimum of 70% of meetings. Members are expected to: - Ensure that they read papers prior to meetings - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress - Contribute fully to discussion and decision-making.
Quorum	A quorum will be 50% attendance. Where a decision is to be taken with financial consequences, the delegated authority for expenditure as contained in the Trust's Standing Financial Instructions must be adhered to.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.

Meeting Frequency	Meetings will be scheduled weekly on a Thursday.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the Trust office secretariat under the direction of the EA to the Chief Executive. Documents submitted to the Committee should be in line with the corporate standard.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	29 May 2024
Agenda Item	**TB24/043**			
Report Title	Trust Objectives 2023/24 – Year End Review			
Executive Lead	Ann Marr, Chief Executive			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required		**To Approve**	X	**To Note**

Purpose

To review progress in delivering the 2023/24 Trust Objectives.

Executive Summary

At the start of 2023/24 the STHK Trust Board and S&O Strategy and Operations Committee approved parallel objectives for the two trusts in anticipation of the transaction to create Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) being completed early in the financial year.

Following the completion of the transaction on 01 July 2023, these have been combined into a single set of MWL Trust objectives which were formally launched with staff.

The lead directors for each objective and the governance arrangements have also been aligned with the new MWL leadership team.

The 31 objectives are 5 split into 9 categories: 5 representing the Trust's Five Star Patient Care criteria of care, safety, pathways, communication, and systems. A further 4 categories covering; organisational culture and support for the workforce; operational performance; financial performance, efficiency, and productivity; and strategic planning are also included.

At the end of 2023/24 progress in achieving these objectives has been assessed as:

22	Objective fully delivered
8	Objective partially delivered
0	Objective not delivered

The detailed assessment against each objective is included in Appendix 1. The review shows that 22 objectives have been fully delivered and 8 are rated as amber.

Amber Rated Objectives

Objective 1.1 – the trust did not achieve all the specific measures, but there is assurance that patients are being hydrated appropriately. This remains a quality improvement priority for 2024/25.
Objective 1.2 – the trust did not consistently achieve all the measures, but performance improved across the year, despite the continued operational pressures in ED. This remains a quality improvement priority for 2024/25.
Objective 4.1 - was changed during the year, however the improvement in the turnaround times for clinic letters has been delivered.
Objective 4.2 – remains a priority, and there have been significant improvements in 2023/24 but the original targets were not achieved.

Objective 5.3 – The Narrative solution was successfully implemented across the legacy STHK sites, but technical difficulties have prevented the roll out to all MWL sites. This is now planned for completion by Q3 2024/25. Objective 6.1 – It has not been possible to complete and agree all the MWL HR policies in the 9 months since the transaction and this process will continue into 2024/25. All other measures for this objective were achieved. Objective 6.4 – the 85% appraisal target was not achieved across MWL, in the 9 months following the transaction. The other measures were achieved, and a harmonised MWL appraisal system has been launched for 2024/25. Objective 7.2 – all access standards except the 6 week diagnostic standard were achieved and significant improvement has been made against this target. Objective 9.2 – the trust worked with each Place but the target bed occupancy level of 92% was not achieved.
Financial Implications
None as a direct result of this paper
Quality and/or Equality Impact
Not applicable
Recommendations
The Board is asked to note the end of year assessment of the 2023/24 Trust objectives.

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

2023/4 Trust Objectives – Year-end Review

Key

	Objective fully delivered by 31/03/2024		Objective partially delivered by 31/3/2024		Objective not achieved by 31/3/2024

Objective	Lead Director	Measurement	Governance Route	Year-end position and RAG Rating
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**				
1.1 Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls (QA)	DoN	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place. • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately. • Quarterly audit of most dehydrated patients to ensure appropriate treatment in place, including IV fluids/fluid balance	Quality Committee	**StHK Sites** The Q4 Nursing Care Indicator scores were: - - Nutrition and Hydration was 96% - Fluid balance was 81% in Q4. There are improvement plans to address this and the objective is being carried forward to 2024/25 **S&O Sites** Red jugs were introduced in Q2 and by Q4 were being used for 74% of appropriate patients. There is an action plan in place to educate staff and improve usage. Audits demonstrate that 85% of fluid balance charts were fully completed. **MWL**

Objective	Lead Director	Measurement	Governance Route	Year-end position and RAG Rating
				Advancing Quality (AQ) audit results rank the Trust first (best) in the local peer group. Most recently published data for December 2023. - Stop nephrotoxic drugs within 24 hours of the 1st AKI alert - 100% - Serum creatinine test repeated within 24 hours of 1st AKI alert – 84% - Specialist renal or critical care discussion within 24 hours of 1st AKI 3 alert – 93% This provides assurance that patients were appropriately hydrated.
1.2 Continue to ensure the timely and effective assessment and care of patients in the emergency department (QA)	COO	• % of patients with triage >15 minutes who have observations undertaken prior to triage • First clinical assessment median time of <2 hours (120 minutes) over each 24-hour period • Compliance with the Trusts Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits. • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring.	Quality Committee	**Whiston ED** In Q4 Audits 100% of patients audited had observations recorded with appropriate escalation. The median time to first clinical assessment for Q4 was 129 minutes. Whilst total attendances to ED have stayed broadly stable, acuity and patient flow have had a major impact on the time to first assessment. There are trust and system wide actions being taken to improve patient flow. NEWS audits during Q4 showed a sustained compliance of 100%. The latest retired commissioning for quality and innovation (CQuIN) data for quarter 4 2023-24 states 84.1% adults were screened and 90.4% adults received first dose of antibiotics. **Southport ED** Appropriate escalation and level of observation was taken in 100% of cases reviewed.

Objective	Lead Director	Measurement	Governance Route	Year-end position and RAG Rating
				The median time to first clinical assessment in Q4 was 94 minutes. 100% of cases audited in Q4 had appropriate frequency of observations in line with the Policy and 95% of patients had a medical team review within 60 minutes. Advancing Quality benchmarking in Q4 showed 100% of NEWS Scores recorded within 1 hour of hospital arrival. 80% of IV fluids commenced within 1 hour of sepsis diagnosis and 62.5% of antibiotics given within one hour. Risk assessments audits for Q4 showed: o Falls – 83% o Alcohol Screening – 93% o Body Chart - 92% o Manual Handling – 85%
1.3. Recognise our deteriorating patients, providing individualised patient-centred care to achieve the right outcome for the patient	MedD/DoN	• Provide education and training for staff to understand how to identify and respond to patient deterioration. • Timeliness of NEWS observations • Completion of deteriorating patient proformas for all patients a NEWS of 5 or above.	Quality Committee	**STHK Sites** Scoping exercise for provision of ALERT course/Deteriorating patient education in progress for band 4 & above. NEWS2 % of breached observations achieved the Trust average target <15 %) with 14.7% in Q4. Pro forma completion for Q4 = 61.2%, with plans in place to digitalise it and to implement local escalation messaging on eVitals to use the pro forma when a patient triggers. BEACH pilot completed with 29 staff from 1A, Bevan Court 1 and Bevan Court 2. Extremely positive feedback from staff who felt it was

Objective	Lead Director	Measurement	Governance Route	Year-end position and RAG Rating
				beneficial and informative. 4 more courses booked in 2024/25. **S&O Sites** Training about deteriorating patients provided at nurse induction sessions. Also, specific training for HCAs and qualified nurses. RAMEDP (recognising, assessing, managing, and escalating of the deteriorating patient) Timeliness of NEWS observations Dec 2023– 98.00% Feb 2024– 93.33% March 2024 – 97.87% The Deteriorating Patient process is being reviewed to pilot in June and roll out from July 2024.
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**				
2.1 Implement and embed the national Patient Safety Incident Response Framework (PSIRF) (QA)	DoN	• Approval of business case for required staffing to implement and maintain PSIRF • Development of Trust-wide education plan • Launch and implementation of PSIRF in line with national requirements.	Executive Committee	PSIRF was implemented in October 2023 and the MWL Patient Safety Incident Response Plan 2023 -24 launched. The PSIRF team is in place. The executive-led weekly safety panel reviews patient safety incident investigation (PSII) reports. Process aligned across MWL. There were 7 PSIIs at various stages of progress at end of 2023-24. Training continues for safety specialist functions and general awareness.

Objective	Lead Director	Measurement	Governance Route	Year-end position and RAG Rating
2.2 Create a unified safety culture for the new Trust.	DoN	• Align the Incident reporting, risk, and incident management, FTSU, safeguarding and IPC frameworks across the new Trust • Provide clear guidance and appropriate training/guidance for staff where the existing reporting systems need to change. • Agree year 1 quality improvement objectives for each service as part of integration planning	Executive Committee	Policies and procedures have been aligned and approved including the Patient Safety Incident Response Plan and Framework, Safeguarding and Freedom to Speak Up, with progress being made in outstanding areas. Training continues to be provided for staff across MWL.
2.3 Improve the overall experience for women using the Trust's Maternity Services (QA)	DoN	Demonstrable improvements in the key areas from previous national surveys shown through regular inhouse surveys of women receiving maternity care; • Increasing involvement of women and their partners in their care • Increased access to medical history of the mother and baby • Increased information about induction and labour • Increased information about physical recovery after birth • Support for infant feeding • Increasing involvement of women and their partners in their care • Timely discharge • Increased access to medical history of the mother and baby Develop an action plan to deliver the National Maternity Strategy (March 2023) recommendations and deliver the year one objectives.	Quality Committee	Maternity survey 2023 results for the areas of focus showed most scores improved: **Ormskirk Unit** Women and partner involvement - maintained scores other than induction and postnatal. Access to medical history of mother and baby showed an improvement except for during birth. Information for induction of labour and physical recovery after birth improved significantly. **Whiston Unit** Infant feeding showed significant improvement. Women and partner involvement showed an improvement other than for induction. Access to medical history of mother and baby showed improvement. Delayed discharge scores improved.
3. 5 STAR PATIENT CARE – Pathways				

Objective	Lead Director	Measurement	Governance Route	Year-end position and RAG Rating
As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient				
3.1 Improve the effectiveness of the discharge process for patients and carers (QA)	COO	• Improved Inpatient Survey satisfaction rates for receiving discharge information. • Improved audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet. • Achievement of 20% target for patients discharged before noon during the week. • Baseline audit of sample of delayed discharges to identify if delay in receiving take home medications and other hospital processes were the primary factors in the delay, with target to reduce this in subsequent quarterly audits.	Quality Committee	**StHK** Inpatient survey 2022 showed improvement in most scores relating to discharge. Audits demonstrated compliance of 98% and above for providing the discharge booklet. Achieved 18.4% discharges before noon in quarter 4. There remains a continued focus on early discharges through the support of Patient Flow Lead Nurses and Discharge Lounge Discharge data for patients with no criteria to reside shows that no patients were delayed due to waiting for medications. **S&O** Inpatient survey 2022 showed similar results to the previous year. 100% of patients audited received the discharge booklet. 20% of discharges before noon in Q4 Discharge data for patients with no criteria to reside showed that no patients were delayed due to waiting for medications.
3.2 Improve access to the Urgent Community Response Team	MD	• Respond to 70% of calls within 2 hours. • Increase the number of local pathways for direct access to services and making these more accessible to patients.	Finance and Performance Committee	Our UCR team has had over 4000 referrals in 23/24 with only 10% of them leading to an acute attendance at hospital. 83% of these patients where all seen within 2 hours.

Objective	Lead Director	Measurement	Governance Route	Year-end position and RAG Rating
		• Reduce unnecessary GP appointments.		Furthermore, this service has taken on the function of delivery the care of the Frailty Virtual Ward which has been successfully implemented for our Whiston footprint. This means we now have the MDT hub, UCR and our virtual ward as fully operational alternatives to attendance and to support primary care escalation of patients.
3.3 Cancer – Early Diagnosis Ambition	COO/ MedD	• Increase the % of cancer's diagnosed at stage 1 and 2 in line with the 75% early diagnosis ambition by 2028. • Achieve the NHS Faster Diagnosis Standard (FDS) for Cancer to ensure that 75% of patients referred with a suspicion of cancer have a this diagnosed or ruled out within 21 days of referral. • Ensure that local pathways support the delivery of the FDS through the FDS Prioritisation Group.	Finance and Performance Committee	MWL overall achieved 75.3% for March 2024 with some variation across STHK and S&O legacy sites and tumour sites. Target for 2024/25 is 77% and MWL have developed 28-day FDS improvement plans at a tumour site level to ensure delivery of best practice timed pathways.
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**				
4.1 Implement a new speech recognition system to improve the turnaround times for clinic letters	DoI/MD/ MedD	• Implement the new system and train staff in its use • Achieve a 48 hour (working week) turnaround target by June 2024	Finance & Performance Committee	Speech Recognition system deferred until further notice, pending site alignment (agreed at Executive Committee meeting on 5 Oct 2023). Interim solution for ex-STHK solution procured that will align to ex-S&O, and due for implementation in Q2 2024/25.

Objective	Lead Director	Measurement	Governance Route	Year-end position and RAG Rating
				There has been a significant improvement in the backlog and turnaround time for clinic letters. As at end March 2024, urgent letters were being turned around within 24 hours (working days) and non-urgent letters in 10 days.
4.2 Improve complaints response times	DoN	• 80% of first stage complaints to have a formal response within 60 working days by Q4. • % of complaints resolved with the first response to increase to 85%	Executive Committee	53.5% of first stage complaints were responded to with 60 working. Improvement actions are ongoing to achieve the Trust ambition. 89% of first stage complaints were resolved.
4.3 Create new staff communication and engagement processes that reflect the enlarged organisation, are accessible for all staff, irrespective of where they work and promote a single culture and values.	DoHR	• Achieve a higher level of participation in the new trust communications systems e.g., Trust Brief Live • Create a range of communication channels to suit staff in different roles and locations • Create two way communications mechanisms • Evaluate the success/impact of Trust wide communications in the first year of the new Trust	Strategic People Committee	Trust brief live takes please every week with circa 200 staff joining and others watching the recording on the intranet. MWL communications is tailored to each site. The MWL Facebook page has become established as a forum for exchanging views and providing feedback. The big conversation took place to inform the new trust values. A range of events have been scheduled throughout the year to promote a sense of identity for MWL. The department issued a survey to gain the views of staff, which will inform the plans for 2024/25.
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**				
5.1 Deliver the 2023/24 Frontline Digitisation Programme Milestones	DoI	• Achieve minimal digital foundation standards as part of the “What good looks like” framework.	Executive Committee	Achieved, milestones signed off as part of Frontline Digitisation Programme EPR Outline Business Case approved.

Objective	Lead Director	Measurement	Governance Route	Year-end position and RAG Rating
		• Produce the EPR replacement Outline Business Case and achieve NHSE/Treasury approval. • Secure the 2023/24 element of the technology funds award.		All technology funds received, £2.6m, albeit late in the year. Managed to spend £2.4m of the allocation
5.2 Convergence of the digital agenda between the STHK and S&O legacy systems to optimise performance and develop a single IT strategy for the new organisation.	DoI	• Create a single digital services team to provide a standardised response across all Trust sites and maintain system access. • Create a single EPR team to maximise the potential to improve patient care. • Improve the reliance and resilience of technology platforms at the Southport and Ormskirk Hospital sites, so that clinicians have access to the systems they need to provide high quality patient care. • Develop a new IT performance dashboard to ensure a consistent service is provided across the Trust as quickly as possible.	Executive Committee	Single management structure in place for the digital services team, standardised response in place and system access improved in many instances. Single EPR team for MWL has been created. Network remediation and printer replacement have been successfully completed. As a result, we are now able to join networks post-transaction and share documentation via shared network drives. Additionally, staff members can now seamlessly connect to the network with their wireless devices while roaming around any site. A performance dashboard has been implemented, enabling the consistent delivery of services to be effectively monitored and evaluated.
5.3 Improve access to patient information via the implementation of Narrative Digital Clinical Documentation.	DoI	• Clinicians can access the patient information they need • Patient information entered electronically only has to be entered once.	Executive Committee	Narrative has been successfully implemented and is live at Whiston, St Helens, and Newton, with over 190,000 forms completed since its launch in early December 2023. However, there is a technical issue that is delaying the implementation of Narrative at Southport and Ormskirk. The estimated date for its implementation at these locations is September 2024. This is being monitored and reported at the 'Frontline Digitisation Programme Group'.
6 DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE **We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.**				

People Plan Pillars – Looking After our People				
6.1 Align HR policies for the new Trust, ensuring that all staff have access to the same levels of support wherever they work	DoHR	• Harmonise HR policies where appropriate, as they become due for review • Provide a consistent range of support services to improve the health, well-being, and resilience of staff • Develop standardised inclusive leadership training and guidance for managers to implement the new Trust policies.	Strategic People Committee	Continuing partnership working with staff side colleagues to ensure all HR policies are reviewed in line with the planned timetable. The Wellbeing Network now has over 150+ champions/ ambassadors. Each champion receives a wellbeing lanyard pin badge for recognition of their role. The health and wellbeing offer is being continually monitored and reviewed to ensure the support on offer is effective, current and meets the needs of the organisation. The two legacy HWWB departments have successfully been working to ensure consistent standards in place for occupational health services this included the reaccreditation of SEQOSH. Bitesize training sessions delivered for managers - wellbeing interventions, management of sickness absence and recruitment, reasonable adjustments and ED&I employment law.
People Plan Pillars - Belonging to the NHS				
6.2 Support the integration of the two trusts teams into to a single organisational structure	DoHR	• Agree the priority actions from the two trust 2022 staff surveys to improve staff experience and engagement and deliver them in 2023/24 • Provide a wide ranging package of support for services/staff groups that are integrating to deliver the new trust operating model, including HR, OD and wellbeing • Provide bespoke change management support/training aligned to the Organisational	Strategic People Committee	Staff survey action plans developed and monitored through the Staff Survey Operations Group. Additional local questions added to the 2023 staff survey to provide further feedback on areas of previously highlighted: materials, sickness, culture. 2023 staff survey results have been released with action plans identifying 2024/25 priorities developed and agreed. Training to support managers through the change process commissioned from external

		Change Policy as the new management and leadership structure is created.		provider and available to support up to 200 managers. Resilience training provided by Rugy League Care on resilience through change. MWL senior leadership team integration has been completed with the agreed operating model in situ alongside the newly formed divisional triumvirates.
6.3. Improve mandatory training compliance, so that all staff across the Trust are equipped with the core skills and knowledge they need to perform effectively.	DoHR	• Achieve 85% compliance with mandatory training collectively and for all staff groups • Align the mandatory training requirements and TNAs across the new Trust, so that all staff are clear on what is expected. • Review delivery models for mandatory training with subject matter experts, to ensure this is fit for purpose for the new organisation	Strategic People Committee	L&OD continually working with leads to increase compliance. 85% compliance achieved for most staff groups. Monthly reports on compliance circulated to the Executive Committee and Directors and Managers for their teams. Appointment of a new role to align MT subjects including the who, when and what, to provide a standardised approach for MWL from FY 2024/25.
6.4 Embed a standardised approach to annual appraisals for the new Trust to support staff to deliver high quality patient care.	DoHR	• Working with subject matter experts create a single approach to high quality and effective appraisals for all staff, based on good practice and acting on feedback from the two former Trust's Staff Surveys. • Achieve 85% compliance with staff appraisals collectively and across all staff groups	Strategic People Committee	82% appraisal compliance reported by the end of 2023/24. Bespoke training delivered to managers across MWL. 2023/24 staff survey results show satisfaction with the effectiveness of the appraisal process has increased when compared to 2022/23. Working towards adoption of the appraisal window across MWL from 2024/25.
People Plan Pillar – New Ways of Working				
6.5 Optimise time to care by implementing a single approach to e-rostering, activity manager and e-job planning systems to ensure the optimal deployment of the workforce to achieve the right number and skill mix of staff	DoHR	• Standardise the application of e-rostering and e–job planning across all sites • Monitor and evaluate the efficacy of the e-rostering and e-job planning applications to support workforce deployment requirements to	Executive Committee	Discussions took place with Northumbria NHS Trust in February to look at their operational plan and advantages of using team-based rostering. Pilot will commence in September 2024 with Whiston ED nursing team. Wards 1B & 1C have also expressed an interest.

		achieve safe patient care and enable flexible working		To assist with the development of Team Based Rostering, the Trust has registered interest in Allocates Transformation Programme. The programme will consist of up to 8 dedicated organisations to work directly with Allocates Customer Success on configuring and implementing team-based rostering and be a showcase organisation following implementation. The rostering reports are being harmonised and expanded to allow for better monitoring of temporary workforce usage and to support with the monitoring of safer staffing.
People Plan Pillar – Growing for the Future				
6.6 Make the Trust the best place to work by increasing opportunities for new staff to join the organisation and existing staff to fulfil their ambitions for career development and progression within our organisation.	DoHR	• Recruit additional nurses and medical and dental staff via international recruitment programmes • In partnership with the Medical Director and Director of Nursing, Midwifery & Governance continue to create a strong pipeline of new clinical roles including Trainee Nurse Associates, Advanced Clinical Practitioners and Physician Assistants • Support flexible approaches to working, maximising the new pensions flexibilities and retire and return options • Expand the internal transfer scheme to all areas of the Trust to improve retention rates • Continue to create diverse and innovative offerings to aid recruitment and retention in staff groups with a traditionally high turnover • Maximise the use of the apprenticeship levy to support more staff to undertake further training	Strategic People Committee	Legacy STHK International Nurse recruitment target met with all 50 arriving by the end of 2023. An additional 35 international medics have been recruited in 2023/24. The international recruitment scheme with BRNO, Czech Republic resulted in 16 placements being offered. Legacy S&O International Nurse recruitment target of 15 was met. There have also been 5 international medics recruited (x4 Radiology and x1 Acute Medicine). Plans continue to be developed with the Corporate Nursing team for annual growth in the number of TNAs required across MWL. 14 Trainee ACPs commenced in Autumn 2023 and following a successful bid 18 further places have been secured for the 2024 cohort. Recruited two PAs and 2 trainee AAs. Retirement policies currently being reviewed for MWL.

		in Advanced Clinical Practice and Leadership Development		Promotion of partial retirement/ flexible retirement schemes, and flexible working opportunities available to staff. Review of opportunities in perceived 'hard to flex' areas being undertaken. Internal transfer scheme extended across MWL. Rolling recruitment is on-going for the two new theatres opening in summer 2024. Continued development of the MWL Healthcare Academy for Healthcare Assistants has reduced turnover in the first 12 months by 30%. Process to transfer from the bank to a substantive post is being streamlined. New resignation and leaver form introduced to enable better quality data collection to inform retention strategies. Increased numbers of staff accessing leadership development funded via an apprenticeship route for new programmes developed by the NHS Leadership Academy and local HEIs
7 OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**				
7.1 Elective Care Recovery	COO	• Eliminate waits of over 65 weeks for elective care by March 2024(except where the patient chooses to wait longer) • Deliver the system specific activity targets assigned to the Trust • Maximise the capacity and efficiency of the Trusts resources to reduce long waiting times.	Finance and Performance Committee	As a result of industrial action in 2023/24 elective care standards were reduced. The 65-week target was replaced by 78-week target by March 2024 and the system activity targets based upon delivery of 2019/20 activity levels were reduced by 4% from 107% to 103%. As at March 2024 MWL reported zero 78+ week waiters.

		• Provide mutual aid in specific specialities to support the delivery of system recovery targets		For 2023/24 MWL achieved 106%. Mutual aid support between STHK and S&O legacy sites to support reduction in long waiters and delivery of the orthopaedic programme over the winter period.
7.2 Urgent and emergency care	COO	• Improve A&E waiting times so that no less than 76% of patient are seen within 4 hours by March 2024 • Achieve year 1 planned progress in achieving the 95% target for diagnostic tests to be completed within 6 weeks by March 2025 • Consistently achieve ambulance handover times of less than 30 minutes • Increase the number of direct access pathways for assessment/speciality review	Finance and Performance Committee	MWL achieved 77.55% A&E 4-hour performance in March 2024. The 30-minute ambulance handover target was achieved for 4/12 months, with a yearly average of 38 minutes. The MDT triage hub was implemented on the Whiston site in March 2023 and is able to directly stream patients into 4 alternative assessment areas to ED (AMU, SAU, Frailty, UTC) as well as offer clinical advice to referring clinicians to avoid unnecessary ED attendances. The MDT Hub took 10,229 calls in 2023/24 and was able to stream or avoid an attendance for 70.92% of patients. Plans are under development to expand the offer at the Southport site. Diagnostic performance for March 2024 for MWL was 87.8%. Significant improvement has been seen in endoscopy and non-obstetric ultrasound. Modality level improvement plans have been developed for continued delivery into 2024/25.
7.3 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data e.g GiRFT to ensure that all services meet best practice standards	MD	• Continued participation in national programme of GiRFT and other reviews and delivery of the resulting action plans and use these to inform the new organisations Clinical Strategy • Previous review action plans monitored at committee level to provide assurance that change has resulted in improved metrics	Finance and Performance Committee	Divisional triumvirates, now in place across the 4 clinical divisions, utilising GiRFT data to monitor progress, identify areas for improvement and inform clinical strategy. The transition and transformation council continues to make good progress on agreed integration plans, as reported to the post transaction delivery oversight group, led by the

		• Complete the integration of services across the new Trust and optimise service delivery utilising the available estate and facilities to address the fragile services at Southport and Ormskirk		NHSE regional team. The resulting impact on fragile services has been the stabilisation of Haematology, Rheumatology, Orthodontics, Stroke and Paediatric dietetics, with plans in place to address the remaining services via the transformation team, new Divisional leadership teams and partnership working.
8 FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**				
8.1 Continue working with partner organisations in the Cheshire and Merseyside Integrated Care System to develop and deliver opportunities for collaboration at scale to increase efficiency.	DoF	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system • Drive forward other opportunities for collaboration with system partners	Executive Committee	LIMs Continued participation in all networks and collaboration at scale programmes
8.2 Delivery of the agreed 2023/24 Trust financial targets: outturn, cash balances and revised capital resource limits.	DoF	• Achieve the approved financial plan for 2023/24 • Delivery of the agreed Cost Improvement Programme and transaction business case benefits • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme, to progress the strategic estates delivery plans	Finance and Performance Committee	Revised financial plan – achieved. CIP – achieved. Cash Balances – achieved. Aged debt – achieved. Capital programme – achieved.
8.3 Deliver the agreed capital schemes	DoCS	• Progress the strategic site development plans, including additional theatre, bed, and diagnostic capacity. • Reduce the high risk back log maintenance at the Southport and Ormskirk Hospital sites and improve facilities for patients and staff.	Finance and Performance Committee	2023/24 capital developments and backlog maintenance programme achieved.

9 STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**				
9.1 Continue to meet all regulatory and accountability requirements, including post transaction conditions whilst working collaboratively to achieve system success.	DoCS	• Meet statutory and regulatory responsibilities/requirements, including for unified reporting for the new Trust both internally and externally. • Meet the post transaction integration, performance and delivery plans including the agreed transaction benefits.	Trust Board	No regulatory action has taken. Unified reporting achieved. Post transaction delivery monitoring has demonstrated good progress to NHSE and the ICBs.
9.2 Work with each of the Place Based Partnerships where the Trust provides services to improve the health of the local population.	DoInt/ MD	• Position the Trust as a key partner in each Place Based Partnership • Maximise the potential of the Trust as an anchor institution in our communities to improve health, education, and employment. • Work in partnership to achieve the 92% acute bed occupancy ambition to improve patient flow in hospital and ensure medically optimised patients are discharged at the right time, to an appropriate care setting to meet the patients' individual needs.	Trust Board	The Trust is represented at 5 Place Partnership and HWB Boards and is an active partner – leading on workstreams and programmes. Trust signed the NHS Prevention Pledge, recognised as a contributor to Social Value. Leading the development of a skills academy for Mid Mersey. Each Place Director has bed occupancy as a key appraisal outcome, plans were submitted to the ICB, but performance continued to be variable in different boroughs and 92% bed occupancy was not achieved.
9.3 Ensure the Trust continues to influence and fully participate in the Integrated Care System to achieve a clinically and financially sustainable acute provider services.	CEO	• Develop areas for collaboration that bring benefits for patients and partner organisations. • Continue the development of effective Provider Collaboratives that enhance collaboration and integration of services and coordinate delivery of the elective activity targets by maximising system capacity	Trust Board	CEO continues to lead the Acute Services Provider Collaborative and develop and deliver programmes of work to reduce elective waiting times, improve patient experience, reduce health inequalities across the ICB and respond to unplanned and emergency care pressures. CMAST awarded Provider Collaborative of the year at the HSJ awards.
9.4 Take forward the Shaping Care Together Programme to identify the options to achieve a safe and sustainable service configuration between Southport and Ormskirk Hospital Sites for	MD/ DoCS	• Continue to develop plans to address the fragile clinical services at the Southport and Ormskirk sites, working with clinicians across the new Trust and other providers as necessary.	Trust Board	Shaping Care Together Programme re launched with revised timetable. Case for change to be approved in May 2024, followed by initial public engagement. Clinical Senate Review to be completed by September 2024

agreement with the Cheshire and Merseyside and Lancashire and South Cumbria ICBs, to be put forward for public consultation.		• Develop a plan, with the Shaping Care Together programme that will deliver sustainable clinical services		and FBC by December (subject to general election timing)