Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 09.30 on Wednesday 30 October 2024
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
09.30	1.	**Employee of the Month (October 2024)** *Purpose: To **note** the Employee of the Month presentations for October 2024*	Film	Chair *(10 mins)*
09.40	2.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	3.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	4.	**TB24/069 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 25 September 2024*	Report	
	5.	**TB24/070 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
09.50	6.	**TB24/071 Integrated Performance Report** 6.1. Quality Indicators 6.2. Operational Indicators 6.3. Workforce Indicators 6.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report for assurance*	Report	L Barnes L Neary AM Stretch obo M Szpakowska G Lawrence *(30 mins)*
Committee Assurance Report				
10.20	7.	**TB24/072 Committee Assurance Reports** 7.1. Executive Committee	Report	A Marr

		7.2. Audit Committee 7.3. Quality Committee 7.4. Strategic People Committee 7.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports for assurance*		S Connor obo I Clayton G Brown L Knight S Connor *(40 mins)*
Other Board Reports				
11.00	8.	**TB24/073 Corporate Risk Register** *Purpose: To **note** the Corporate Risk Register*	Report	N Bunce *(10 mins)*
11.10	9.	**TB24/074 Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	Report	N Bunce *(10 mins)*
11.20	10.	**TB24/075 Learning from Deaths Quarterly Report** *Purpose: To **note** the Learning from Deaths Quarterly Report*	Report	P Williams *(10 mins)*
11.30	11.	**TB24/076 Aggregated Incidents, Complaints and Claims Report** *Purpose: To **note** the Aggregated Incidents, Complaints and Claims Report*	Report	L Barnes *(15 mins)*
11.45	12.	**TB24/077 Workforce Reports** 12.1. Workforce Race Equality Standard Report (WRES) (including action plan) 12.2. Workforce Disability Equality Standard Report (WDES) (including action plan) *Purpose: To note the Workforce Reports for assurance and to **approve** the action plans*	Report	AM Stretch obo M Szpakowska *(15 mins)*
12.00	13.	**TB24/078 Infection Prevention and Control Annual Report 2023/24** *Purpose: To **approve** the Infection Prevention and Control Annual Report 2023/24*	Report	L Barnes *(20 mins)*
12.20	14.	**TB24/079 Nurse Staffing Establishment Review**	Report	L Barnes *(10 mins)*

		*Purpose: To **note** the Nurse Staffing Establishment Review*		
Concluding Business				
12.30	15.	**Effectiveness of Meeting**	Report	Chair *(5 mins)*
12.35	16.	**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 27 November 2024 at 09:30 / 10:00		**12.45 close**
15 minutes break				

Chair: Richard Fraser

The Board meeting is held in public and can be attended by members of the public to observe but is not a public meeting. Any questions for the Board may be submitted to Juanita.wallace@merseywestlancs.nhs.uk 48 hrs in advance of the meeting.

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 28 September 2024
(Approved at Trust Board on Wednesday 30 October 2024)

Name	Initials	Title
Richard Fraser	RF	Chair
Gill Brown	GB	Non-Executive Director & Deputy Chair
Ann Marr	AM	Chief Executive
Anne-Marie Stretch	AMS	Deputy Chief Executive
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
Lisa Knight	LK	Non-Executive Director
Gareth Lawrence	GL	Director of Finance and Information
Lesley Neary	LN	Chief Operating Officer
Hazel Scott	HS	Non-Executive Director
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Acting Director of Human Resources
Rani Thind	RT	Associate Non-Executive Director
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Liz Cargill	LC	Parkinson's Disease Nurse (Agenda Item 2) (via MS Teams)
Hanah Horsfield	HH	Executive Account Manager, GE HealthCare (Observer via MS Teams)
Michelle Kitson	MK	Matron, Patient Experience (Agenda Item 2) (via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager
Emma Williams	EW	Divisional Director of Operations for Clinical Support and Community (Observer via Teams)

Apologies

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

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for August 2024 was Martin Abrams, Spiritual Care and Chaplaincy Manager, Southport and Ormskirk Hospitals and the Board watched the film of AMS reading the citation and presenting the award to Martin. 1.2. The Employee of the Month for September 2024 was Leila Eccles, Clinical Psychologist, Clinical Support and Community Services Division and the Board watched the film of LN reading the citation and presenting the award to Leila. **RESOLVED:** The Board **noted** Employees of the Month for August and September 2024 and congratulated the winners.
2.	**Patient Story**
	2.1. RF welcomed MK and LC to the meeting. 2.2. MK introduced the Patient Story video in which the patient's daughter shared the experience of the care her mother received when she had been admitted to Southport Hospital in June 2023, and the lack of specialist knowledge about the care her mother required for Parkinson's Disease, particularly administering drugs via a Apomorphine pump. The patient's daughter had raised her concerns with the Director of Nursing, Midwifery and Governance and as a result several immediate actions were taken. This was followed by the recruitment of a Parkinson's Disease Specialist Nurse to support patient care and education, and the patient's daughter described the positive impact of this role on her mum's care and her own experience as a family member. 2.3. RF commented that this was a powerful patient story because it demonstrated the importance of listening to the feedback of patients and their carers, and this had then been transformative for this patient and the many other patients with Parkinson's Disease who were cared for at Southport Hospital. RF thanked LC on behalf of the Trust and all future patients for changing the experience of patients and their families in such a positive way. 2.4. AM asked what mechanisms were in place to ensure that patients with Parkinson's disease were identified and referred when they were admitted to hospital. LC explained that she had been in post for a year and had used best practice examples from other local hospitals to build the service. All admitted patients with a diagnosis of Parkinson's Disease were now notified to her via an alert on the Electronic Patient Records (EPR) system. When patients received a new diagnosis, a referral was made to the specialist nurse service

for review. LC was also visible on the wards and had promoted the service, so ward staff knew to contact her.

2.5. AM explained that the reason for raising this was that she had received a complaint from a patient with Parkinson's Disease who had not been able to access the specialist care they needed when admitted to Whiston Hospital. LC advised that she was working with the Specialist Nursing team based at Whiston to align processes across Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). LC noted that most of the workload for the more established Whiston team was focused on Outpatients which was vital to keep patients well and out of hospital. As a new service the majority of LC's work during her first year in post had been to identify inpatients and ensure they received the appropriate care. RF commented that this was another opportunity to build best practise pathways across MWL.

2.6. RT reflected that the patient's daughter had been in contact with LC when her mother was at home and asked if there was any community support services available. LC confirmed that there was community support and a neurological rehabilitation team, but as this patient approached the end of her life additional specialist care was required. LC confirmed the main diagnostic pathway was via the Walton Centre and patients could also have specialist care provided on an outreach basis, but patients identified via the Care of the Elderly pathway would be referred to herself.

2.7. GB thanked MK and LC for an interesting story and reflected on the importance of the patient experience team in listening and acting when something had not gone according to plan for a patient.

2.8. GB asked whether the administration of Parkinson's medication via an Apomorphine pump was a recent development or a standard treatment. LC advised that this was an advanced therapy that was offered to a patient when oral medication was not working to help maintain quality of life.

(MK and EC left the meeting)

2.9. RT commented that she had been surprised that initially the administration of the patient's medication via the Apomorphine pump had been undertaken by a family member, and asked if there were many other situations where it would be common for staff to rely on relatives to handle an element of care for patients because they did not have the necessary skills. AM agreed with RT's comment and added that it was disappointing to hear this. AMS advised that when the Patient Story had been discussed at Executive Committee it had been noted that, prior to the appointment of a Parkinson's Disease Nurse, the Walton Centre had been available for telephone advice, but clearly the appointment of the local Parkinson's Disease Nurse had transformed the service. RC felt it was important to remember that where a patient is unable to communicate their needs, it is usual to talk to a family member who can provide information about their care needs. RC also commented on the

	different strengths of the EPR systems at each legacy trust that had been illustrated by the discussion, namely the legacy STHK had functionality to note time critical medication, whilst the legacy S&O system could flag individual care needs. Going forward it would be important that both features were incorporated into the planning for the new MWL EPR. 2.10. RT commented that the service currently relied on one individual who worked Monday to Friday, and queried what would happen at the weekend. AMS agreed and felt that having a single Nurse specialist was an advance on the previous situation but did result in a single point of failure if the individual was absent, and suggested the Executive Committee review how the teams were being integrated to reduce this risk. 2.11. RF concluded that this patient story had highlighted two things, firstly that the Trust had responded to feedback and made changes to improve the service and secondly that there was now an opportunity to incorporate best practice from both legacy trusts into a better MWL service. **RESOLVED:** The Board **noted** the Patient Story
3.	**Chair's Welcome and Note of Apologies**
	3.1. RF welcomed all to the meeting including HH and EW who were attending as observers. RF noted that EW had joined the Trust on 23 September 2024 as the Divisional Director of Operations for Clinical Support and Community Services. 3.2. RF noted the apologies of AB, LB, and SR. 3.3. RF acknowledged the following awards and recognition that the Trust had recently received: 3.3.1. Congratulations to the Haematology Service at Ormskirk Hospital, who received the Myeloma UK Clinical Excellence Programme (CSEP) Award. 3.3.2. The Trust has been named as a finalist in two categories of this year's Patient Experience Network National Awards for its work to deliver a training programme to raise Deaf awareness among staff. 3.3.3. Staff from Vinci Facilities and Trust staff rode 240 miles from London to Paris in three days to raise funds for MWL NHS Charity. 3.3.4. Caroline Attwood, Lead Nurse for Community Nursing and Sandra Ryan, Directorate Manager for Community Nursing both received the prestigious Queen's Nurse Award for their dedication to providing the highest standards of care. 3.3.5. MWL's Inpatient Smokefree Team celebrated visiting more than 1,000 patients since their launch in April. The Team provides support to patients who were identified as current smokers in hospital and gives help and advice to support them to give up.

	Apologies for absence were **noted** as detailed above
4.	**Declaration of Interests**
	4.1. There were no declarations of interests in relation to the agenda items.
5.	**TB24/060 Minutes of the previous meeting**
	5.1. The meeting reviewed the minutes of the meeting held on 31 July 2024 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board **approved** the minutes from the meeting held on 31 July 2024
6.	**TB24/061 Matters Arising and Action Logs**
	6.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 6.2. The following action was closed: 6.2.1. Agenda Ref 12 (MWL TB24/010 Learning from Deaths Annual Report) – it was noted that the annual report had been deferred from the meeting held on 31 July 2024 and was to be presented under Agenda Item TB24/06 at this meeting. **Action closed.** 6.2.2. Agenda Ref 7 (TB24/051 Executive Committee Assurance Report, Quality Ward Rounds) – LB had circulated further information and guidance about the new MWL Quality Ward Rounds process to Board members. **Action closed.** 6.3. GB asked whether the Cheshire and Merseyside (C&M) Urgent and Emergency Care programme governance and success metrics had been circulated to all Board members. LN advised that this had been circulated but undertook to reshare with GB. **Action closed**. **RESOLVED:** The Board **approved** the action log.
Performance Reports	
7.	**TB24/062 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for August 2024 was presented.
7.1.	**Quality Indicators**
	7.1.1. PW, on behalf of LB, presented the Quality Indicators and highlighted the following:

	7.1.1.1. The Hospital Standardised Mortality Ratio (HSMR) data reported was still from December 2023 and was 84.1, as had been reported for several months. PW noted that the action plan to reduce the backlog of coding at the Southport and Ormskirk Hospital sites was nearing completion and it was anticipated that the HSMR data would be updated next month. 7.1.1.2. Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation remained within expected levels at 1.06 for the period until end of March 2024. 7.1.1.3. The inpatient Friends and Family Test (FFT) recommendation rate in August 2024 was 94.7% against a target of 90.0%, despite the lower recommendation rates from the maternity areas. It was noted that there was an action plan in place which covered the four maternity touch points. 7.1.1.4. The Nurse fill rate was 93.1% against a target of 90% (YTD 95.8%). 7.1.1.5. There had been nine cases of Clostridioides difficile (C.Diff) in August 2024 (33 YTD). PW advised that the Trust had now received its annual tolerance level for 2024/25 which was no more than 113 cases. PW noted that the C.Diff improvement plan remained on track and covered environmental cleanliness, antimicrobial prescribing, staff awareness and training. As part of this plan the Trust was now using Hydrogen Peroxide vapour for cleaning on all sites. 7.1.1.6. There had been 14 cases of Escherichia coli (E.coli) reported in August 2024 (72 YTD). PW noted that the target for the year was no more than 171. The Trust continued to collaborate with the Integrated Care Board (ICB) led North Mersey Infection Prevention Control (IPC) / Antimicrobial Resistance (AMR) action plan with a focus on reducing E.coli blood stream infections and improving hydration. 7.1.1.7. There had been no still births , and one neonatal death in August. 7.1.1.8. There had been no never events reported in August. 7.1.1.9. The Falls Team had developed targeted action plans for areas with higher incidence and risk of falls, with focussed support for the Emergency Departments (ED). The trial project on decaffeinated beverages was currently on going. 7.1.1.10. The number of complaints responded to within 60 days in August was 51.6% against the target of 80.0%, with work on-going to reduce the backlog.
7.2.	**Operational Indicators**
	7.2.1. LN presented the operational indicators and highlighted the following: 7.2.1.1. Urgent Care performance remained pressured. 7.2.1.2. The 4-hour performance (mapped) in August was 81.1% against a target of 78%, national performance was 76.2% and C&M performance was 74.3%. MWL was the best performing acute Trust in C&M. The Trust had been in escalation on several occasions at both the Whiston and Southport Hospital sites. Bed occupancy remained high and there were long waits for admission in the Emergency Departments, increased ambulance handover times and additional staff had been required for corridor care and escalation bedded areas.

	7.2.1.3. The Trust had achieved 55.4% of Ambulance handovers within 30 minutes against a target of 95%. 7.2.1.4. Bed occupancy across all sites was 104.3% in August (88 additional patients) which was a slight decrease compared to 105.8% in July. There had been a peak of 125 Non-Criteria to Reside (NCTR) patients in August 2024 which included patients in general and acute beds, escalation areas and those waiting for ED admissions. 7.2.1.5. The percentage of NCTR patients had increased to 22% (a 1.6% increase from July 2024). Patient flow had also been impacted by several IPC challenges, where beds had to be closed to new admissions. 7.2.1.6. The second ICB-led Super Multi Agency Discharge Event (MADE) event had taken place in preparation for the August bank holiday and this had achieved a reduction in the number of NCTR patients increased discharges and reduced bed occupancy levels which had resulted in improved patient flow over the bank holiday weekend, but unfortunately the impact had not lasted. LN noted that the Trust had also introduced several new internal processes as part of the Super MADE event which included a Multi-Disciplinary Team (MDT) Hub "call before convey" with North West Ambulance Service NHS Trust (NWAS) which had resulted in 89% of patients being deflected from Whiston ED to an alternative service. LN noted that the continued use of this was being discussed with NWAS. Additionally, a decision was made to remove the Same Day Emergency Care (SDEC) area at Southport Hospital from the Trust's escalation flow chart to bed in times of pressure, to ensure it was always available for SDEC and did not get blocked with patients in beds, this would allow for an additional 75 patients through this area daily. 7.2.1.7. There were several trusts nationally who had been identified as requiring additional support for winter and LN noted that five trusts in C&M had been identified as Tier 1 and this included MWL. A meeting would be held with the Emergency Care Improvement Support Team (ECIST) to discuss what type of support that could be provided. 7.2.1.8. For elective care LN reported there was a risk of not achieving the national target of zero 65+ week waiters by the end of September 2024, which was mainly due to Plastics which as a specialty continued to have the highest number of long waiters. Mutual aid had been sought from Lancashire Teaching Hospitals NHS Foundation Trust for the plastics cases. In addition, there remained some long waiters for vascular surgery which was delivered via a Service Level Agreement (SLA) with Liverpool University Hospitals NHS Foundation Trust (LUHFT). Some waits were also because of patient choice and patient cancellations. 7.2.1.9. There would be an increase in activity as the two new theatres at Whiston became fully operational. 7.2.1.10. The Trust continued to exceed the diagnostics performance target in August with performance at 86%, which was ahead of national performance of 77.6% (latest month published was July 2024). C&M performance was 91% and MWL were the best performing acute Trust. 7.2.1.11. The Cancer Performance Improvement Plans had been presented at the Finance and Performance Committee. The cancer 28-day standard

	increased in July 2024 to 74.6% against the target of 77%. Performance against the 62-day target had increased to 80.8% against the target of 85% (C&M performance was 75.9% and national was 67.7%). LN noted that the Trust was now in the top 20% nationally. Tumour site specific action plans were in place and significant improvements had been seen for gynaecology and urology. 7.2.2. RT reflected on the improved performance against 62-day standard but noted the deterioration in performance against the two-week referral standard and asked if there was an issue with capacity at any of the sites and if so whether there were any plans to address this. LN noted that the two-week waiting time standard had been replaced by the 28-day faster diagnosis target and performance against this target was improving. LN acknowledged that achieving low waiting times was a key enabler to delivering the 28-day faster diagnosis standard and for this reason the Trust continued to monitor waiting times to first appointment. LN commented that historically legacy S&O has performed well against the two-week waiting time standard but less well against the 62-day cancer target, whereas for legacy STHK it had been the other way round. 7.2.3. RT asked which specific tumour sites were most challenged, and LN confirmed that the skin cancer pathway had the most referrals and therefore had the greatest challenges in achieving two-week waiting times. AM commented that there had been a 5% increase in referrals for suspected skin cancer and reflected on the importance of maintaining the two-week standard as this was the right thing to do for patients. 7.2.4. AMS reflected on the success of the MDT Hub Call before Convey scheme with NWAS and asked whether this would be formally evaluated to determine if the project had been a success and whether it created additional work for NWAS. LN responded that ensuring a consistent approach was part of the challenge and this was being discussed with NWAS. The Super MADE event has been evaluated by the ICB and LN advised that she would discuss the results with the Executive Committee as part of planning for the coming winter. 7.2.5. CS commented that the main target for NWAS was response times and asked whether the Trust has access to the same data as NWAS to track what had happened to those patients that had been deflected from ED. PW commented that, in his interactions with NWAS, there was support for the approach from the senior clinicians and leadership team , however, the challenge would be to ensure consistency so it became normal for the ambulance crews to access alternatives to ED. CS asked if the MDT Hub concept could be used for ambulances on site that were waiting to handover patients. RC responded that the purpose of the MDT Hub was for decisions to be made before a patient reached site, and the key success metric for NWAS would be a reduction in the time to handover when using the MDT Hub and putting suitable patients on alternative pathways. RC commented

	that this process was already in place in Greater Manchester but had not yet been adopted in C&M, and it was incumbent on the Trust to insist that this approach be rolled out to all A&E Departments in C&M.
7.3.	**Workforce Indicators**
	7.3.1. MS presented the Workforce Indicators and highlighted the following: 7.3.1.1. The compliance rate for appraisals in August was 74.2% against the target of 85% by the end of the appraisal window (legacy STHK was 72.5% and legacy S&O was 77.5%). A monthly compliance report is discussed at the Executive Committee and any services or teams with low compliance were being identified and targeted to increase compliance. The Trust's appraisal window was due to end on 30 September 2024. 7.3.1.2. For August core mandatory training compliance was 89.2% against the target of 85%. 7.3.1.3. August sickness absence was 5.7% against the target of 5% and this was similar to the same period in 2023/24. There had been a decrease in nursing sickness absence. A Task and Finish Group had been established to explore the reasons for higher Health Care Assistants (HCA) sickness and MS noted that there had been a slight improvement in month. 7.3.1.4. Staff turnover in August was 1.9% against a target of 1.1%, but this increase was attributable to the Foundation Year 2 doctors moving to their next rotation placement, and the end of some fixed term contracts in the Lead Employer service. The YTD figure was 1%.
7.4.	**Financial Indicators**
	7.4.1. GL presented the financial indicators and highlighted the following: 7.4.1.1. The final approved MWL financial plan for 2024/25 was a deficit of £26.7m which assumed: • Payment of £12m funds in line with the transaction business case • A Cost Improvement Programme (CIP) target of £48m (£36.2m recurrent and £11.8m non-recurrent) • Delivery of the 2024/25 activity plan 7.4.1.2. At month 5 the Trust had reported a deficit of £19.9m which was a £1.9m negative variance from plan. This was due to the impact of the junior doctors' industrial action in June and July 2024. GL advised that the ICB had now received a £4m allocation of funding for the impact of the industrial action. GL commented that it was not yet clear how this would be distributed to the provider organisations, but he was concerned it was not sufficient to mitigate the total financial impact. 7.4.1.3. The Trust had achieved £31.7m of the CIP target and this included £29.1m which was recurrent CIP, with a further £1.4m identified but not yet transacted. 7.4.1.4. The cash balance at month 5 was £3.9m and, in line with plan, the Trust had requested £9m of cash support from NHSE during September, however, only £5m had been received because of the cash preservation mitigations nationally. GL noted that the impact of this would be reflected

	in the Trust's Better Payment Practice Code (BPPC) performance as there would not be sufficient cash to pay all suppliers within 30 days. 7.4.1.5. The Trust continued to forecast full delivery of the Capital Programme (circa £28m), excluding the Laboratory Information Managements System (LIMS) and Electronic Patient Record system replacement capital. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
8.	**TB24/063 Committee Assurance Reports**
8.1.	**Executive Committee**
	8.1.1. AM presented the Executive Committee Assurance report from the meetings held in July and August 2024 and noted that any bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. Additionally, the meeting received Assurance Reports from the Premium Payments Scrutiny Council and the weekly vacancy control panel. 8.1.2. AM highlighted the following: 8.1.2.1. The Committee had received the Patient Advice and Liaison (PALS) review which set out the actions being taken to improve the complaints response times, focusing mainly on the service at Whiston Hospital. AM noted that there had been a reduction in the formal complaints' response times at Southport Hospital due to changes in the PALs processes and these were now being rolled out at Whiston Hospital. 8.1.2.2. The Committee had received the Temporary Workforce Harmonisation Update following the harmonisation of nursing temporary pay rates across all MWL sites. 8.1.2.3. The Committee had reviewed the Theatre Utilisation Improvement Plan which focused on opportunities to improve theatre productivity and increase activity levels. 8.1.2.4. The Committee had approved a business case for the recruitment of three whole time equivalent (WTE) substantive consultant posts for the ED at Southport Hospital to achieve a compliant rota and to reduce locum spend. AM noted that the Clinical Director had been confident that the Trust would now be able to recruit to these posts. 8.1.2.5. The cost effectiveness of an additional fifth bed in a ward bay on the wards at Whiston Hospital had been evaluated and, whilst this was not the most cost-effective option to increase bed numbers, it was recognised that the escalation beds were still required to minimise the need for corridor care in the ED. The Committee had agreed to also review other options. 8.1.2.6. The Committee received the first MWL Care Quality Commission (CQC) Inpatient Survey results and noted that the results in several areas had been disappointing. The results had been impacted by the long waits for admission and this had been reflected in the patients' comments. The

	Committee had agreed an action plan to try and address the areas for improvement. 8.1.2.7. The Committee had received an update on the new MWL 5 Star Ward Accreditation Scheme which was designed to set a consistent high standard for ward care across all sites. The initial feedback was positive, and the scheme would continue to be rolled out. 8.1.3. RT asked about the review of neonatal unit closures and reflected that in light of the increased number of complex pregnancies and subsequent acuity pressure on the neonatal unit, if there was anything the Trust could do in advance of the specialist commissioning review of neonatal cot capacity. AM agreed that MWL should review the distribution of neonatal cots across the Trust to ensure the capacity was in the right place to meet the demand and avoid closures AM suggested LN undertake a review and report back to the Executive Committee. The remainder of the report was **noted.**
8.2.	**Extraordinary Audit Committee**
	8.2.1. IC presented the assurance report following the Extraordinary Audit Committee that had been held on 30 July 2024 and advised that the lengthy discussions with the external auditors regarding the treatment of capital items for the 2022/23 legacy STHK accounts had delayed the start of the 2023/24 audit, which led to the requirement for an Extraordinary Audit Committee to approve the 2023/24 annual accounts. 8.2.2. IC advised that the External Auditors Draft Audit Findings Report and draft Annual Auditors Report had not highlighted any issues of concern. There was one unadjusted non-material misstatement in the accounts which related to the treatment of an asset under construction and IC advised that the Audit Committee were content that this should not be changed. 8.2.3. The MWL Accounts adoption and MWL annual Report and Annual Governance Statement (AGS) were approved by the Audit Committee subject to the satisfactory conclusion to the external audit and the approval of the final accounts was delegated to IC, as Chair of the Audit Committee, and GL, as the Director of Finance and Information. 8.2.4. The Audit Committee had reviewed and approved the revised Standards of Business Conduct Policy. 8.2.5. GB asked how a staff declaration for a gift or hospitality was reviewed to ensure that it was in line with the Trust's policy. GL responded that declarations registered were checked to ensure that they were valid. Additionally, GL advised that in his time with the Trust, there had not been any declarations that had been deemed inappropriate. AM asked who was responsible for the check and challenge and NB noted that declarations were recorded via the Electronic Staff Records (ESR) system and were then

	flagged to the line manager for review via an ESR notification. GL suggested that the process be included as part of the internal audit programme to test these controls to provide assurance that the policy was being followed. 8.2.6. RT reflected that there was a possibility of a Clinical Director not being comfortable challenging the declaration of a more senior staff member. 8.2.7. AMS reminded the Board that the Declaration of Interests Register was published annually on the Trust's website in line with the national guidance. The remainder of the report was **noted.**
8.3.	**Quality Committee**
	8.3.1. GB presented the Quality Committee Assurance Report for the meeting held on 17 September 2024 and highlighted the following: 8.3.1.1. The Southport site had made some good advances in improving the complaints process and this had resulted in a reduction in the complaints backlog, however, there was still more work to do. Resources had been temporarily redirected from Southport to Whiston Hospital to assist with improvement work. The Quality Committee had recognised the value to a strong PALs service in dealing with patient concerns before they became formal complaints. 8.3.1.2. From the review of the maternity dashboard metrics the Committee had requested more information about an admission to the Intensive Care Unit (ICU) from Maternity. 8.3.1.3. There had been an increase in forceps deliveries to 9.5% and this was being monitored. 8.3.1.4. GB reflected on her recent visit to Southport Hospital and commented that the improvements to the estate had made a difference. GB noted that she had visited the Intensive Therapy Unit (ITU), the Orthopaedic ward as well as the new waiting area for theatres. 8.3.1.5. GB noted that the Orthopaedic ward had reported a case of Methicillin-Resistant Staphylococcus Aureus (MRSA) and had realised the need for additional training. GB had noted the positive impact of the Practice Educators on the ward in raising standards and compliance with mandatory training. 8.3.1.6. The Committee had discussed the sharing of best practice and cross working across the Southport and Whiston Stroke units. The differences in the Sentinel Stroke National Audit Programme (SSNAP) outcomes and in particular therapies were discussed. It was however noted that the units were part of two different stroke pathways and Whiston was a Hyper Acute Stroke Unit for Mid-Mersey and Southport a rehabilitation unit for the North Mersey stroke pathway. 8.3.1.7. The Committee had reviewed the Terms of Reference (ToR) for the Clinical Effectiveness, Clinical Engagement and Patient Safety Councils and had requested some additional amendments before they could be approved. 8.3.1.8. The Committee had received the 12-month review of the Patient Safety Incident Response Framework (PSIRF), and it was noted that mixed

	feedback had been received from families about their level of involvement in the process. Supportive conversations had taken place with staff about the learning opportunities, but it had been noted that some of the investigations had required a lot of resources to complete. The impact of the Thirwell Enquiry and how the outcome would feed into any future changes for NHS processes had also been discussed. 8.3.1.9. The Committee had received the Patient Safety Report and had requested additional information regarding the alert process for histology reports when the was a significant finding. 8.3.1.10. The Committee had received the National Inpatient Survey (NIP) 2023 results following publication by the CQC, and it was noted that there had been a deterioration in the patients' perception of staff kindness and compassion, which was a cause for concern. GB alerted to the meeting that the next survey was due to take place in November 2024 and this allowed little time for changes to be made, however, there was an improvement plan in place. 8.3.1.11. The Committee had approved the Quality Committee annual effectiveness review improvement plan. 8.3.2. RT reflected that the MRSA case reported on the Orthopaedic Ward, had been mainly attributed to inadequate cannula training, and asked how ward improvements were monitored. AM responded that the new Ward Accreditation scheme would focus on basic care standards and following the accreditation the Corporate Nursing team worked with the wards to ensure actions were delivered and improvements maintained. 8.3.3. RF reflected on the importance of learning from patient feedback in the national patient surveys and GB agreed but felt it would be more beneficial if the results took less time to be collated and released. 8.3.4. AMS noted that mini surveys that recreated the key questions of the national inpatient survey had been undertaken to gain a better understanding of what was meant by kindness and compassion for the patients. Feedback received from patients had suggested staff morale was important, and AMS reflected that there had been a lot of change during the last 12 months and the Trust remained under intense operational pressures and this could potentially impact on the upcoming staff survey results. AM reflected that this had been a difficult period of adjustment for all staff and the impact of this could not be underestimated. The remainder of the report was **noted**.
8.4.	**Strategic People Committee**
	8.4.1. LK presented the Strategic People Committee Assurance report for the meeting held on 16 September and highlighted the following: <u>Southport Incident</u>

	8.4.1.1. The Committee received a presentation from the Health and Wellbeing Team (HWB) which gave an overview of the support provided to staff during and after the major incident in Southport. HWB staff were on-site from 30 July and there was ongoing periodic remote and in-person engagement support for targeted areas and teams since then. Dedicated landing pages had been created on the Trust's intranet with specific post incident resources and support for staff. 8.4.1.2. Human Resources support included welfare check-ins and continued supportive welfare conversations with identified staff. 8.4.1.3. LK noted that, the impact of the incident for Lead Employer (LE) staff had not been recognised immediately, but there had been several enquiries from trainees who were due to join placements in August, mainly in General Practice, who had been worried about their safety after the riots which followed the incident, but once highlighted support had been put in place . 8.4.1.4. Work was ongoing with Merseyside Police around crime prevention and reduction and bodycams had been introduced to the ED at Southport Hospital to give staff more confidence, following their successful use in the ED at Whiston Hospital. The Crime Prevention and Reduction Officer was now based at the ED at Southport Hospital one day per week to provide onsite guidance, support, and reassurance. 8.4.1.5. A trial of the MWL Management of Violence, Abuse and Unacceptable Behaviour Policy was being undertaken to support the Trust zero tolerance approach. <u>Staff Story – Southport Incident</u> 8.4.1.6. A staff member who lived with his family in Southport shared the experiences of himself, his family, and friends and other Black and Minority Ethnic (BME) staff following the Southport incident and its aftermath. 8.4.1.7. The staff member had set up a WhatsApp support group for emotional and practical advice. 8.4.1.8. The staff member had also arranged drop-in sessions to support colleagues and, whilst the individual was normally based at Whiston Hospital, they spent time over at Southport Hospital with the support of their manager. LK noted that these drop-in sessions continued to take place weekly. <u>Medical Workforce Leadership Programme Update</u> 8.4.1.9. The Committee received an update on the Medical Leadership Programme, and it was noted that the first cohort would be reserved specifically for the Clinical Directors to support the current organisational change process. The remainder of the report was **noted**.
8.5.	**Finance and Performance Committee**
	8.5.1. SC presented the Committee Assurance report for the meeting held on 19 September 2024 and noted that the Committee had reviewed the CPR and

monthly finance report, but the key points had already been discussed in earlier reports so would not be repeated. Other points to highlight were:

8.5.1.1. The Director of Finance report had highlighted two issues:

- MWL would be excluded from the National Cost Collection data submission due to the exclusion of the impact of Public Finance Initiative (PFI) IFRS16. SC noted that the Trust had raised concerns that this would create inconsistency for the benchmarking data.
- Following the agreement of national pay awards a significant amount of cash would be needed for the back pay as the pay awards were backdated to April. This was a particular issue for the payment of Lead Employer Doctors as the MWL payroll paid over 11,000 lead employer staff each month. The cash requirement for this was circa £120m to be able to make the payments. GL was liaising with NHSE and the relevant host trusts, so the re-charges were paid to mitigate the risk of running out of cash.

8.5.1.2. SC noted that the Trust was part of two of system wide financial recovery reviews, undertaken by PricewaterhouseCoopers International Limited (PWC) and a NHSE led review of the forecast outrun and required mitigations.

8.5.1.3. The Committee received a report about implied efficiency/productivity and how MWL was rated on this measure. This was based on data from 2019/20 to 2023/24, and SC noted that there had been a national reduction of circa 12.5% and 7.2% for MWL in implied efficiency. The calculation was driven by increased costs compared to activity levels, and the finance team had re-calculated the figures with Trust data which resulted in a 0.6% improvement. SC noted that the Trust had compared favourably with the other acute trusts in C&M.

8.5.1.4. CIP continued to make significant progress against the plan with £10m more to be delivered by year end.

8.5.1.5. The Committee had received the review of cancer performance and improvement plan and had noted the focus on capacity for first appointments by learning from the faster diagnosis programme as well as the Community Diagnostic Centre (CDC) workstreams to maximise current capacity and reduce delays from diagnosis to treatment. Additionally, work was ongoing to improve the quality of referrals in conjunction with primary care partners.

8.5.2. The Committee received the assurance reports from the Procurement Council, the CIP Council, the Capital Planning Council, the Estates & Facilities Management Council, and the IM&T Council.

8.5.3. GL commented on the implied productivity report and clarified that the Trust had taken on the community nursing staff after the baseline year (2019/20) and the Trust also hosted several services on behalf of the wider system, such as payroll and Lead Employer but the full costs of these services had been attributed to the Trust, so there was not a like for like comparison.

The remainder of the report was **noted**.

	RESOLVED: The Board **noted** the Committee Assurance Reports
Other Board Reports	
9.	**TB24/064 Medical Revalidation Annual Declaration 2023/24**
	9.1. PW presented the Medical Revalidation Annual Declaration 2023/24 and noted that the format of the report was mandated by NHSE. PW highlighted the following: 9.1.1. At the end of 2023/24 857 doctors had Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) as their registered Designated Body. 9.1.2. 768 doctors had completed medical appraisals in line with General Medical Council (GMC) guidance. 48 doctors had completed an appraisal within the correct timescale; however, these had not been signed off by the 31 March 2024 deadline and PW noted that these would previously have been reported as agreed exceptions. 9.1.3. 41 doctors had not completed an appraisal, and all were approved missed appraisals (e.g. due to sickness). 9.1.4. 277 revalidation recommendations were made to the GMC with 259 doctors being positively recommended for revalidation. All doctors who were recommended for revalidation were deemed to be engaging with the revalidation process and had provided the appropriate evidence of this. 9.1.5. No (zero) doctors were referred to the GMC for further action or referred to the Practitioner Performance Advice Service for support and no (zero) doctors were excluded from practice. 9.1.6. In January 2024, Dr Kathryn Clark became the Trust's Responsible Officer to cover for the long-term absence of the substantive Responsible Officer. 9.1.7. The Medical Revalidation Teams had aligned processes to ensure a standard approach to appraisal and revalidation across MWL. 9.1.8. During 2024/25, the organisation would continue to work towards complying with Medical Professional Regulations and would agree and implement a new Medical Appraisal and Revalidation Policy following the implementation of a single appraisal IT system for MWL. 9.2. RT referred to Appendix A regarding the total number of claims made to employment tribunals by doctors (two) and the number of these claims upheld (not applicable) and asked whether the reason for this was that these claims had not been processed. PW confirmed that this was correct. 9.3. RT asked whether there was guidance in place to assist an appraisee or appraiser with any issues that might arise. PW responded that this was included in the Appraisal Policy and any issues could be escalated to the Appraisals Lead first and if a resolution was not reached to the Responsible Officer, the appraisee was able to raise any issues or concerns during the process and also provide feedback following an appraisal.

	9.4. HS asked whether it was normal to report zero referrals to the GMC and whether this in line with expected rates. PW responded that this was in keeping with expected rates and noted that in 2022/23 there had been two referrals to the GMC. **RESOLVED:** The Board **approved** the Medical Revalidation Annual Declaration 2023/24
10.	**TB24/065 Learning from Deaths Annual Report 2023/24**
	10.1. PW presented the Learning from Deaths Annual Report 2023/24 which provided had been requested by the Board to provide an overview of the work of the Learning from Deaths team and the learning from deaths that had been reviewed during the year. It was noted that the report had been deferred from the meeting on 31 July 2024, when PW had to leave the Board due to the Southport incident. 10.2. PW advised that the two legacy organisations had adopted different processes to the learning from deaths process. Legacy S&O had a combined merged medical/learning from deaths process where all deaths were initially reviewed by the medical examiner team and anywhere there were potential concerns about the care were referred to the learning from deaths team for a structured judgement review (SJR). At legacy STHK the two processes were separate and deaths within scope were identified for an SJR. Both organisations had a Mortality Surveillance Group, which reported via the Clinical Effectiveness governance forum. These two processes were now being combined to give a single approach across MWL. 10.3. PW highlighted the following from the report: 10.3.1. In 2023/24 there had been 2,174 deaths reported at legacy STHK and 328 had been selected for SJRs. From the completed SJRs (237), four were graded as Amber and these were being managed via the Patient Safety Incident Framework (PSIRF). 124 were graded as green and 50 were graded as green with learning. There had been no SJRs graded as red. 10.3.2. During 2023/24 there had been 937 deaths reported at legacy S&O of which 48 had been selected for SJRs. From the completed SJRs (42), two were graded as Amber and were being managed via the Patient Safety Incident Framework (PSIRF). 12 were graded as green (adequate overall), 16 were graded as green (good overall) and 13 were graded as green (excellent overall). There had been no SJRs graded as red. 10.4. The following themes had been identified during 2023/24: 10.4.1. Continued use of usual medication at End of Life. It had been found that in some cases that advanced care plans were not followed as intended, resulting in avoidable hospital admissions and patients not dying in their place of choice. 10.4.2. Emergency Department patients flow created challenges for all acute hospitals and long waits for admission to a ward could have a negative effect.

	Whilst the mortality reviews had not identified any deaths directly attributed to delays in the ED, the impact on quality of care has been noted. 10.5. The key lessons learnt from Mortality Reviews were: 10.5.1. The importance of accessing translation services for patients whose first language was not English. A Task and Finish Group had been established to review translation services. Additionally, communications had been sent to all staff in the Medicine and Emergency Care Division advising how to access the current translation services. 10.5.2. The learnings identified in the three coroner cases had previously been detailed in the quarterly learning from deaths reports. 10.6. RT recalled that not accessing translation services had been identified at legacy STHK as a learning from other complaints and investigations, so it was a concern that staff were still not aware of how to access the service. RT felt that it was important that all staff knew how to access the translation services. PW responded that the specific learning from the SJR had applied to ED and emergency situations, however, the Task and Finish Group was reviewing the issue across all services, for MWL. 10.7. MS noted the recent expansion of the role of the medical examiner and sought assurance that the MWL approach would meet the requirements. PW responded that the separation of the Learning from Deaths and Medical Examiner roles was being addressed via the plans to integrate the two legacy teams. 10.8. GB thanked PW and the team for drafting the report which she had found useful. 10.9. GB also noted the number of falls that resulted in serious incidents and suggested this should be an area for targeted improvement work. AMS noted that this was a Quality Account improvement objective for 2024/25, and therefore part of the Trust objectives. AMS commented that even when the risk assessment had been completed some patients still had a fall. AM suggested that a forensic audit of the Root Cause Analysis (RCA) reports following falls be undertaken to identify the common themes associated with falls and a report be presented at Executive Committee. **Action** AMS to undertake a forensic audit of the Root Cause Analysis (RCA) to identify the common themes associated with falls and a report to be presented at the Executive Committee. 10.10. RF commented that the Trust compared well to peers for the number of falls per 1,000 bed days but acknowledged that it was still important to do better.

	10.11. PW commented that the actions to prevent falls had an impact on a patient's liberty, sometimes created trip hazards and also had implications for IPC, so there was always a need to balance the different risks. 10.12. IC commented that, following his personal experience of hospital stays, there were patients who despite being advised that they were at risk of falling, had not listened and a fair number of the falls were unavoidable. 10.13. RT commented that previously reports had distinguished between avoidable and unavoidable falls and asked if this could be re-instated. NB advised that the national reporting definitions had changed, and all falls were now reported, and this was how the Trust was monitored externally. **RESOLVED:** The Board **noted** the Learning from Deaths Annual Report 2023/24
11.	**TB24/066 Emergency Planning Response and Resilience (EPRR)**
11.1.	**Annual Report 2023/24**
	11.1.1. LN, on behalf of SR, presented the 2023/24 Emergency Planning Response and Resilience (EPRR) Annual Report and noted that the report had already been presented at the EPRR Working Group Meeting, Risk Management Council, and the Executive Committee. The report provided : 11.1.1.1. An overview of how the Trust had met each of the legal obligations, the number of training exercises, and other training and communication during 2023/24. There was also a breakdown of the actual incidents where the Trust had needed to enact its business continuity plans. 11.1.1.2. Details of the Trust's compliance level for 2023/24 for the Core Standards for EPRR were noted. 11.1.1.3. LN highlighted the strategic and tactical training undertaken in 2023/24 as well as legal awareness training. **RESOLVED:** The Board **approved** the 2023/24 EPRR annual report
11.2.	**Statement of Compliance with National Core Standards**
	11.2.1. LN presented the Statement of Compliance with national core standards for Emergency Planning Response and Resilience (EPRR) for 2024/25 and advised that as a Category 1 responder, the Trust was required to meet the NHSE Core Standards for EPRR. 11.2.2. LN advised that there were 62 core standards over ten domains that were applicable to all acute trusts. Following a self-assessment the Trust was fully compliant with 50 of the 62 core standards areas and partially compliant with 12 of the 62 core standards. The Trust was therefore assessed as being partially compliant against the EPRR Core Standards.

	11.2.3. LN advised that achieving full compliance had become more challenging for all NHS bodies as the standards had changed following : 11.2.3.1. A number of major incidents (such as the Manchester Arena bombing and Grenfell Tower fire) where there had been public enquiries and intense scrutiny of the response from the emergency services. The Trust's evidence of compliance for 2024/25 was submitted to NHSE and would be reviewed to confirm the Trust's self-assessment. LN noted that MWL had been the highest performing acute Trust in C&M for the 2023/24 declaration. 11.2.3.2. Increased focus on training exercises which included tactical and legal training. 11.2.3.3. A greater emphasis on demonstrating effective multiagency collaboration with Local Health Resilience Partnership (LHRP), ICB, and other EPRR peers. 11.2.3.4. The transaction, which was completed in July 2023, had significantly expanded the Trust's operations and had introduced the necessity to harmonise emergency plans across the newly unified Trust. 11.2.4. LN advised that the deadline for submission of Statement of Compliance with National Core Standards was 27 September 2024. 11.2.5. A review of the submission evidence was scheduled as part of the internal audit programme to provide additional assurance to the Board. 11.2.6. GB asked what would happen if a mass casualty was declared. LN responded that there were escalation plans in place for each site and for the Trust as a whole, and this included the cancellation of planned activity to free up beds and support from system partners. **RESOLVED:** The Board **approved** the 2024/25 EPRR Statement of Compliance with National Core Standards
12.	**TB24/067 Statutory Pay Gap Report 2023/24**
	12.1. MS presented the 2023/24 Statutory Pay Gap Report and noted that the report now included the pay gap for a range of protected characteristics including disability, ethnicity, sexuality and gender. 12.2. MS highlighted the following: 12.2.1. The mean gender pay gap of 30% was mainly due to the number of men occupying higher paid senior medical posts, and while this was predicted to change as the gender profile of the medical workforce changed it would be a few more years before there was parity. The Ethnicity Pay Gap for MWL was -39.15% in favour of ethnic minorities, and this was due to a significant number of senior medical staff being from ethnic minorities as well as the recruitment of overseas Band 5 nurses.

12.2.2. The Disability Pay Gap was 13.54% and it was noted that this figure was lower than for gender which indicated that there was a more equal distribution of disability throughout the pay grades across the Trust, However, the Trust's disclosure rates for disability remained relatively low, which was common throughout the NHS.

12.2.3. The Sexuality Pay Gap was 4.59% and MS noted that this was lower in the Agenda for Change staff group at less than 3%, however, it was higher in the Medical and Dental staff groups.

12.3. MS advised that there were actions in place to address the pay gaps and there had been an improvement in certain areas, particularly around the disability disclosure rates. The introduction of the Staff Voice Networks had created a forum where staff could raise concerns and help shape the actions the organisation could take to address them.

12.4. MS advised that other actions included:

12.4.1. Reviewing the routes into healthcare, specifically around what the Trust was doing to recruit men, ethnic minorities, and disabled people. MS commented that this included challenging the perceptions of roles that were viewed as traditionally either male or female.

12.4.2. The Recruitment Team had undertaken work to support our neurodiverse colleagues who might not perform as favourably in the structured interview process.

12.4.3. Career development opportunities for underrepresented groups in the workforce to break down the barriers to career progression.

12.5. AM commented that it was important that staff had confidence they would be treated fairly, and support offered if they made a disclosure about having a disability. Several recent cases had highlighted the importance of tailoring support for each individual.

12.6. AMS agreed that the solutions were often multifaceted, but it was important for staff to feel comfortable to declare that they had a disability and equally important that managers felt equipped to respond

12.7. AM asked whether it was possible to provide an analysis of the different types of disabilities that have been declared as well as the numbers. AMS noted that she did not think that this data would be available from the Electronic Staff Records (ESR), but MS agreed to review what was available.

Action
MS to undertake a review of ESR to determine if different types of disabilities can be analysed.

12.8. CS asked if there was a definition of disability. AMS responded that the question that was asked of staff on ESR was 'do you consider yourself to have a disability' and no further information was requested, and this was consistent across the NHS. CS commented that, in her opinion, this was a negative

	question as an individual might not view themselves as disabled. AMS responded that it was about giving the individual the power to interpret the question and if they thought that they had a disability then they had one. MS advised that one of the resources available to staff was the Reasonable Adjustments Passport which helped everyone understand the support that individual needed. 12.9. RT reflected on the increase in use of the term neurodivergent and asked if the Trust had appointed specialists in this area. PW added that specialist insight was needed for both staff and patients who had a disability. MS responded that the Equality, Diversity, and Inclusion (EDI) team, whilst not specialists, were familiar with this area and were also able to reach out for advice when needed. 12.10. GB reflected on one of the Trust's core values which was 'we are inclusive' and what this meant for staff and suggested that this could be explored further at the Strategic People Committee. **Action:** Strategic People Committee asked to consider how the trust value 'we are inclusive' means for staff. **RESOLVED:** The Board **approved** the Statutory Pay Gap Report 2023/24
13.	**TB24/068 Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement and Committee in Common refresh**
	13.1. NB presented the updates to the CMAST Joint Working Agreement (JWA) and Committee-in-Common (CIC) Terms of Reference (ToR) and noted that it had been agreed that a review would be undertaken every two years. The review had been requested by the CMAST Leadership Board and signed off by the CMAST Board (Trust CEOs and Chairs) on 06 September 2024. The proposed changes were highlighted in the report and did not alter the governance arrangements of CMAST. 13.2. NB noted that there had been a decrease in the number of member organisations following the completion of the transaction. **RESOLVED:** The Board **approved** the Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement (JWA) and the Committees-in-Common (CIC) Terms of Reference

Concluding Business	
14.	**Effectiveness of Meeting**
	14.1. RF invited reflection on the effectiveness of the meeting. No concerns or issues were raised.
15.	**Any Other Business**
	15.1. RF invited reflection on the effectiveness of the meeting. No concerns or issues were raised. 15.2. RF provided feedback on his attendance at the Open Day hosted by the Southport Society Mosque on Sunday 15 September. The mosque had been affected by the recent riots in Southport and had hosted this event to thank the local community, police services and the Trust. The being no other business, the Chair thanked all for attending and brought the meeting to a close at 13.06. The next Board meeting would be held on **Wednesday 30 October 2024 at 09:30**

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

Trust Board (Public)
Matters Arising Action Log
Action Log updated 25 October 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
10	25/09/2024	**TB24/065 Learning from Deaths Annual Report 2023/24**	AMS to undertake an audit of the Root Cause Analysis (RCA) reports to identify the common themes associated with falls.	AMS	Nov-24	Report to be presented at Executive Committee	
12	25/09/2024	**TB24/067 Statutory Pay Gap Report 2023/24**	MS to undertake a review of ESR to determine if different types of disabilities can be analysed.	MS	Jan-25		
12	25/09/2024	**TB24/067 Statutory Pay Gap Report 2023/24**	Strategic People Committee asked to consider how the trust value 'we are inclusive' means for staff	MS	Jan-25	Report to be presented at Strategic People Committee	

Completed Actions

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	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	**25/09/2024** - Annual Learning from Deaths report presented at meeting (Agenda item TB24/064. **Action closed**	**Closed**
7	31/07/2024	**TB24/051 Executive Committee Assurance Report** (Quality Ward Rounds)	LB to circulate further information and guidance about the new MWL Quality Ward Round process	LB	Sep-24	**25/09/2024** - LB circulated the information and guidance about the new MWL Quality Ward Round process to Board members. **Action closed**	**Closed**
8	31/07/2024	**TB24/052 Integrated Performance Report** 8.2 Operational Indicators	LN to share the F&P presentation about the C&M UEC programme governance and success metrics with all Board members.	LN	Sep-24	**25/09/2024** - LN circulated the presentation to Board members. **Action closed**	**Closed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	30 October 2024
Agenda Item	**TB24/071**			
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 Mersey and West Lancashire Teaching Hospitals NHS Trust (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 2024/25 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 assurance.

Strategic Objectives

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Overview

Mersey and West Lancashire Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.
The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.
The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-24	84.5	100	92.7	Best 30%
FFT - Inpatients % Recommended	Sep-24	94.7%	90.0%	94.8%	Best 50%
Nurse Fill Rates	Sep-24	97.0%	90.0%	96.0%	
C.difficile	Sep-24	14	113	47	
E.coli	Sep-24	13	171	85	
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.22	0.00	0.15	
Falls ≥ moderate harm per 1000 bed days	Aug-24	0.16	0.00	0.20	
Stillbirths (intrapartum)	Sep-24	0	0	0	
Neonatal Deaths	Sep-24	0	0	5	
Never Events	Sep-24	0	0	1	
Complaints Responded In 60 Days	Sep-24	55.8%	80.0%	65.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-24	74.4%	77.0%	72.8%	Worst 30%
Cancer 62 Days	Aug-24	80.2%	85.0%	79.5%	Best 20%
% Ambulance Handovers within 30 minutes	Sep-24	48.8%	95.0%	51.2%	
A&E Standard (Mapped)	Sep-24	79.4%	78.0%	77.7%	Best 30%
Average NEL LoS (excl Well Babies)	Sep-24	4.4	4.0	4.2	Best 30%
% of Patients With No Criteria to Reside	Sep-24	19.1%	10.0%	21.2%	
Discharges Before Noon	Sep-24	18.1%	20.0%	18.0%	
G&A Bed Occupancy	Sep-24	97.3%	92.0%	97.4%	Worst 30%
Patients Whose Operation Was Cancelled	Sep-24	1.2%	0.8%	0.9%	
RTT % less than 18 weeks	Sep-24	57.8%	92.0%	57.8%	Best 50%
RTT 65+	Sep-24	147	0	147	Worst 40%
% of E-discharge Summaries Sent Within 24 Hours	Sep-24	84.7%	90.0%	82.9%	
OP Letters to GP Within 7 Days	Aug-24	70.1%	90.0%	71.1%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Sep-24	86.9%	85.0%	86.9%	
Mandatory Training	Sep-24	88.8%	85.0%	88.8%	
Sickness: All Staff Sickness Rate	Sep-24	5.7%	5.0%	5.7%	
Staffing: Turnover rate	Sep-24	0.9%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Sep-24		22,600	12,425	
Cash Balances - Days to Cover Operating Expenses	Sep-24	1.5	10		
Reported Surplus/Deficit (000's)	Sep-24		-13,209	-10,271	

Board Summary - Quality

Quality

Friends and Family Test – achieved the overall target despite lower recommendation rates within Maternity areas. An action plan which covers all four maternity touch points is in place, with the intention of increasing response rates and improving the overall care experience. The Trust will review the comparison to peers alongside the national maternity survey results which are expected soon, and will continue to work with MNVP colleagues.

Clostridium difficile infection – A CDI Improvement Plan remains on track, incorporating the key elements of environmental cleanliness, appropriate antimicrobial prescribing and staff awareness and training. Hydrogen peroxide vapour will be used for terminal cleaning following cases of CDI across the three main sites and the feasibility of a preventative bay-by-bay deep clean programme continues to be scoped and trialled within this improvement plan. The Trust is below the NHSE threshold for 2024/25.

E coli -The E coli Improvement Plan continues, 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.

Pressure Ulcers - The TVN team continue to identify areas of concern, deliver ward education, and provide ongoing quality improvement to ensure the sustained reduction in the number of avoidable harms that occurs from pressure ulcers.

Patient Falls – The Falls Team have put together a specific action plan to reduce the risk of falls in higher incidence areas, with focussed support offered to the A&E department. There are regular audits of falls compliance and bespoke ED falls teaching sessions have been arranged. Falls team ward visits and reviews and Senior nurse walk-abouts are ongoing across MWL. Trial project on decaffeinated beverages is currently ongoing on 2 wards.

Never Events – No Never Events were reported in September (YTD 1).

HSMR - Latest data available up to and including Mar-24. The final 23-24 HSMR remains low at 92.7, with both sites below 100 (legacy STHK site 90.7 and legacy S&O 97.5). Action has been taken to ensure that patients are coded as accurately as possible to ensure an accurate HSMR. HSMR is monitored via Clinical Effectiveness Council and diagnoses alerting due to a higher than expected number of deaths are reviewed by the Mortality Surveillance Group. SHMI remains within expected levels.

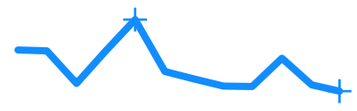
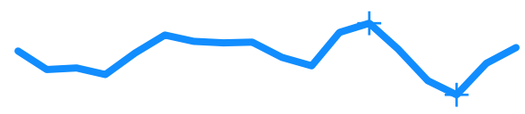
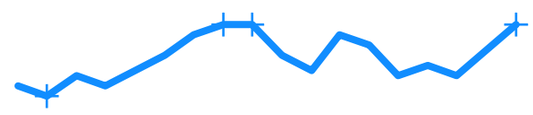
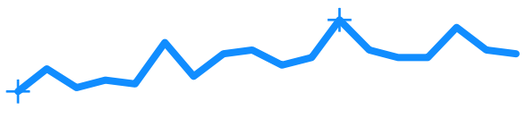
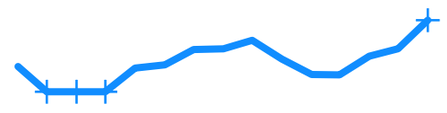
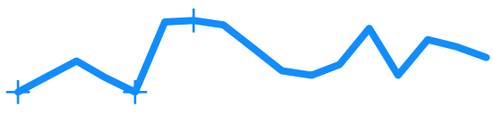
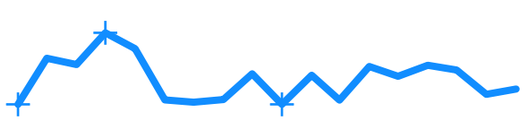
Complaints - % of stage 1 complaints resolved in 60 working days – Performance has been impacted by signing-off the backlog of overdue complaints. There is targeted work ongoing to target specific breaches which is producing positive results thanks to the collaborative working of the corporate and divisional teams. It is anticipated there will be a much-improved position in the next reporting cycle.

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	Mar-24	84.5	100	92.7	Best 30%	
FFT - Inpatients % Recommended	Sep-24	94.7%	90.0%	94.8%	Best 50%	
Nurse Fill Rates	Sep-24	97.0%	90.0%	96.0%		
C.difficile	Sep-24	14	113	47		
E.coli	Sep-24	13	171	85		
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.22	0.00	0.15		
Falls ≥ moderate harm per 1000 bed days	Aug-24	0.16	0.00	0.20		
Stillbirths (intrapartum)	Sep-24	0	0	0		
Neonatal Deaths	Sep-24	0	0	5		
Never Events	Sep-24	0	0	1		
Complaints Responded In 60 Days	Sep-24	55.8%	80.0%	65.4%		

Board Summary - Operations

Operations

A&E - 4-Hour performance decreased in September, achieving 74.4% (all types). Trust performance remained ahead of national (74.2%) and Cheshire and Mersey (72.9%), whose performance also decreased in September. The Trusts mapped 4-Hour performance achieved 79.4%. The Trust continue to utilise all escalation capacity across both sites.

Patient Flow - Bed occupancy across MWL averaged 105.4% in September equating to 96 patients - an increase from 104.3% in August. There was a peak of 133 patients (32 at S&O, 101 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 4% lower than last September, driven by a 9% decrease in 0 day, with a 2% increase in 1+ LOS activity. Average length of stay for emergency admissions is high, at 9.4 at S&O and 8.2 at StHK, with an overall average of 8.8 days, the impact of non-CTR patients being 19.1% at Organisation level, 3% lower than August (21% StHK and 16% S&O).

18 Weeks - The Trust had 2,402 52-week waiters at the end of September (351 S&O and 2,051 StHK) and 1 78 week waiter. The 52-week position is a decrease of 350 from August. 18 Week performance in August for MWL was 57.8%, S&O 65.6% and StHK 54.9%. National performance (latest month August) was 58.3% and C&M regional performance was 56.3%.

Cancer - Cancer performance for MWL in August decreased marginally to 74.4% for the 28 day standard (target 77%). Latest published data shows national performance of 75.5% and C&M regional performance of 73.2%. Performance for 62-day also decreased, achieving 80.2% (target 85%) but remained ahead of C&M (74.6%) and National (69.2%). Tumour site specific improvement plans are in place which set out the key actions being taken to achieve the 28 day and 62 day standards for 2024/25.

Diagnostics - Diagnostic performance continued to exceed the target, achieving 96.8%. MWL performance is ahead of national performance (latest month August) of 76.1% and C&M regional performance of 89.9%.

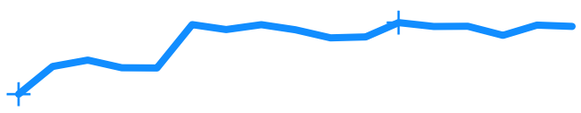
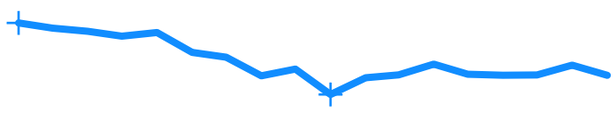
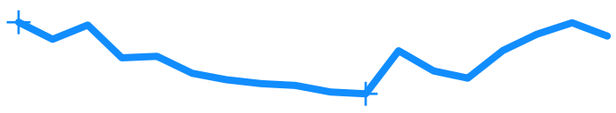
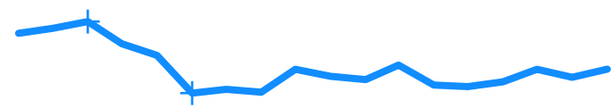
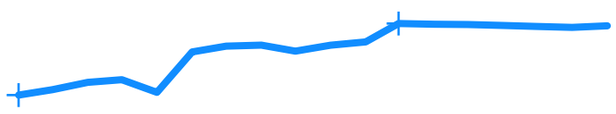
Letters - The Trust had a significant improvement in performance in letters sent to GP's within 7 days. The interim solution will continue to be rolled out. Urgent letters are being produced within 48 hours of appointment.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Aug-24	74.4%	77.0%	72.8%	Worst 30%	
Cancer 62 Days	Aug-24	80.2%	85.0%	79.5%	Best 20%	
% Ambulance Handovers within 30 minutes	Sep-24	48.8%	95.0%	51.2%		
A&E Standard (Mapped)	Sep-24	79.4%	78.0%	77.7%	Best 30%	
Average NEL LoS (excl Well Babies)	Sep-24	4.4	4.0	4.2	Best 30%	
% of Patients With No Criteria to Reside	Sep-24	19.1%	10.0%	21.2%		
Discharges Before Noon	Sep-24	18.1%	20.0%	18.0%		
G&A Bed Occupancy	Sep-24	97.3%	92.0%	97.4%	Worst 30%	
Patients Whose Operation Was Cancelled	Sep-24	1.2%	0.8%	0.9%		
RTT % less than 18 weeks	Sep-24	57.8%	92.0%	57.8%	Best 50%	
RTT 65+	Sep-24	147	0	147	Worst 40%	
% of E-discharge Summaries Sent Within 24 Hours	Sep-24	84.7%	90.0%	82.9%		
OP Letters to GP Within 7 Days	Aug-24	70.1%	90.0%	71.1%		

Board Summary - Workforce

Workforce

Mandatory Training - The Trust continues to exceed its mandatory target at 88.8% against a target of 85%.

Appraisals - The Trust appraisal window closed on 30th September achieving 86.9% against a target of 85%.

Sickness - In-month sickness remains relatively static at 5.68% against the 5% target.

The top reason for absence continues to be Anxiety, Stress and Depression and 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 including regular support sessions for managers who are supporting staff.

The staff group with the highest levels of sickness continues to be our HCA workforce, a targeted task and finish group has been established to focus on HCA absence. A deep dive in key workforce metrics has been undertaken to identify key themes and trends and staff listening events are taking place in conjunction with the launch of 2024 staff survey. A detailed action plan and metrics to be presented to People Performance Council in November

Further targeted work has also been undertaken as part of our overall absence management approach:

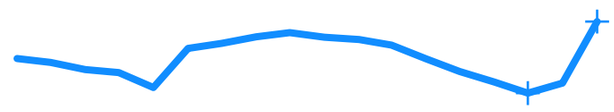
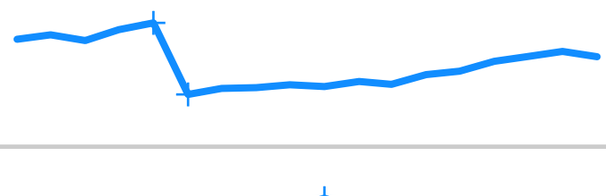
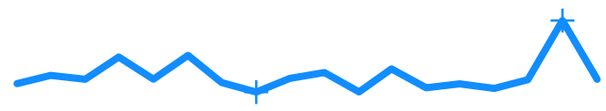
- Ensuring that welcome-back conversations welfare meetings and trigger meetings are being undertaken
- Delivering Attendance Management training sessions to new and existing managers.
- Holding bi-weekly review of Trust absences by HR Operations Team and HWWB Team.
- Facilitating early engagement of all employees who are absent due to musculoskeletal problems.

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	Sep-24	86.9%	85.0%	86.9%		
Mandatory Training	Sep-24	88.8%	85.0%	88.8%		
Sickness: All Staff Sickness Rate	Sep-24	5.7%	5.0%	5.7%		
Staffing: Turnover rate	Sep-24	0.9%	1.1%	1.0%		

Board Summary - Finance

Finance

The final approved MWL financial plan for 24/25 gave a deficit of £26.7m, which assumed:

- Payment of £12m funds in line with transaction business case
- Delivery of £36.2m recurrent CIP
- Delivery of £11.8m 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

Additional non-recurrent deficit support was been agreed with commissioners during September. This has reduced the planned deficit by £15.8m, to a £10.9m deficit for 24/25. The Trust still awaits information on how the residual IA pressure will be dealt with within the system.

Surplus/Deficit – At Month 6, the Trust is reporting a year to date deficit of £10.3m which is £2.9m better than plan. This favourable variance relates to £4m of transaction support being received in September. The plan assumed all funding would be received in March 2025.

CIP - The Trust's CIP target for financial year 2024/25 is £48.0m, of which £36.2m is to be delivered recurrently and £11.8m non-recurrently. As at Month 6, the Trust has successfully transacted CIP of £33.0m, of which £26.2m is recurrent, with a further £1.5m of recurrent CIP at finalisation stage.

Cash - At the end of M6, the cash balance was £3.7m, with a plan of £2.7m at the end of the financial year. The Trust has now recieved all revenue support to enable delivery of I&E plan. The Trust still requires further cash to support delivery of the capital programme.

Integrated Performance Report

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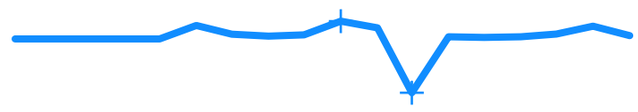
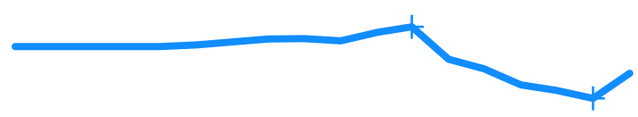
NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Sep-24		22,600	12,425		
Cash Balances - Days to Cover Operating Expenses	Sep-24	1.5	10			
Reported Surplus/Deficit (000's)	Sep-24		-13,209	-10,271		

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy S&O

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-24	82.0	100	97.5	
FFT - Inpatients % Recommended	Sep-24	94.6%	90.0%	94.2%	
Nurse Fill Rates	Sep-24	98.5%	90.0%	94.6%	
C.difficile	Sep-24	6		19	
E.coli	Sep-24	6		32	
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.16	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	Aug-24	0.08	0.00	0.20	
Stillbirths (intrapartum)	Sep-24	0	0	0	
Neonatal Deaths	Sep-24	0	0	1	
Never Events	Sep-24	0	0	0	
Complaints Responded In 60 Days	Sep-24	50.0%	80.0%	66.3%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-24	70.2%	77.0%	68.8%	
Cancer 62 Days	Aug-24	67.2%	85.0%	65.8%	
% Ambulance Handovers within 30 minutes	Sep-24	64.2%	95.0%	63.2%	
A&E Standard (Mapped)	Sep-24				
Average NEL LoS (excl Well Babies)	Sep-24	5.3	4.0	5.4	
% of Patients With No Criteria to Reside	Sep-24	16.2%	10.0%	16.4%	
Discharges Before Noon	Sep-24	19.4%	20.0%	19.0%	
G&A Bed Occupancy	Sep-24	96.5%	92.0%	97.2%	
Patients Whose Operation Was Cancelled	Sep-24	1.3%	0.8%	1.0%	
RTT % less than 18 weeks	Sep-24	65.6%	92.0%	65.6%	
RTT 65+	Sep-24	23	0	23	
% of E-discharge Summaries Sent Within 24 Hours	Sep-24	84.4%	90.0%	79.7%	
OP Letters to GP Within 7 Days	Aug-24	69.3%	90.0%	74.1%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Sep-24	89.2%	85.0%	89.2%	
Mandatory Training	Sep-24	90.1%	85.0%	90.1%	
Sickness: All Staff Sickness Rate	Sep-24	6.0%	5.0%	5.9%	
Staffing: Turnover rate	Sep-24	1.0%	1.1%	1.0%	

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy STHK

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-24	85.4	100	90.7	
FFT - Inpatients % Recommended	Sep-24	94.8%	94.0%	95.0%	
Nurse Fill Rates	Sep-24	95.5%	90.0%	97.4%	
C.difficile	Sep-24	8		28	
E.coli	Sep-24	7		53	
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.25	0.00	0.17	
Falls ≥ moderate harm per 1000 bed days	Aug-24	0.21	0.00	0.20	
Stillbirths (intrapartum)	Sep-24	0	0	0	
Neonatal Deaths	Sep-24	0	0	4	
Never Events	Sep-24	0	0	1	
Complaints Responded In 60 Days	Sep-24	58.3%	80.0%	65.0%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-24	77.7%	77.0%	75.5%	
Cancer 62 Days	Aug-24	85.5%	85.0%	85.3%	
% Ambulance Handovers within 30 minutes	Sep-24	40.1%	95.0%	44.8%	
A&E Standard (Mapped)	Sep-24				
Average NEL LoS (excl Well Babies)	Sep-24	4.1	4.0	3.8	
% of Patients With No Criteria to Reside	Sep-24	20.8%	10.0%	23.9%	
Discharges Before Noon	Sep-24	16.6%	20.0%	17.0%	
G&A Bed Occupancy	Sep-24	97.7%	92.0%	97.5%	
Patients Whose Operation Was Cancelled	Sep-24	1.2%	0.8%	0.9%	
RTT % less than 18 weeks	Sep-24	54.9%	92.0%	54.9%	
RTT 65+	Sep-24	124	0	124	
% of E-discharge Summaries Sent Within 24 Hours	Sep-24	84.8%	90.0%	83.8%	
OP Letters to GP Within 7 Days	Aug-24	70.6%	90.0%	69.3%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Sep-24	85.8%	85.0%	85.8%	
Mandatory Training	Sep-24	88.2%	85.0%	88.2%	
Sickness: All Staff Sickness Rate	Sep-24	5.6%	5.0%	5.6%	
Staffing: Turnover rate	Sep-24	0.8%	1.1%	1.0%	

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

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 October 2024
Agenda Item	**TB24/072 (7.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in September 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 September 2024. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. At each meeting the weekly vacancy control panel decisions were also reported.			
05 September 2024			
Freedom of Information (FOI) Report	• The Director of Informatics presented the report which detailed compliance year to date. • There were 101 open FOIs, with 32 draft responses awaiting director approval. • Committee discussed some revisions to the internal process to ensure time was not wasted gathering information that did not meet the criteria to be released or was already published in a slightly different form. • It was agreed the FOI triage process would be adapted to incorporate these suggestions.		Assurance
Place Partnership Update	• The Director of Integration presented a briefing on recent developments in each place and borough. • The Cheshire and Merseyside (C&M) Integrated Care Board (ICB) had initiated a review of its operating model, which was scheduled for completion in November. • The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) footprint Urgent and Emergency Care (UEC) Recovery Programme progress to date was noted and the Senior Responsible Officer (SRO) and Programme Director were to be invited to attend the Executive Committee in October to discuss the impact of the three workstreams – admissions avoidance,		Assurance

	reduced length of stay and early discharge, for winter 2024/25.	
Cheshire and Merseyside Cancer Alliance funded posts	• The Chief Operating Officer reported that the C&M Cancer Alliance currently funded 58.8 FTE posts across MWL, of which there were six Clinical Nurse Specialist posts where the funding ended in January 2025 but was then being taken over by Macmillan on an ongoing basis. • Going forward it was agreed that improved oversight was needed at an organisational level of the type of temporary funding and the implications for the Trust if the posts continued and were incorporated into the staffing establishment.	Assurance
Elective Waiting Times	• Committee discussed the elective waiting list and actions being taken to achieve the elimination of 65+ week waiters by the end of September. • There were risks to achievement in orthopeadics, gyaeccology and plastics for some complex procedures, but the admission dates were being reviewed to ensure the numbers breaching were reduced as much as possible.	Assurance
12 September 2024		
Emergency Preparedness Resilience and Response (EPRR) annual report 2023/24 and annual compliance declaration 2024/25	• The Chief Operating Officer presented the draft EPRR annual report for 2023/24 and the draft annual compliance statement for 2024/25 that were due to be presented to the Board for approval at the September Board meeting. • The improvements in compliance for 2024/25 compared to 2023/24 were noted. • The EPRR compliance submission would be audited and independently verified by the ICB following submission.	Assurance
Financial Improvement	• The Director of Finance and Information presented the month 5 financial position, and the improvement to the run rate needed for the remainder of the financial year to achieve the financial plan. • There was a combination of income being less than planned and variable costs such as temporary workforce increasing. • Actions to improve the position were discussed, including establishing a 12 week financial improvement programme. • The actions were approved.	Approval
National Inpatient Survey 2023 – Action Plan	• The Acting Director of Nursing, Midwifery and Governance introduced the report which detailed the actions planned to address areas of poor	Assurance

	performance from the 2023 national inpatient survey. • The key themes where action was needed were identified as pain control, communication, respect and dignity and kindness and compassion. • There was concern that the perception of patients was impacted by long waits and corridor care in the Emergency Department (ED) before they were admitted to an inpatient bed. • Following a review of each action, it was agreed that further detail was needed to be able to measure the impact of each action on the inpatient survey scores.	
Premium Payment Scrutiny Council (PPSC) – Medicine and Urgent Care	• The Acting Director of Human Resources (HR) introduced the report which provided assurance against the actions agreed at the PPSC for the Medicine and Urgent Care Division. • The main areas where premium payments were being used were the Emergency Department and Acute Medical Unit and the respiratory medicine service, which had relied on locum and agency staff to maintain service levels. • Actions in relation to all grades of medical staff were reviewed. • It was agreed that the actions needed to have timescales and to include a profile of the reduced spend.	Assurance
Integrated Performance Report (IPR)	• The Director of Finance and Information presented the August IPR for review. • Changes and additions to the commentary were agreed for the detailed Committee Performance Reports.	Assurance
Norovirus Outbreak	• The Chief Operating Officer reported that norovirus had been detected on the stroke unit at Whiston Hospital, with both patients and staff affected. • The stroke team were working with infection prevention control to manage the outbreak and other local stroke units in case diverts were required for new stroke patients.	Assurance
19 September 2024		
East Pathology Hub Outline Business Case	• The Managing Director provided an update on the plans to create three pathology hubs across C&M, and the specific proposal to create an East Pathology Hub, with collaboration between MWL and Warrington and Halton NHSFT (WHH).	Approval

	• The Committee recognised that the implementation of the C&M Laboratory Information System was an important enabler (but not essential) for the pathology hubs. • The Committee supported the presentation of the business case to take forward the development of the East Pathology Hub to the September Closed Board for approval on behalf of MWL, acknowledging that WHH would also need to approve the case.	
Statutory Pay Gap Report 2024	• The Acting Director of HR introduced the report which met the statutory requirement to annually publish pay gap information. • The report covered several protected characteristics – gender, ethnicity and disability. • The committee reviewed the information and the high level action plan which would be incorporated into the equality, diversity and inclusion operational plan. • Changes, including the addition of trend and benchmarking data were requested to the final report that was due to be presented to the September Trust Board.	Assurance
Quarterly Cyber Report	• The Director of Informatics presented the report which detailed the measures taken to protect the Trust from a cyber attack.	Assurance
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the assurance report from the September RMC meeting. • In August there were 1,105 reported risks with 40 risks escalated to the Corporate Risk Register. • The Council received an update on the Quality Impact Assurance (QIA) process for the 109 live Cost Imporvement Programme (CIP) schemes. It was reported that 71% of the QIA's had been completed. • The RMC had reviewed the EPRR annual report for 2023/24 and the 2024/25 compliance assessment. • The RMC approved Situation Report (Sitrep) Completion and Sign Off Standard Operating Procedure.	Assurance
Mandatory Training and Appraisal Compliance – August 2024	• The Acting Director of HR presented the report. • Mandatory training compliance was 89.2% against the 85% target. • Compulsory training compliance was 87.2%	Assurance

	• Committee reviewed the teams and staff groups where the target of 85% had not been achieved but noted the general improvement and upward trajectory. • Appriasal performance was 74.2% at the end of August with one month remaining of the appraisal window and significant activity reported in month.	
26 September 2024		
Nurse Safer Staffing Report - August	• The Deputy Director of Nursing presented the report which detailed the staffing levels in August. • The reporting systems between the legacy organisations were now aligned and fill rates based on the nurse staffing establishment for each ward. • Registered Nurses/Midwives (RN/M) fill rate was 93.7% and the Health Care Assistants (HCA) fill rate 122.2%, giving 8.4 Care Hours Per Patient Day (CHPPD). • The HCA fill rate included supplementary care requests • The legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) sites had filled 89% of temporary staffing requests (bank and agency) while the legacy Southport and Ormskirk Hospital NHS Trust (S&O) sites had filled 76% of temporary staffing requests.	Assurance
Financial Improvement Groups (FIG) - Update	• The Director of Finance provided feedback on the initial FIG meetings with each Division. • Progress will be reported weekly to assess the impact of the agreed actions on the run rate.	Assurance
Paediatric Consultant Business Case	• The Chief Operating Officer introduced the business case which sought approval for the recruitment of a six month eight PA Acute Paediatric Consultant post to support the eating disorders service that was provided with Mersey Care. • Income from Mersey Care via the Service Level Agreement would cover the costs of the post. If the model was successful the aim would be to create a substantive post. • The business case was approved.	Approval
Post Transaction 12 Month Review	• The Director of Corporate Services detailed the agenda for the 12 month post transaction review meeting with NHSE (national and regional teams). • Committee discussed the agenda and the Trust presentation to address each of the specific issues for review.	Assurance

Resident Doctors Pay Award – Cash Risk	• The Acting Director of HR presented a briefing detailing the national pay award for resident doctors and the challenge for the Trust in paying all the lead employer doctors in November if the cash was not received from every host Trust in time for the November payroll. • The issue had been raised with NHSE and every host Trust. • The value of the pay award and back pay for all the lead employer doctors was circa £120m.	Approval
Primary Care Contract Dispute	• The Medical Director reported on a letter sent to all C&M Medical Directors advising the actions that had been agreed by general practitioners in support of their national contractual payment dispute. • The impact on patients being referred to the acute sector was being assessed and a collective response was being prepared on behalf of the Trust Medical Directors.	Assurance
Alerts:		
None		
Decisions and Recommendations:		
Investment decisions taken by the Committee during September 2024 were: • Recruitment of 0.8 WTE temporary Acute Peadiatric consultant to support the eating disorders service.		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 October 2024
Agenda Item	**TB24/072 (7.2)**		
Committee being reported	Audit Committee		
Date of Meeting	16 October 2024		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Financial Statements 2023/24	The Director of Finance and Information summarised the approval process and sign-off of the Trust's annual report and accounts (AR&A) for 2023/24. Grant Thornton (GT) confirmed that an unqualified opinion was issued and the normal audit cycle should resume for the Trust for 2024/25.	Assurance
External Audit Progress Report	GT summarised the audit progress report and updated Committee members on when the new engagement lead (EL) will be announced (possibly early to mid November 2024). GT confirmed that the audit manager and audit team will likely remain the same. GT confirmed that a debrief session will take place following the 2023/24 audit and that the audit plan will likely be issued March 2025. GT will still operate under National Audit Office (NAO) guidance and the annual audit will be conducted in accordance with the national timetable.	Assurance
Internal Audit Reports	MIAA summarised the internal audit progress reports key messages section. Four reports highlighted, three received substantial assurance and one received high assurance. Three reports currently in progress.	Assurance
MWL Audit Log	The Assistant Director of Finance, Financial Services and highlighted key movements on the audit log, both in relation to internal and external audit recommendations.	Assurance
Anti-Fraud Annual Report	MIAA's Anti-Fraud Specialist (AFS) summarised the anti-fraud progress report executive summary section.	Assurance

	The Conflict of interest (COI) return percentage rate (currently 50%; target 80%) and how to improve performance was discussed. AFS clarified that the 50% return percentage rate relates specifically to the decision-making staff cohort.	
Financial Reports	The Assistant Director of Finance, Financial Services summarised the losses and special payments report. Total losses identified year to date approximately. £193k (£409k 2023/24). The Assistant Director of Finance, Financial Services summarised the aged debt report, and the impact that aged debt has on cash. Specific attention was paid on some of the analysis that makes up aged debt and what progress needs to be made to clear some of these older invoices. The Deputy Director of Procurement (DDoP) summarised the tenders and quotation waivers report. The DDoP referred to the process followed and the Trusts performance against neighbouring organisations.	Assurance

Alerts:

Anti-Fraud Annual Report

- Committee agreed that COI percentage rate return and how to improve performance and ensure compliance should be escalated and discussed at Board.

Decisions and Recommendation(s):

Not applicable

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 October 2024
Agenda Item	**TB24/072 (7.3)**		
Committee being reported	Quality Committee		
Date of Meeting	22 October 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 17 September 2024: The minutes were approved as a correct and accurate record of the proceedings.	Approved
Matters arising/Action Log	Matters Arising and Action Log reviewed / agreed, as appropriate.	Assurance
Quality Committee Corporate Performance Report (CPR)	• One Bacteraemia noted – no lapses in care. Management and pressures on clinical flow of outbreaks of infections not reported in the CPR eg Norovirus, Covid noted. • Validated Pressure Ulcers: focus on interventions and leadership in key areas. • Patient Falls (with moderate harm or above): Normal variation in month - decaffeinated drinks project completed. No direct impact to falls cases however recognising benefits from wider health impacts for example dementia, quality of sleep. Roll out Trust-wide proposed. • Supplementary Care - under review to assure on best practice through shared learning from external colleagues and engagement with Cheshire and Mersey Enhanced Therapeutic Observation of Care Levels project planned. • Safe Staffing: up to 97% fill rate against 90% target. Site reporting now fully aligned.	Assurance

	• Venous Thromboembolism (VTE) - areas of concern reporting through Patient Safety Council in November 2024.
	
	• Nutrition – further enhanced reviews through Quality and Safety walkabouts are being undertaken. Further progress required. Clarity of proceed for referral to dietician process completed with areas for enhanced support identified. Audits aligned and rationalised. Ward Accreditations supporting improvements.
	
	• Complaints: 15% decrease in the number of open complaints,12.5% decrease in overdue complaints (July to Sept). Decrease in number of new complaints. Previous spike in complaints relating to Patient Advise and Liaison Service (PALS) responsiveness - backlog work now completed.
	
	• Mortality:
	  • HSMR for 23/24 - Annual figure for Trust 92.7.
	  • SHMI - 1.05.
	  • Weekend admissions mortality - Mortality Outcome Group at Southport reviewing data.
	
	• Sentinel Stroke National Audit Programme (SNAPP) data – guidance and reporting changed from Oct 2024. Trust is identifying reporting process going forward for Southport (established at Whiston).
	
	• Sepsis - alignment of AQUA and NICE measures, guidance and reporting on-going with mitigations in processes / reporting in place.
	
	• Take Home Medications (TTO) supplied within two hours - trials underway to support improvement works. Request for trust-wide CPR data reporting.	

Quarterly review of Trust Objectives Aligned to Quality Committee	• Committee received progress report which is also reported through Executive Committee. Partial assurance in all areas noted. • Emergency Department (ED) - some metrics achieved. Triage needs more support and focus.	Assurance

	• Methicillin-Resistant Staphylococcus Aureus (MRSA): Aseptic Non-Touch Technique (ANTT) compliance – variable assurance. Training Needs Analysis reviewed and aligned across all staff groups. Visual Infusion Phlebitis (VIP) score and Cannular care - improvements noted, however more focus required. • Hydration - Nursing Care Indicators (NCIs) now aligned across the Trust with improvements seen. Focus on further focus and improvement for S&O sites. Acute Kidney Injury (AKI) data overall is positive, update requested for urine dipstick analysis and ultrasound slots. • Discharge: meeting some targets. Further focus on information - improvement required for Southport site, with interventions in place. • Maternity Services Patient Experience - provisional report on Maternity Survey 2024 received will be shared at a future Quality Committee when full information has been received. • Electronic Prescribing and Medicines Administration (EPMA) – in place on Spinal Injuries Unit (SIU) at Southport Hospital. When Electronic Patient Records implemented EPMA to be rolled out across S&O sites.	
Councils Terms of Reference (ToR) for review	• Terms of Reference for Clinical Effectiveness, Clinical Engagement and Patient Safety Councils approved.	Assurance
Clinical Effectiveness Report (including. Council Chair's report).	• September and October 2024 Council meetings detailed. • 24 MWL Clinical Policies approved. Communication and socialisation of the policies in place to assure staff aware of changes/new policies. • Resus Services - focused work on Do not attempt cardiopulmonary resuscitation (DNACPR) with positive audit outcomes. Deteriorating Patient project reported significant improvement. National cardiac arrest audit for 2023/24 reported improvement noting a difference for cardiac arrest rates per 1,000 across the STHK and S&O sites with Learning from Deaths lead undertaking a review.	Assurance

	• National Emergency Laparotomy Audit (NELA) July 2024 received. Care of the Elderly team are working to free up resource to deliver reviews required for one of the audit's quality metrics – this has been difficult to meet due to staffing constraints. • QICA (Quality Improvement and Clinical Audit) – Team now using AmaT (Audit Management and Tracking), a web-based solution, for clinical audit / NICE and quality improvement. • Pharmacy Aseptic Group -following external re-audit (Quality Control Northwest) of the Aseptic Unit improved assurance received with commendation of the improvements. • Research, Development and Innovation Annual Report - new research hubs at Whiston Hospital and Marshals Cross opened. High recruitment and positive patient feedback. Increased collaboration with Liverpool and Edge Hill Universities. Several awards and increased number of colleagues with academic qualifications. • Sepsis quarterly report - Team working with AQUA to identify reporting of Red and Amber flags - new policy released across the Trust and training ongoing. • Slight increase in mortality in Orthopaedic emergency – Learning from Deaths team reviewing for early or rapid actions to be shared. • Excellent Stroke performance noted. • Learning from Deaths Team and AKI teams working site specific. Plan to merge these teams under a single leadership structure within the next financial year. Identifying resource for AKI team S&O. • Confirmation on review of deaths within the community will be managed by the Trust's medical examiner team in the future which will be implemented by the lead Medical Examiner's office.	
CQC Quarterly Report	• Five recent inspections with action plans for reports received. • Southport Medicine and Spinal report – weekend cover for Allied Health Professionals (AHP) business case being worked through. • Awaiting Emergency Department Whiston report.	Assurance

	• Monthly assurance group meetings ongoing. • Ward accreditation programme going well with sharing of practice and wards taking responsibility and accountability, noting aspiring wards seeing significant improvement. Congratulations to 4 Star accredited wards across MWL. • Structure of quality ward rounds positively acknowledged noting ward accreditations had taken place prior to quality ward rounds. •	
Patient Safety Report (incl. Council Chair's Report)	• August 2024 activity reported. • 15 Patient Safety Incident Investigations (PSII) recorded so far since October 2023 • Nine Patient Safety Incident Response (PSIR) currently open • One multidisciplinary team (MDT) review completed. • One PSII appropriate for Maternity and Newborn Safety Investigation (MNSI) process report received in October. • 2,853 incidents reported for month. • 407 Pressure Ulcers reported. • 229 Falls reported. • Deep dive in Hospital Acquired Pressure Ulcers (HAPU) - lapses in recording noted and improvements in recording of actions taken led by Deputy Divisional Director of Nursing Medicine and Emergency Care. Specific targeted work in ED including bespoke training to staff. • Decrease in number of falls per 1,000 bed days-introduction of decaffeinated drinks on pilot wards with positive patient feedback. Targeted work within ED as a hot spot area for falls. • Maternity safety activity – one neonatal death elsewhere to MWL. Mother presented late for first trimester screening. • PSII training continues with 34 staff trained. • Section 7 – Gastroenterology update. Appropriate pathways and surveillance assurance provided. • Patient Safety Committee – Infection Prevention and Control (IPC) policies approved, Tendable update provided.	Assurance

	Patient Safety Incident Investigation (PSII) – feedback at speciality and individual level. Further consideration for messages to all via consistent processes across MWL and further work ongoing. To be included in future reporting to assure Board to floor learning.	

Maternity & Neonatal Services Quarterly Report (CQSG)	• Quarter 2 2024/25 update provided.
	• Maternity Incentive Scheme (CNST MIS)
	  • On track for all MIS Safety Actions. Additional evidence and work required for:
	  • Safety Action 3 (Transitional Care): Whiston site: Staffing: recruitment underway, some staff already commenced in post. Anticipating implementation of transitional care by January 2025. Ormskirk site: Further review of staffing provision.
	  • Safety Action 4 (Workforce): Relates to audits required. On track.
	  • Safety Action 7 (Relates to Maternity and Neonatal Voices Partnership (MNVP)). Whiston site currently supported by Ormskirk site MNVP Chair.
	  • Safety Action 8 (Training). Rolling 12-month compliance noting 01/12/2023 to 30/11/2024 trajectory also shared in report (CNST figures commence 01 December).
	• Training – not yet compliant for some staff groups competencies for Clinical Negligence Scheme for Trusts (CNST) requirements. Plans in place for compliance, with sessions booked and maintenance going forward monitored monthly.
	• CNST Compliance Year 6 - will be reportable to Committee in November. Assurance given these training competencies will report under 'Compulsory Training' reporting in future.
	• Working with Mersey Internal Audit Agency in November – MIAA commissioned to review evidence submission for 2024/25.
	• Assurance given that data for Neonatal Basic Life Support Training data at the Ormskirk has been validated.
	• Clinical Outcomes / Dashboard (Current Areas of Focus):
		Assurance

	• Key areas of focus on women who smoke during pregnancy - maintained 100% compliance at Whiston with focused work to improve compliance for Ormskirk site including harmonisation of guidelines and practices. • 3rd/4th degree tears – rates consistent with national incidents with assurances all incidents are reviewed. Year to Date (YTD) 1.88% (national average 2.97%). • Severe Post-Partum Haemorrhage (PPH) – review of 2023/24 across MWL reports 2.6% -below the national average (3.1%). Perinatal Mortality: • Q2 5 reportable deaths. All reviewed with no concerns and lessons learnt shared across the service. • MNSI – one case reported in Q1 - no care issues identified and no active cases ongoing. Q2 reports received, compiling actions and lessons learnt to be reported going forward. • No Never Events or serious incidents. • No active cases ongoing. Neonatal Unit Medications Monitoring – Chief Pharmacist gave the following update: • Pharmacy benchmarking data to be considered across the System. • Levels of harms to be included in future reporting. • Key Findings and Themes noted. Similar to previous reports. • Recommendations - noted. • New Prescription Chart for Neonatal Unit – imminently awaiting final ratification. • Neonatal sepsis pathways – work ongoing. • Pharmacy Teaching - ongoing. • Drug Library on Neonatal Unit – ongoing. Ratification of intravenous drug monographs – to date 22/30 ratified and in use. • Teaching from Pharmacist and MDT - Assurance received. • Assurance given against completion of outstanding three recommendations by January 2025.	

	• Committee requested additional actions:
	
	  • Action 1: Review of each quarters performance against previous quarter going forward to show performance trend.
	  • Action 2: Metrics for the proportion of medication errors/incidents requested for future reporting e.g. per 1000 bed days.
	  • Action 3: Deep dive agreed into Critical Medications storage and administration.
	
	Saving Babies Lives:
	• Part of Safety CNST MIS Acton 6
	• MWL compliant working towards full compliance. Trust meets with LMNS quarterly - noting data is validated externally.
	• Q2 fully compliant at Ormskirk, with improvement against compliance for Whiston site - now working towards full compliance.
	
	CQC Action Plan:
	• 'Should and 'Must Do's' actions noted in report with work ongoing.
	• Focus on mandatory training - monthly figures received and agenda item through Divisional Governance meeting.
	• Audits e.g. MEWS, Fresh Eyes, CTG - ongoing work and standardisation of the processes. Findings to be reported in next quarterly report to Quality Committee.
	
	• Action: Committee requested updated CQC Action Plan to provide Committee oversight and additional assurance in January 2025.
	
	Safety Champions:
	• Areas for improvement to be further reported in January 25 report to Committee.
	
	Complaints and Claims:
	• All responses undertaken by Q2 including outstanding complex complaints from Q1.
	• Most recent claims scorecard include in the report.
	• MNSI referrals showing significant decreased trend in referrals from 2019 to end of 2023/24. This is attributed to the increased investment,	

	scrutiny, commitment and concerted efforts by the Maternity Teams to improve outcomes for babies.
	
	Maternity Red Flags:
	• Noting September 2024 high activity at Ormskirk relate to the numbers reported. No harms reported.
	
	Workforce:
	• Ormskirk have seen an increase in births in Q2. Maternity services interviews scheduled for ongoing vacancies. Ormskirk maternity staffing above Birthrate+ plus due to additional agreed funded posts.
	• Whiston site increase in births from previous Quarter. Establishment aligned to Birthrate+. Ongoing recruitment to vacancies.
	• Neonatal Units:
	  • Ormskirk Neonatal Unit - establishment funded against British Association of Perinatal Medicine (BAPM).
	  • Whiston Neonatal Unit - recruitment to site vacancies is on-going.
	• There has been 100% compliance for the provision of 1-1 care in labour and the availability of a supernummary Delivery suite shift coordinator for Q2 2024/25.
	
	Unit suspensions / closures:
	• No suspensions of Maternity services.
	• Closures noted in Neonatal services, however, units remained open to emergency admissions. Reviews undertaken recognising closures based on acuity. Reviewed and monitored across the region.
	
	Patient Experience:
	• Friends and Family Test (FFT) - showing some improvement with ongoing patient experience interventions.
	
	NHS Three-year Delivery Plan:
	• Completed oversight document and quarterly reporting ongoing.
	• Annual provider site visit in November.	

Six Monthly Safer Staffing Establishment Review	• Biannual staffing review presented (data collected in June 2024). • 54 inpatient wards included across MWL. • Neonatal, Maternity Services, Critical Care and Theatres completing separate staffing reviews. • Alignment of ward management supervisory team • Further harmonisation across MWL against agreed parameters including Headroom, ward management supervisory time etc. • Skill mix harmonisation of roles i.e. Ward Housekeeper roles to be reviewed. • Harmonisation of pay rates in August for temporary staffing. Options appraisal ongoing for long term provision for MWL. • Key recommendations noted including business case for ED and two ward areas and future investments to be confirmed against commissioned services. • Supplementary Care Review and Improvement Project to be undertaken. • Assurance given against ongoing business case for Stroke Services.	Assurance
IPC Annual Report 2023/24	• Exceeded thresholds for 2023/24 related to six MRSA Bacteraemia – four cannula related • MRSA screening compliance remains area of focus. • MRSSA bacteraemia – Positive position as seen a reduction on previous years. • Clostridium Difficile – above threshold at Whiston Hospital. Improvement plan to address and seeing the benefits of the plan with a return to baseline performance. • Ecoli bacteraemia - improvement plan to address performance above trajectory and reporting a reduction with MWL below the Cheshire & Mersey rate for last 12 months. • Covid and respiratory viruses' cases for the year remains main causes for hospital outbreaks manged by IPC team. • Measles preparedness – four cases across MWL – reassured and prepared with PPE and FIT Testing and review of patient pathways. • Surgical site infection – mandatory reporting, Orthopaedic surgery S&O within accepted parameter. Considered outlier for Whiston site	Assurance

	for Hip surgery with improvement plan in place with positive steps forward. • National Joint registry Audit (annual). No themes/concerns noted considered individual patient factors as contributory factors due to complexity of patients. • Estates and facilities - plans in place to embed the national standards of Healthcare Cleanliness across 2024/25. • Antimicrobial Stewardship (AMS) - established AMS team for STHK sites with vacancy at S&O sites recruited to in September 2024. • Thresholds set for 2024/25 for MWL – assurance provided in maintaining performance against thresholds (noting above Threshold for MRSA) and improvement plans. • Assurance against ongoing recruitment to vacant posts, current mitigation through remote working to Microbiology Consultant post. • Urinary catheter care and management point prevalence to commence at Whiston with a future plan for Southport and Ormskirk sites. • Assurance from detailed comprehensive action plan for 2024/25 provided to the Committee.	
Any Other Business	• None	

Alerts:

- CNST Compliance:
  - On track for full compliance for year 6 (01/12/2023 to 30/11/2024). Two Safety Actions were highlighted:
  - Safety Action 8: Training – not yet fully compliant for some staff groups / competencies for MIS requirements. Plans in place to train staff with sessions booked and maintenance going forward. Compliance being closely monitored.
  - Safety Action 3: Transitional Care – Whiston site: Staffing: recruitment underway, some staff already commenced in post. Anticipating implementation of transitional care by January 2025. Ormskirk site: Further review of staffing provision to be undertaken.
- CNST Compliance will be reported to Quality Committee in November 2024. Assurance given that training competencies will be detailed in 'Compulsory Training' reports to board committees in future.

Decisions and Recommendation(s):

The Board is recommended to note the report, alerts and the assurances sought by the Committee

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 October 2024
Agenda Item	**TB24/072 (7.4)**		
Committee being reported	Strategic People Committee		
Date of Meeting	21 October 2024		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Minutes of the previous meeting	The Committee reviewed the minutes of the meeting held on the 16 September 2024 and approved them as a correct and accurate record of proceedings.	Decision
Action Log and Matters Arising	The Committee reviewed the outstanding actions and approved the completed actions.	Assurance

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 88.8% (target 85%)
	• Appraisal – the Trust annual appraisal window closed on the 30 September achieving an overall compliance rate of 86.9%.
	• Sickness - in-month sickness remains above target, at 5.69% against the 5% target.
	• Turnover in month is below target at 0.9% and remains positively below target over a rolling 12-month period (12.1%).
	• Vacancies – are positively below target at 7% (target 8%). Vacancy rates for Health Care Assistants (HCA) are 14.1% in month with legacy S&O challenged at 16% compared to legacy STHK at 13%. The Trust does have a strong pipeline of candidates across all staff groups as report to People Performance Council.
	  • Nursing and midwifery – 154.03 FTE
	  • Allied Health Professionals (AHPs) – 87.52 FTE
	  • HCAs – 147.94 FTE
	  • Medical – 101.5 FTE
		Assurance

	• Time to Hire – is exceeding the 40-day target with performance at 65.4 days in month. From October the time to hire target has been reduced to 30 days in line with NHS best practice and NHS England requirements. • It was also noted that there are early discussions ongoing with Edge Hill doing some research about sickness absence in HCA that could be beneficial to understanding how the Trust can support staff to improve their attendance.	
Q2 Trust HR Objectives & People Plan & Q2 Lead Employer People Plan update	The Committee received a report and presentation on the Q2 2024/25 position for achievement of the NHS People Plan and Trust Objectives mapped against the four pillars of the NHS People Plan. It detailed a summary of actions focusing on specific improvements delivered in Q2 as well as areas for concern and development. The actions for the 2022-25 plan achieved in previous years will continue to be monitored as business-as-usual activities. The plan was in two sections as applicable to the Trust and Lead Employer. Trust Actions Tracker Q2 • Actions in progress - 52 • Actions in progress but behind tolerance - 3 • Actions complete in Q2 - 2 • Actions not started (with rational) -1 Total Trust - 58 **Highlights from Trust Objectives Q2:** **Looking after our People** - Health & Wellbeing support post a traumatic incident realised successful deployment of a multidisciplinary team (MDT) approach in supporting MWL Staff with effective outcomes. The Seasonal Flu and Covid vaccine programmes have been launched. **Belonging to the NHS** – The integration of the new MWL Values and Behaviours into key development activities has commenced to start embedding culture change. Line manager training programmes have commenced with a cohort of 28 registered on the training which will be completed in October 2024. All Agenda for Change staff across MWL are now on a single consolidated appraisal process, including use	

	of Robot Process Automation (RPA) to upload completed appraisals to Electronic Staff Records (ESR) for consistent reporting which has achieved 86.9% compliance in September 2024. **New ways of Working & delivering care** – a business case has been approved for a new Occupational Health system to be procured and implemented across MWL. ESR system has been harmonised across both legacy organisations. Pilot of Workforce Dashboard has been rolled out to capture weekly updates for operational colleagues. RPA developments have been identified with transactional HR services. On track for implementation during 2024/25 **Growing for the Future** - 15 trainee Advanced Clinical Practitioners (ACP) have registered at University in September to start their studies with a further two being recruited to start their education in Spring 2025. Reporting on turnover is allowing focused work on targeting recruitment and retention of specific hotspots. The new workforce dashboard highlights key areas of focus for each Division and staffing group. **Highlights from the Trust People Plan Achievements - Q2** **Looking after our People** - Health and Wellbeing conversations are offered through the new appraisal process and wellbeing support is available to staff and managers. Medical leadership framework developed and in use supporting Clinical Director Leaders and Managers. Associated development programme launched for existing Clinical Directors in September 2024. **Belonging to the NHS** - New dashboard has developed and signed off by the Employee Relations Oversight Group which includes all protected characteristics to ensure trends and themes are identified for appropriate action to be taken. Held two further Team Talk sessions at St Helens and Knowsley with the support of Executive Directors and Non-Executive Directors (NED). A further two planned in November and December. A new Women's staff Network has been launched. New Equality, Diversity, and Inclusion (EDI) pages on S&O	

	intranet, ensuring staff have the same level of information. New posters have been released. **New ways of working & delivering care** – the Trust has delivered training sessions for Radiology Assistants in Radiology Outpatients on undertaking physical observations, use of NEWS2 and supporting deteriorating patients. A business case is being developed to support cyclical Trainee Nursing Associate (TNA) Programme. **Growing for the Future** - the Trust has submitted its Workforce Operational Plan linked to the financial plan and continues to work with Integrated Care Board (ICB) and NHSE colleagues in the monitoring of this both internally and externally and the Q2 plan is currently on trajectory. Successful work experience programme has taken place at Southport and Ormskirk Hospitals in July 2024 and a pilot is scheduled for Whiston and St Helens Hospitals in November 2024. The recruitment for five Registered Nurse Degree Apprenticeships is underway. **Looking after our People** - Health, Work and Well Being (HWWB) Services delivered a successful health clearance campaign for +3,500 Doctors in Training (DIT) August and September 2024 intakes. Ensured fitness for work outcomes put DIT to work safely and effectively. In addition to the 11 Core Skills Framework Training Subjects, an additional seven subjects have been added to the shared training record for Resident Doctors which will enable at reduction in the repetition of training on rotation between hosts and free up time to care/train. **Belonging to the NHS** - Awareness sessions and education events have been held for the Human Resources (HR) team and Lead Employer (LE) stakeholders on the "Too Hot to Handle" and "Surviving in Scrubs" publications. In Q2 four policies are being updated and consulted on with the Local Negotiating Committee (LNC) for ratification in Q3. LE continues to minimise pay errors making up only 0.4% of payments, of these only six were attributable to LE and two to payroll. Other overpayments were caused by the host/other organisation and NHSE. **New ways of working and delivering care** - the	

	Lead employer implementation of new help desk system and achieved 96% of calls being resolved during the first contact through the Helpdesk team. During Q2 processes identified in Q1 are being progressed into programmes of work to be assessed for their suitability for the RPA discovery pipeline. The exit interview process has been reviewed to enable improved management information to be provided to NW trusts with the aim of supporting retention. **Growing for the Future** – the Lead Employer Collaborative Bank has been re-branded to the NHS Collaborative Bank (MWL) to recognise our ambitions for growth nationally and support other organisations in the future. Stakeholder engagement with NW HR Directors (HRD) and Chief People Officers (CPO) has commenced to explore the "art of the possible" for the future development of the LE Bank offering with the aim of improving fill rates, reducing agency spend and removing unwarranted variation in rates of pay. Lead Employer Actions Tracker Q2 • Actions in progress - 17 • Actions in progress but behind tolerance -1 • Actions complete in Q2 -1 • Actions not started (with rational) 0 • Total Lead Employer - 19 The Committee noted that any risks were being managed with mitigation plans by the respective councils.	
Workforce Development Operational plan	The Committee received a report on the MWL Workforce Operational Plan (2022-25) within which contains 4 pillars: • Clinical Models of Care • Workforce Planning • Widening Participation • Career Pathways The Strategic People Committee noted the priorities for 2024/25 which included key drivers, measures of success and progress to date. The Trust is making good progress across all priorities for 2024/25. The report highlights achievement in the provision of work experience placements across the Trust's four	Assurance

	main sites with Southport and Ormskirk sites welcoming 29 students during week commencing 08 July and Whiston and St Helens sites will be due to welcome a cohort of students in November. The Workforce Development team have attended several careers events at local schools over the last six months with the aim of raising the profile of careers in healthcare and MWL as an employer. The Trust welcomed 110 students to an event on Tuesday 15 October 2024 that had been organised by the Health Care Science (HCS) team and was supported by the Trust. The event showcased the variety of HCS careers available within the NHS to support students in understanding the choices available to them. Other deliverables highlight in the report were as follows: • The S&O legacy work experience programme was very successful. The Trust is currently trying to replicate this across MWL for students interested in both clinical and non-clinical roles with supervision from Education teams to allow students to see full patient journey. Additional skills training and mock interviews are also included, and the team are currently working on building relationships with local schools. • Healthcare science events have been held for five different schools, highlighting 52 different types of roles as Healthcare Scientists. To date this has received positive feedback. • The Trust are currently recruiting the next group of Nursing Degree Apprentice's and Trainee Advanced Clinical Practitioners. • There are early discussions with St Helens Council about hosting an internship programme. • The Workforce Development team have prioritised going forward work on; Retention, Career Development, Apprenticeships, Widening Participation, Workforce Planning (considering the age profile of the workforce) and New Roles & Models of Care and breaking down barriers to careers in healthcare.	
Staff Survey Action Plan Q3 Update & Staff Engagement – Values & Culture Update	The Strategic People Committee received a report on the final update from the results of the 2023 staff survey, which alongside a range of other staff, safety,	Assurance

	and patient experience measures, are being used to drive a range of actions identified. The key points from the 2023 staff survey actions plan were summarised as follows: • **Raising concerns** - four Speak-up Champions induction sessions have been held and a Champions Awayday was held on the 01 October 2024. There are also engagements sessions and an Executive Lead walkabout at the five Trust sites during Freedom to Speak Up Month in October took place. There are nine fully inducted Champions at STHK sites with six yet to be inducted. S&O sites have 22. The "Work in Confidence" telephone line is being promoted for staff who wish to remain anonymous. This is including in manager training. • **Compassionate Leadership** - Compassionate conversation sessions are to be rolled out across the Trust with support of Medical Director and handling difficult conversations training has also been offered. • **Equality, Diversity & Inclusion** - Black, Asian and Minority Ethnic (BAME) careers support workshops have been delivered with more planned along with training for managers around disability awareness, reasonable adjustments, equality impact assessments and harassment and discrimination. The ED&I team have developed and rolled out a comprehensive programme of training for managers on Disability Awareness and Reasonable Adjustments, Equality Impact Assessments and Harassment and Discrimination. As part of October 'Anti-Racism Month' a series of round-table workshops are being held. • **We work Flexibly** - Divisional action plans to include Flexible Working along with outlining specific action to be taken this year. This will also include retire and return moving forward Trust-wide roadshows to be developed to showcase the information to various sites / departments and discuss locally available options to them. ESR data on Flexible Working will be monitored and reported via People Performance Council (PPC) to	

	ensure the required timescales for responses is met and consistency in decision making will also be reviewed. • **Appraisals & Development** - the appraisal process has been implemented across the whole of MWL for the 2024 appraisal window, including the appraisal bot to support managers in the consistent recording of completed appraisals. The new appraisal form includes questions for employees about their career aspirations, present and future development needs and their demonstration of Trust values and behaviours. The Trust has invested in a new 'Your Personal Development' Portal which is available to all staff. This resource can help staff learn new skills, review career progress and plan for next steps. Since launch, the system has recorded 3,619 instances of activities (as at 16/09/2024). It was noted that the 2024 National Staff Survey has now been sent to staff and that Executive Directors have been visiting sites to meet with staff and encourage their engagement with the staff survey as an important opportunity to gain feedback. The staff survey for 2024 will be available from 01 October 2024 until the 29 November 2024. 'You Said We Did' information has been updated to showcase the real and significant changes and improvements made by the Trust based on response to the 2023 Staff Survey and the homepage of the staff intranet also features a banner that directly links to the Staff Survey page to make it easier and quicker for staff to access information.	
Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Report from the People Performance Council and the Employee Relations Oversight Group	Assurance
Terms of Reference (ToR)	The Committee deferred the approval of the People Performance TOR until November 2024.	Decision
Items for Escalation to Trust Board	None	Assurance
Any Other Business	A discussion took place about the potential content of the summary report to the Strategic People Committee about themes and challenging arising	Assurance

	during the last 12 months from cases under the terms of reference of the Employee Relations Oversight Group. It was suggested that this could include a deep dive into the issues resulting in formal action, learning from cases and how we feed into case investigations about improvements to people practices as a case progresses. It was agreed that the Q3 People Plan Update should include targets to show progress. It was noted that Anne Potter, HR Business Partner, Lead Employer had won the KPMG Excellence Award for work on Neurodiversity at the recent HPMA Conference.	
Effectiveness of Meeting	Feedback from the Committee indicated this meeting has been effectively chaired.	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 October 2024
Agenda Item	**TB24/072 (7.5)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	24 October 2024		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Director of Finance Update	• Next phase of system financial recovery following external reviews; Integrated Care Board (ICB) established finance improvement command centre to closely monitor the financial position and provide assurance on the delivery of plans.	Assurance
2024/25 Plan adjustment – deficit funding	• Following acceptance of the ICB £150m deficit plan for 2024/25, non-recurrent deficit support revenue of £150m has been allocated by the national team. • Cheshire and Merseyside (C&M) has allocated this across the trusts with a deficit, £15.8m for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), improving income and expenditure (I&E) by an equal amount. • Committee approved an amendment to the 2024/25 plan to incorporate this.	Approval
Financial Improvement	• Committee reviewed system and Trust financial position at M6 and projections to year end including actions undertaken to continue delivering the 2024/25 plan. • Controls and supporting actions outlined including internal financial improvement groups and external reviews/data collections alongside existing assurance frameworks.	Assurance
Integrated Performance Report Month 6 2024/25	• Bed occupancy across MWL averaged 105.4% in September equating to 96 patients, an increase from 104.3% in August. • Average length of stay for emergency admissions is high at 8.8 days, (9.4 at S&O and	Assurance

	8.2 at STHK), the impact of Non-Criteria to Reside (NCTR) patients remains high but has decreased slightly in September, being 19.1% at organisation level (21% STHK and 16% S&O). • 4-Hour performance decreased in September achieving 74.4% (all types), national performance 74.2% and providers across C&M averaging 72.9%. • 18 Week performance in September for MWL was 57.8%, S&O 65.6% and STHK 54.9%. National performance (latest month August) was 58.3% and C&M regional performance was 56.3% • The Trust had 2,402 52-week waiters at the end of September (351 S&O and 2,051 STHK) and one 78-week waiters. • Diagnostic performance in September for MWL exceeded the target at 96.8%, S&O 94.8% and STHK 97.8%. • Cancer performance for MWL in August decreased slightly to 74.4% for the 28-day standard and 80.2% for the 62-day standard.	
Finance Report Month 6 2024/25	• The Trust is reporting a deficit of £10.3m which is £2.9m better than the revised plan due to the recognition impact of industrial action. • The Trust's combined 2024/24 Cost Improvement Target (CIP) target is £48m of which £11.8m is non-recurrent. As at Month 6, the Trust has transacted CIP of £34.4m in year and £29.6m recurrently. • At Month 6, agency spend is £12.7m to date, 4.2% of total pay costs. Premium Payment Scrutiny Council review and address the drivers of agency costs with actions taken through executive committee. • The Trust has a closing cash balance of £3.7m at Month 6. Cash approvals are now being reviewed monthly by NHSE. Ongoing discussions regarding mitigating cash risk regarding requirement for pay awards. • Better Payment Practice Code (BPPC) has not been achieved for non-NHS suppliers but has been impacted by a large volume of small value agency invoices.	Assurance

	• The capital plan for the year is £48.4m (including Public Finance Initiative (PFI) Lifecycle). Spend to date is £12.4m in line with plan. The plan requires external Public Dividend Capital (PDC) support (£17m) which has not yet been drawn down.	
Corporate benchmarking update	• Results of the national corporate benchmarking return were reviewed • Trust lower cost than ICB median, slightly higher (£0.2m) than the national median. • Corporate leads reviewing alongside peers in other organisations to understand any opportunities.	Assurance
Month 6 2024/25 CIP Programme Update and Surgical Division CIP update	• Total targets for 24/25 is £48m in year and £36.2m recurrently. • There is currently a delivered/low risk value of £36.2m in year (75% of the £48m target) and £30.9m recurrently (85% of the £36.2m target). • Schemes identified to date are £56m with £53.8m recurrent. Based on historic performance a further £10m of schemes is required to be identified to continue with the progress made to date. • Division CIP update provided including overview of governance process to provide assurance.	Assurance
Elective Care recovery review	• Overview provided of the latest position on elective care for MWL including update of key actions being taken to improve performance. • Focus on maximising the use of all resources to reduce long waits including exploring any options for mutual aid where appropriate. • Update on the national further faster 20 programme, aim is to provide targeted support for systems to improve and streamline elective pathways for patients in areas with high levels of economic inactivity.	Assurance
Assurance Reports from Subgroups:	• Procurement Council • CIP Council • Capital Planning Council - CPC Terms of reference included for approval • Estates & Facilities Management Council • IM&T Council update	Assurance/ Approval

Alerts
None
Decisions and Recommendation(s):
2024/25 Plan adjustment – deficit funding • The Committee noted the adjustment to the plan and agreed to amend the Trust plan to include the deficit funding and associated improvement in the I&E of £15.8m. **Capital Planning Council** • CPC Terms of reference approved

Title of Meeting	**Trust Board**		**Date**	30 October 2024
Agenda Item	**TB24/073**			
Report Title	Corporate Risk Register (October 2024)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

1. Risk Management Systems

There is an MWL Risk Management Framework that has been approved and implemented. However, the risk management and reporting mechanisms will continue to rely on the legacy trusts separate DATIX systems, until a new single system is implemented which is now being planned for early 2025. The structure of the new system will align each service/department to its Division in the MWL operating model.

Any member of staff can still easily report a new risk wherever they work in the organisation.

This report provides an overview of the risks reported across MWL, and those risks that have been escalated to the CRR.

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

- have been identified and reported
- have been scored in accordance with the standard risk grading matrix.
- initially rated as high or extreme have been reviewed and approved by the relevant divisional
- triumvirate and a director.
- have an identified target risk score, which captures the level of risk appetite and has a mitigation plan
- that will realistically bring the risk to the target level.

2. Risk Registers and Corporate Risk Registers

This report is based reflects a snapshot of the risk registers initially on 01 October and then repeated on 08 October 2024 following further Executive review. The report reflects risks reported and reviewed during September 2024.

Risk Register Summary (Appendix 1)

The total number of risks on the MWL risk register was 1,116 compared to 1,068 in July.

21 risks are escalated to the CRR compared to 39 in July, this reduction is due to senior Executive review and the removal of single item equipment bids, rationalisation and grouping of risks and the linking of duplicate risks.

Four new escalated risks are reported on the CRR in October compared to July and 21 risks have been closed or de-escalated from the CRR.
Financial Implications
None as a direct result of this report
Quality and/or Equality Impact
Not applicable
Recommendations
The Board is asked to note the Corporate Risk Register.

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

October 2024 – Corporate Risk Register Quarterly Board Report

1. Risk Register Summary for the Reporting Period

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

RISK REGISTER STHK SITES	Current Reporting Period (October 2024)	Previous Reporting Period (September 2024)	Previous Reporting Period (August 2024)
Number of new risks reported	34	27	49
Number of risks closed or removed	26	10	39
Number of increased risk scores	5	0	2
Number of decreased risk scores	11	10	13
Number of risks overdue for review	149	89	59
Total Number of Datix risks	**886***	**881**	**870**

*870 approved scored risks, 9 new risks yet to be scored, 7 unapproved high risks

This table provides a high-level overview of the "turnover" in the risk profile of the legacy **S&O** sites compared to previous reporting periods.

RISK REGISTER S&O SITES	Current Reporting Period (October 2024)	Current Reporting Period (September 2024)	Previous Reporting Period (August 2024)
Number of new risks reported	15	7	9
Number of risks closed or removed	9	5	10
Number of increased risk scores	1	1	0
Number of decreased risk scores	1	0	2
Number of risks overdue for review	65	82	63
Number of tolerated risks	**16**	**16**	**16**
Total Number of Datix risks	**230***	**224**	**222**

***182 open/scored risks, 32 new risks awaiting approval, 16 tolerated risks

2. Risk Profiles

Legacy STHK Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
15	**56**	**24**	**87**	**10**	**164**	**69**	**176**	**41**	**213**	**6**	**7**	**2**	**0**
95 = 10.92%			**261 = 30%**			**499 = 57.36%**				**15 = 1.72%**			

870 risks scored and approved.

Legacy S&O risk profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**1**	**11**	**10**	**1**	**34**	**28**	**45**	**12**	**72**	**0**	**6**	**4**	**0**
12 = 5.22%			**45 = 19.56%**			**163 = 70.87%**				**10 = 4.35%**			

230 risks in total including unapproved and tolerated risks

A single MWL risk profile and risk profiles for each Division will be reported once the new integrated system is implemented.

3. Corporate Risk Register

No	ID	ADO/Exec Lead	CBU/Care Group/Service	LEGACY SITE	Title	Next review date	Rating (current)	Last updated
1	762	Malise Szpakowska	Human Resources	STHK	Risk of the Trust not being able to provide safe levels of staffing	30/09/2024	16	25/09/2024

2	1152	Malise Szpakowska	Human Resources	STHK	Risk for quality of care, contract delivery and finance due to increased use of bank and agency staff	30/09/2024	16	31/07/2024
3	1263	Rob Cooper	Medical Care	STHK	Risk of patient harm due to poor patient flow and delays in discharging NCTR patients – leading to increased staffing requirement, escalation beds, corridor care, ambulance handover delays	15/10/2024	15	02/08/2024
4	1772	Malcolm Gandy	Health Informatics	STHK	Risk of malicious cyber attack	31/01/2025	16	30/08/2024
5	2227	Lynne Barnes	Quality & Risk	STHK	Risk that the Trust will fail to maintain CQC fundamental standards if procedural documents are not regularly reviewed and kept up to date	06/11/2025	16	05/09/2024
6	2750	Malcom Gandy	Health Informatics	STHK	Risk of data quality and patient mismatch errors for diagnostic imaging results downloaded from the national PDS spine	29/11/2024	15	30/09/2024
7	3251	Malcolm Gandy	Health Informatics	STHK	Trust solution for outpatient letter printing is end of life / unsupported and standard letters cannot be amended	31/10/2024	20	13/09/2024
8	3527	Rob Cooper	Surgical Care	STHK	Risk to the adequate delivery of care for plastic surgery patients in North Wales due to lack of commissioned capacity by NHS Wales	28/10/2024	20	26/09/2024
9	3574	Malcolm Gandy	Clinical Support	STHK	Risk that patients with an open referral in careflow are not linked to future activity	29/11/2024	15	30/09/2024
10	3748	Rob Cooper	Medical Care	STHK	Risk of not meeting dermatology 2ww target due to increasing demand	16/09/2024	15	20/08/2024
11	3850	Lesley Neary	Clinical Support	STHK	Risk to the Paediatric Dietetics service for West Lancashire as commissioners have not confirmed requirements	15/11/2024	15	27/09/2024
12	3872	Peter Williams	Medical Care	STHK	Risk that requests for advice from the Trust advice and guidance are not sufficiently detailed	16/12/2024	15	13/09/2024
13	3959	Lesley Neary	Clinical Support	STHK	Risk of Patients having more than one hospital number until move to a single EPR/PAS completed	15/10/2024	15	16/09/2024
14	4096	Lynne Barnes	Quality & Risk	STHK	Risk that the harmonisation to national AfC T&Cs at the legacy S&O sites will impact recruitment and retention	15/11/2024	16	25/09/2024

15	4126	Peter Williams	Medical Care Group	STHK	Risk of patients being lost due to partial booking historic practices at the legacy S&O sites	28/10/2024	20	29/09/2024
16	2122	Rob Cooper	Clinical support & Community	S&O	Pharmacy staffing at legacy S&O sites	16/10/2024	16	03/09/2024
17	2230	Rob Cooper	Corporate Services	S&O	Fragile Services	07/11/2024	16	28/05/2024
18	2432	Nicola Bunce	Corporate Services	S&O	Critical Estates Infrastructure	31/10/2024	20	27/08/2024
19	2545	Lesley Neary	Clinical Support & Community	S&O	Risk of correct temperature monitoring and control practices not being complied with at Ward/Department level	16/10/2024	20	03/09/2024
20	2601	Peter Williams	Surgery Division	S&O	Risk that anaesthetic out of hours cover is not sufficient to support a 2nd time critical emergency at Ormskirk Hospital	07/10/2024	20	30/09/2024
21	2752	Lynne Barnes	Urgent Care	S&O	Risk of not having sufficient substantive staff to maintain patient safety in ED at Southport Hospital	05/09/2024	20	12/09/2024

*blue text denotes new risks added to the CRR since the last board report

4. Risks closed or de-escalated from the CRR since the last quarterly board report.

ID	ADO/Exec Lead	Care Group/CBU/ Service	LEGACY SITE	Title
2082	Peter Williams	Medicine & Urgent Care	STHK	Medical Provision post take consultant reviews for patient whose stay in ED is delayed
2083	Lesley Neary	Medicine & Urgent Care	STHK	If medical bed occupancy increased above 95% there will be no capacity to admit patients from ED
2223	Rob Cooper	Medicine & Urgent Care	STHK	If ED attendances and admissions increase beyond panned levels, there will not be sufficient inpatient beds to meet demand

2985	Lesley Neary	CSS & Community	STHK	If there are not sufficient Phlebotomy Staff recruited and retained to meet demand this will impact waiting times
2996	Lynne Barnes	Medicine & Urgent Care	STHK	If the Medical Division cannot maintain safe nurse staffing levels there is a risk to patient safety, patient experience, and the quality of care
3013	Lesley Neary	CSS & Community	STHK	The X ray equipment at Newton Community Hospital is end of life and needs to be replaced.
3043	Rob Cooper	CSS & Community	STHK	Shortage of Microbiology Consultants
3178	Lesley Neary	CSS & Community	STHK	High turnover rates and national shortages resulting in a risk that there may not be sufficient substantive staff to meet demand
3349	Lesley Neary	Medicine & Urgent Care	STHK	Olympus managed endoscopy scope equipment contract due to end.
3371	Lynne Barnes	Medicine & Urgent Care	STHK	Ward areas having to accommodate an extra patient during times of heightened capacity demands
3475	Lesley Neary	Medicine & Urgent Care	STHK	Delays in NWAS transport for patients requiring neuro radiology thrombectomy / surgical intervention at a tertiary centre
3598	Rob Cooper	Surgery	STHK	If Orthopaedic Desouter drills are not replaced, then there will be an impact on some surgical procedures
3624	Lesley Neary	Surgery	STHK	Out of hours endoscopy assistance
3647	Lesley Neary	Medicine & Urgent Care	STHK	St Helens endoscopy re-design
3795	Lesley Neary	Medicine & Urgent Care	STHK	Endoscopy waiting lists for urgent or 2WW appointments
4018	Lesley Neary	Surgery	STHK	Admissions department staffing issues
2590	Lesley Neary	Surgery	S&O	ENT Provision Service
2572	Rob Cooper	CSS & Community	S&O	Malfunction and failure of the ADS (Automatic Dispensing System) Pharmacy Robot
2031	Lesley Neary	Medicine & Urgent Care	S&O	Risk to Patient Flow and Capacity on Southport site
1528	Rob Cooper	CSS & Community	S&O	Risk of medication errors and patient harm due to lack of an Electronic Prescribing and Administration of Medicines (EPMA) system at legacy S&O sites
1603	Rob Cooper	Surgery	S&O	Replacement of aging Autoclaves

Title of Meeting	**Trust Board**			**Date**	30 October 2024
Agenda Item	**TB24/074**				
Report Title	Board Assurance Framework (October 2024)				
Executive Lead	Nicola Bunce, Director of Corporate Services				
Presenting Officer	Nicola Bunce, Director of Corporate Services				
Action Required	X	**To Approve**		**To Note**	

Purpose

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

Executive Summary

The MWL BAF is reviewed four times a year, the last review was in July 2024, and this review captures the changes that have occurred during Q2 (2024/25).

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

Each BAF risk is assigned a lead Executive, who is responsible for ensuring the risk is updated at each quarterly review.

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

Key to proposed changes (appendix 1):
~~Score through~~ = proposed deletions/completed
Blue Text = proposed additions
Red = overdue actions

Proposed changes to risk scores.

BAF 3 – score to be increased to 20, in light of challenges delivering key elective and non-elective targets

Financial Implications

None directly because of this report.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the changes to the Board Assurance Framework.

Strategic Objectives

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

Board Assurance Framework Quarterly Review – Q2 2024/25

BOARD ASSURANCE FRAMEWORK 2024-25								
BAF Dashboard 2024-25 – Quarter 1 Review								
BAF	**Risk Description**	**Exec Lead**	**Risk Score**					
			Inherent	**Jan 24**	**April 24**	**July 24**	**Oct 24**	**Target**
1	Systemic failures in the quality of care	Medical Director/ Director of Nursing	**20**	**20** ↑	**20** ↔	**20** ↔	**20** ↔	**5**
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Director of Finance and Information	**20**	**20** ↑	**20** ↔	**20** ↔	**20** ↔	**10**
3	Sustained failure to maintain operational performance/deliver contracts	Chief Operating Officer	**16**	**20** ↔	**16** ↓	16 ↔	20 ↑	**12**
4	Failure to protect the reputation of the Trust	Director of Human Resources	**16**	**12** ↔	**12** ↔	**12** ↔	**12** ↔	**8**
5	Failure to work in partnership with stakeholders	Director of Human Resources/ Managing Director	**16**	**12** ↔	**12** ↔	**12** ↔	**12** ↔	**8**
6	Failure to attract and retain staff with the skills required to deliver high quality services	Director of Human Resources	**20**	**15** ↔	**15** ↔	**15** ↔	**15** ↔	**10**
7	Major and sustained failure of essential assets and infrastructure	Director of Corporate Services	**16**	**12** ↔	**12** ↔	**12** ↔	**12** ↔	**8**
8	Major and sustained failure of essential IT systems	Director of Informatics	**20**	**16** ↔	**16** ↔	**16** ↔	**16** ↔	**16**

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

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

Blue Text = proposed additions

Red = overdue actions

BAF 1 Systemic failures in the quality of care

Exec Lead: Medical Director/Director of Nursing

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver the Clinical and Quality standards and targets. • Failure to deliver CQUIN element of contracts, if required • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care. • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness, or timeliness of reporting • Failure in the supply of critical goods or services **Effect:** • Poor patient experience • Poor clinical outcomes • Increase in complaints. • Negative media coverage **Impact:** • Harm to patients • Loss of reputation • Loss of contracts/market share	• Clinical Strategy • Nursing and Midwifery Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings • NHSE Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • Maternity Incentive Scheme. • CNST premium • Patient Safety Incident Response Framework (PSIRF) • Safer staffing/ establishment and Birth Rate + staffing reviews	**LEVEL 1** Operational Assurance • Staff Survey • Friends and Family scores • Quality Ward Rounds • Ward accreditation programme **LEVEL 2** Board Assurance • IPR/CPR • Patient stories • Quality Committee • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Nursing & Midwifery Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • IPC Board Assurance Framework **LEVEL 3** Independent Assurance • National clinical audits • Annual CQUIN Delivery (if required) • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital	Embedded divisional performance management/governance systems. Complete implementation of post transaction corporate nursing and medical management structures.	Routinely achieve 30% of discharges by midday 7 days a week to improve patient flow. Single set of key clinical and quality policies for MWL Fully integrated MWL quality governance structure (revised to December 2024) ~~Selection of a single risk and incident reporting system for MWL (October 2024)~~ Assurance of the 2024 Maternity Incentive Scheme across all domains (November 2024) Internal Review commissioned of the impact of ED congestion and ambulance handover delays (November 2024) Completion of post transaction quality governance review (November 2024)	MWL wide deteriorating patient improvement project - phase 2 (December 2024) ~~Alignment of key clinical and quality policies across the new organisation (September 2024)~~ Achieve new complaints response time of 60 days (Revised to December 2024) Achieve quality improvement objectives for 2024/25 (March 2025). ~~Implement changes agreed in the Nurse Establishment Review (September 2024).~~ Implement the new incident and risk reporting system for MWL following approval of the new system (February 2025) Implement actions from the Maternity CQC inspections (November 2024) Provide assurance on ED safety to ICB following NHSE letter (December 2024) ~~Evaluate new MWL 5 star ward accreditation process (August 2024)~~ Delivery of the GMC trainee survey results action plan (September 2025) Review of medical bed base and non-elective pathways (December 2025)

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

Exec Lead: Director of Finance

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to achieve the Trusts statutory breakeven duty. • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders. • Failure to deliver strategic financial plans. • Failure to control costs or deliver CIP. • Failure to implement transformational change at sufficient pace. • Failure to continue to secure national PFI support. • Failure to respond to commissioner requirements. • Failure to respond to emerging market conditions. • Failure to secure sufficient capital to support additional equipment/bed capacity. • Failure to obtain sufficient cash balances. • Failure to obtain on going transaction support. • Failure to deliver financial plans. **Effect:** • Failure to meet statutory duties. • NHSE/I Single Oversight Framework rating. **Impact:** • Unable to deliver viable services. • Loss of market share • External intervention	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 3-year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all ICBs and Spec Comm • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Conflict of interest declarations • Benchmarking and reference cost group • Workforce vacancy panel ToR	**LEVEL 1** Operational Assurance • Monthly CBU Finance and Performance Meetings • CIP Council Meetings • Agency and locum spend approvals and reporting process. • Operational planning • Premium Payment Scrutiny Council • Vacancy control panel **LEVEL 2** Board Assurance • Finance and Performance Committee and reporting Councils • Annual Financial Plan • Audit Committee • Integrated Performance Report • Benchmarking and market share reports (inc. GIRFT) • Internal Audit Programme • CQUIN Monitoring **LEVEL 3** Independent Assurance • ICB & NHSE monthly reporting and review meetings • Contract Review meetings • Place Based Partnership Boards • Financial sustainability self-assessment • External Audit reports including VfM Assessment • Head of Internal Audit Opinion • NHSE scrutiny of cash applications	Continue collaboration across C&M to deliver transformational CIP contribution. Medium and long-term financial plan, taking into account current position and savings from any reconfiguration, that addresses drivers of the underlying financial position of services at legacy S&O sites. ~~Complete the review of financial controls so they are standardised across MWL (September 2024)~~	Develop capacity and demand modelling and a consistent approach to service development business case approval. Foster positive working relationships with health economy partners to help create a joint vision of the future of health services. Continue to achieve cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances. At the earliest opportunity move back to longer term financial planning with rolling plans for 3 – 5 years. Delivery of the 2024/25 financial recovery actions to reduce run rate (January 2025) Cash flow to support payment of the lead employer doctors pay award and backpay (November 2024)	~~Continue to track the activity and financial impact of continued Industrial Action and national guidance/direction on how the impact will be funded or activity plans revised (on-going for Junior Doctors)~~ Deliver the agreed 2024/25 financial and activity plans, including CIP targets, reduction in bank and agency spend and delivery of minimum national activity targets (March 2025) Deliver the agreed 2024/25 capital programme. ~~Complete review of financial position with PWC as part of NHSE support (September 2024)~~ Weekly monitoring of temporary staff spending and financial controls and reporting to C&M Financial Incident Command Centre (December 2024)

BAF 3 Sustained failure to maintain operational performance/deliver contracts

Exec Lead: Chief Operating Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. **Effect:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Patients treated in ED or escalation beds. **Impact:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Negative impact on patient outcomes and experience	• NHS Constitutional Standards • Divisional activity profiles and work plans • System Winter Plan • Divisional Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Tumour specific cancer waiting time recovery plans • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events • Bed occupancy rates • Number of super stranded /patients who no longer meet the criteria to reside	**LEVEL 1** Operational Assurance • Winter resilience plans • Divisional Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • IA EPRR response and recovery plans • Weekly performance review meetings **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance monthly oversight meetings	Implementation of routine capacity and demand modelling A defined preferred option and capital secured for Shaping Care Together programme. Implementation of CDC at Southport and Ormskirk sites.	Assurance that there is sufficient system response to operational pressures and reducing the number of patients who no longer meet the criteria to reside. Progress against 2024/25 waiting list reduction and recovery targets. National HIT visits to improve theatre utilisation (January 2025). UEC/ED – GIRFT and ECIST reviews (January 2025)	Deliver the agreed 2024/25 activity and access time performance improvements (April 2025) ~~Develop new non-elective winter strategy to achieve 2024/25 targets (Revised to September 2024)~~ 2024/25 winter plan to be agreed (November 2024) Implement cancer performance improvement plans across MWL (April 2025) ~~Work with the Mid Mersey UEC improvement programme, aligned to the MWL footprint, to reduce corridor care and reliance on escalation beds, in support of the NHS C&M 2024/25 priorities (September 2024)~~ Continue to work to support the MWL UEC Improvement Programme and ensure trajectories agreed for each of the three workstreams so all parties can be held to account for the improvement needed for winter 2024/25 (March 2025) Actions plan to achieve 2024/25 RTT reduction targets across all specialties (March 2025) Deliver the internal transition and transformation programme to address fragile services by service integration and alignment across MWL (July 2025)

BAF 4 Failure to protect the reputation of the Trust — Exec Lead: Deputy CEO

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. • Failure of FPPT procedure **Effect:** • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff. • Increased external scrutiny/review. **Impact:** • Reduced financial viability and sustainability. • Reduced service safety and sustainability • Reduced operational performance. • Increased intervention	• Communication, Media and Public Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR/FOI	**LEVEL 1** Operational Assurance • Winter resilience plans • Divisional Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • Daily/weekly media briefings and board flash reports for urgent issues **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance oversight of pathways • Provider representative at Place quarterly ICB performance meetings		Creation of good working relationships with new Healthwatch/PBP areas post transaction. Continue to support the Shaping Care Together Programme and provide information to stakeholders and the public as the programme moves to the Pre-Consultation Business Case phase (January 2025)	Develop the MWL Communications, Media, and Public Engagement strategy for approval by the Trust Board (revised to April 2025) MWL stakeholder newsletter (revised to January 2025) Monthly media activity reports to Executive Committee (draft report developed and first report now due for Q3 activity – January 2025) ~~With partners deliver the communications and engagement programme for the Shaping Care Together pre-consultation business case (September 2024)~~ ~~Launch of the MWL Hospital Charity (July 2024)~~

BAF 5 Failure to work effectively with stakeholders

Exec Lead: Director of HR/ Managing Director

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media. • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. **Effect:** • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff. **Impact:** • Unable to reach agreement on collaborations to secure sustainable services. • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff. • Failure to win new contracts. • Increase in complaints and claims	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • Place Director Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • St Helens Cares Peoples Board • Involvement in Halton and Knowsley PBP development • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care Board governance structure • Exec to Exec working • MWL Hospitals Charity annual objectives • Regular meetings with local MPs, OSCs etc. • Equality impact assessments • Anchor institution development plan	**LEVEL 1** Operational Assurance • LUHFT Partnership Board • North Mersey Ophthalmology Steering Group • Shaping Care Together Programme • Membership of CMAST • Capital Assurance Group • ED&I Steering Group • Monitoring of NHS Choices comments and ratings • Review of digital media trends • Healthwatch feedback **LEVEL 2** Board Assurance • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • Quality Account • Annual staff engagement events programme **LEVEL 3** Independent Assurance • NHSE review meetings • Participation in C&M ICB leadership and programme Boards • Collaborative working with Place Directors to develop plans for PBPs • Membership of St Helens People Board • OSC attendance/presentations	Health inequalities improvement objectives to be agreed with each Place and the ICBs	**C**&M Integrated Care System performance and accountability framework ratings and reports Develop and maintain good working relationships with each Place Partnership, ICB and Primary Care Network ~~Maintain or improve NHS Operating framework segment 2 (April 2024)~~ Maintain effective working with Place leads to take forward the UEC improvement programme workstreams and reduce the % of NCTR patients in acute beds.	Re start the Shaping Care Together Programme to develop a new PCBC for the configuration of services between the Southport and Ormskirk Hospital sites (revised to November 2024 due to timing of the general election) ~~Work with NHSE/ICB post transaction to continue to support fragile services for MWL as required (September 2024)~~ Continue to work with the SCT programme and other system partners to reduce the number of legacy S&O Trust fragile services (March 2025)

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

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff **Effect:** • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff **Impact:** • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	• Trust brief live • MWL News • Mandatory training • Appraisals • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/LNC • Workforce & Development Operational Plan • Learning and Organisational Development Operational Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Operational plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • Trust Values • Medical Workforce OD plan • Talent Management action plan • Equality, Diversity, and Inclusion Operational plan	**LEVEL 1** Operational Assurance • Premium Payments Scrutiny Council • Monitoring of bank, agency and locum spend • Workforce operational plans • Vacancy control panel **LEVEL 2** Board Assurance • Strategic People Committee • People Performance Council, Valuing Our People Council and HR Commercial Services Council • Finance and Performance Committee • Committee Performance Report • Staff Survey • Monthly monitoring of vacancy rates Labour stability and staff turnover • WRES, WDES, EDS3 and Gender Pay Gap, EDI reports and action plans • Quality Ward rounds • Employee Relations Oversight Group **LEVEL 3** Independent Assurance • HR Benchmarking • Nurse & Midwifery Benchmarking • Freedom to Speak Up Guardian reports • Guardian of Safe Working Hours report	Improve ease with which staff can move roles internally (March 2025). Review of education structure across MWL and complete Integration (revised to April 2025) Monthly Provider Workforce Returns (PWR) ~~MDT approach to HR support to Divisions including recruitment, retention, staff engagement and wellbeing. (October 2024)~~ Development of a workforce information dashboard to support divisional oversight of key workforce metrics (December 2024) Optimise utilisation of the apprenticeship levy to attract and retain staff (March 2025) Delivery of the NHS EDI Improvement Plan high impact actions (March 2025) Achieve bronze level North West Anti-Racism Framework (March 2025)	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g., international recruitment and working closely with NHSE. CDC recruitment campaign continues with recruitment events and new training opportunities for Physician Associates, Phlebotomy, international recruitment, and use of apprenticeships (On-going) C&M Endoscopy bank pilot extended to October 2024 and piloting the hybrid employment model, transitioning to BAU (March 2025). Achieve 2023/24 targets for international medical recruitment and Nurse Associate expansion (March 2025)	Continue to provide the necessary support for organisational change to implement the remaining management structure for the MWL integrated operating model (on-going) Achieve the mandatory and compulsory training target of 85% (April 2025) Achieve 85% compliance with staff appraisals (April 2025) Implement the NHS Sexual Safety Charter (March 2025) Delivery the 2023 staff survey action plan (March 2025) Deliver the HR Operational plans for 2024/25 (March 2025) Healthcare Support Worker quarterly recruitment events for each hospital site (March 2025) Complete single temporary workforce resourcing solution for MWL (July 2025)

BAF 7 Major and sustained failure of essential assets or infrastructure

Exec Lead: Director of Corporate Services

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services **Effect:** • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints **Impact:** • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5-year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning, food standards • Compliance with NHS Estates HTMs • Green Plan	**LEVEL 1** Operational Assurance • Major Incident Plan • Business Continuity Plans • Planned Preventative Maintenance Programme • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee to capture ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance • S&O safety groups and E&F Governance Group **LEVEL 2** Board Assurance • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • Integrated Performance Report • ERIC returns/data **LEVEL 3** Independent Assurance • Authorising Engineer Appointments • Authorising Engineer Audits • Condition surveys • Premises Assurance Model (PAM) benchmarking • Model Hospital • PLACE Audit Results and benchmarking • Building Safety Act	Maintain up to date 10-year strategic estates development plans for MWL n to support the Trusts service development and integration strategies. Development of an Estates Strategy in response to Shaping Care Together preferred service configuration option (aligned to SCT timetable)	Develop the final business case to fully implement National Standards of Cleaning across MWL and present to the Executive Committee for approval (revised to take account of changes to cleaning schedules at Southport in ED – December 2025) Implementation of the national Hospital Food Review recommendations and mandatory standards (Gap analysis being undertaken) Compliance with the new Protect legislation for premises security – Consultation closed in July 2022 and draft legislation not yet published. ~~Commission up to date 6 facet survey of the Southport and Ormskirk Hospital sites (October 2024)~~	3-year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2024/25) Deliver the S&O sites backlog maintenance programme for 2024/25. Deliver the MWL capital works plans for 2024/25. Review impact of Building Safety Act on planned schemes (December 2024)

BAF 8 Major and sustained failure of essential IT systems

Exec Lead: Director of Informatics

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure **Effect:** • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity • Loss of data or patient related information **Impact:** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share contracts	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register • Service improvement plans • MWL Digital Strategy 2024-2027 • Microsoft Defender for Endpoints • MFA protection for confidential data – enforced on non-Trust devices • Annual DSPT self-assessments	**LEVEL 1** Operational Assurance • Information security dashboard • Information asset owner register • Information security dashboard • IT On Call (including network specific cover provided by MMDA) • Benefit realisation framework monitoring • Monthly cyber security operational meeting **LEVEL 2** Board Assurance • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • IM&T Council • Information Security Assurance Group • MMDA Service Operations Board • MMDA Strategy Board • Programme/Project Groups • Information Governance Steering Group **LEVEL 3** Independent Assurance • Internal/External Audits • CareCert, Cyber Essentials, External Penetration Testing • Cyber Essentials Plus accreditation - MMDA. • Support contracts for core systems • Quarterly NHS Digital simulated phishing attack reports • Digital Maturity Assessments	Annual IT Corporate Governance Structure review Technical Development of staff	Compliance with ISO27001 – with gap analysis being in progress (March 2025) IT communications strategy Digital Maturity assessment Cyber Essential Certification/Accreditation – achieve by January 2026 Migration from end-of-life operating system at S&O sites ~~Multi-factor authentication to provide additional protection for confidential data~~	Achieve HIMMS Level 5 2018 standards and core digital capabilities and WGLL standards (March 2025) ~~Decommission Windows 12 Servers (October 2024).~~ Windows Server 2008 and 2012 Servers are gradually being retired and will be fully replaced (March 2025). Delivery of the Frontline Digitisation Programme to optimise Careflow EPR and implement new functionality to meet the core digital capability standards (March 2025) Delivery of Community EPR (revised to September 2025 due to system issues which have resulted in the service delaying further implementation of the solution) Respond to cyber threat alerts and update systems as required (on going) Deliver the 2024/25 IT capital expenditure plan (March 2025) Cyber Essentials Plus for MWL - cannot be fully achieved until the end-of-life operating systems are removed from the network (March 2026)

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	30 October 2024
Agenda Item	**TB24/075**			
Report Title	Learning from Deaths Report (Quarter 4)			
Executive Lead	Dr Peter Williams, Medical Director			
Presenting Officer	Dr Peter Williams, Medical Director			
Action Required		**To Approve**	X	**To Note**

Purpose

To describe mortality reviews which have taken place throughout the Trust and to provide assurance that deaths occurring in hospital undergo a robust review to identify lessons which can be learned to prevent similar incidents occurring again.

Executive Summary

At legacy STHK, 76 deaths within scope in Q4 2023/24 - 66 have undergone a Structured Judgement Review undertaken with ten outstanding. Of those cases reviewed, one was rated Amber and none as Red.

At legacy S&O, 177 deaths were reviewed by the Medical Examiner Team, of which four were referred to the coroner. 13 Structured Judgement Reviews took place, of which one case was rated as Amber.

All cases rated as Amber or Red will undergo more detailed review at their respective Mortality Groups with learning and additional actions fed back via the respective Divisions.

Financial Implications

None

Quality and/or Equality Impact

Learning from Deaths contributes to the Trust's continuous learning culture

Recommendations

The Trust Board are asked to note the Learning from Deaths Report (Quarter 4).

Strategic Objectives

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

1. **Outcome from reviews undertaken**

STHK - Number of reviews carried out Q4 2023/24

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
76 *(10)*	33	16	16	1	0

Summary	SJR Rating	Comments
71 year old male, ME referral. Necrotising fasciitis, multiorgan failure	AMBER	For discussion at the October Mortality Surveillance meeting

S&O – Number of reviews carried out Q4 2023/24

No. of reviews *(outstanding)*	Excellent	Good	Adequate	Poor	Red
SJR 13	4	3	5	1	0
ME Reviews 177	N/A	173	N/A	2	2

Red and Amber outcomes come from ME reviews resulting in coroner's referral and are subject to further review at Mortality Outcome Group where their outcome may be downgraded.

Summary	SJR Rating	Comments
55 male with ALD & pancreatitis. Admitted with decompensated ALD with sepsis. Drained 3.5L. Minor improvement but then deteriorated and died. Son had been translating for the team on each occasion.	AMBER	Issues with translation services identified which are subject to an ongoing quality improvement group.
75 male with metastatic bowel cancer (under palliative care), COPD, heart failure, frailty. Treated for sepsis, but after a course of abx and some improvement, patient then suffered a further deterioration and died.	AMBER	Case reviewed in medical patient safety meeting. Downgraded to Amber and learning point around documentation of decision making.
83 female, Dementia, bed bound, hoisted. Long-term catheter removed previous admission. Presented with urosepsis, MDR e-coli.	RED	Coroners Investigation closed on 1/7/2024

Deteriorated and suffered UGI bleed.		Cause of death: Aspiration Pneumonia (Natural causes) PSII Ongoing at trust level – for review at mortality outcomes group following this
73 female, spinal stenosis, COPD Previous ICU admission for accidental opiate OD – not thought appropriate for readmission. Presented again with accidental Opiate OD. Naloxone infusion commenced after minor response to boluses. Progressed to multiple organ failure.	RED	Issue with confusion around naloxone use and morphine for symptom control Awaiting inquest outcome then review at mortality outcomes group

2. Key learning points

Update 24	<u>Imaging with contrast</u> Inpatients who receive imaging with contrast are at a higher risk of renal complications if their fluids are not correctly managed. Please consider IV fluids for these patients as they are particularly vulnerable	<u>Observe caution in the use of Lorazepam in the elderly.</u> Click here Guidance is given in the Delerium assessment and management pro-forma under the elderly & frail, medication, ED section of the intranet ***Start low and go slow*** Haloperidol or Lorazepam if haloperidol contraindicated
Update 24 Cont.	<u>DNACPR communications on Transfer</u> On a transfer form there is a specific box to indicate a DNACPR in place, this must be ticked and they must ensure the lilac form is prominent at the front of the case	
Update 23	<u>GKI (Glucose / Potassium / Insulin regime)</u> This is only to be used with patients who have a definite diagnosis of diabetes. If used on patients that are non-diabetic, this can lead to a detrimental outcome.	<u>Palliative Care (SPCT)</u> • Methadone should not be stopped, this can be given via, syringe driver, contact SPCT for advice • Blood glucose monitoring may still be required on a dying patient who is T1DM to prevent the further detrimental impact of a hypoglycaemic episode during their vulnerable stage of dying. • Parkinsons medication can be converted to a patch (conversion charts available via the intranet) • Anti-convulsion medication should not be stopped, can be given via syringe driver, contact SPCT for advice • Fentanyl patches must not be removed, they are to continue to be replaced as patients are dying. • Consider environmental factors before using benzodiazepines i.e. have the patients passed urine, do they smoke, have we prescribed a nicotine patch, when did they last have bowels open?
Further updates can be found on the intranet Learning from Action		

Learning into Action

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

Coroners Cases Q4 – STHK

Total referrals	99
Inquests	8
PFD (Preventing future deaths)	0

Coroners Cases Q4 – S&O

Coroners Inquests Concluded in Q4

- Misadventure 2
- Narrative 2
- Natural Causes 3
- Open Verdict 1

Important Themes

- Unwitnessed falls in hospital / falls in community
- Pressure Ulcers
- Radiology reporting

ENDS

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	30 October 2024
Agenda Item	**TB24/076**			
Report Title	**Aggregated Incidents, Complaints and Claims Report** (Quarter 1 and 2, 2024/25)			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery & Governance			
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery & Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

The aim of this paper is to provide the Board with a report on the management of incidents, complaints, concerns and claims during Quarter 1 and Quarter 2 2024/25

Executive Summary

Incidents

- 5,556 in Q1 and 5,707 incidents reported in Q2 at STHK.
- 2,719 in Q1 and 3,055 incidents reported in Q2 at S&O.
- 4,236 patient safety incidents in Q1 and 4,311 patient safety incidents reported in Q2 at STHK.
- 2,100 patient safety incidents in Q1 and 2,360 patient safety incidents reported in Q2 at S&O.
- 27 patient safety incidents graded as moderate or above during Q1 and 22 patient incidents of moderate or above during Q2 at legacy STHK.
- 25 patient safety incidents graded as moderate or above during Q1 and 24 patient incidents of moderate or above during Q2 at legacy S&O.

Complaints

- The Trust received 109 complaints in Quarter 1 and responded to 139.
- The Trust received 122 complaints in Quarter 2 and responded to 156.
- Clinical treatment was the main reason for complaints, in line with previous quarters.
- Emergency Department remained the main areas to receive complaints.

PALS

- The Trust received 1,167 PALS enquiries in Q1, and 1,117 in Q2 (excluding signposting).

Claims

- In Q1 the Trust received 20 new confirmed claims and 59 requests for medical records.
- In Q2 the Trust received 21 new confirmed claims and 52 requests for medical records.
- The Trust successfully defended 2 cases at trial during this period, with both claimants found to be fundamentally dishonest.

Inquests

- The Trust was notified of 28 new inquests in Q1 and concluded 35.
- The Trust was notified of 33 new inquests in Q2 and concluded 31.

The report presents combined data, where available, for the whole of MWL.

Financial Implications

None as a direct consequence of this paper.

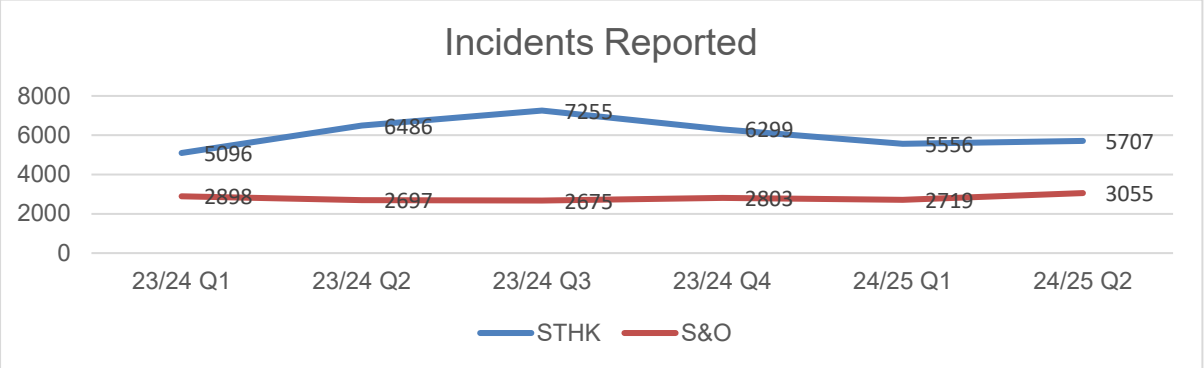
Quality and/or Equality Impact

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

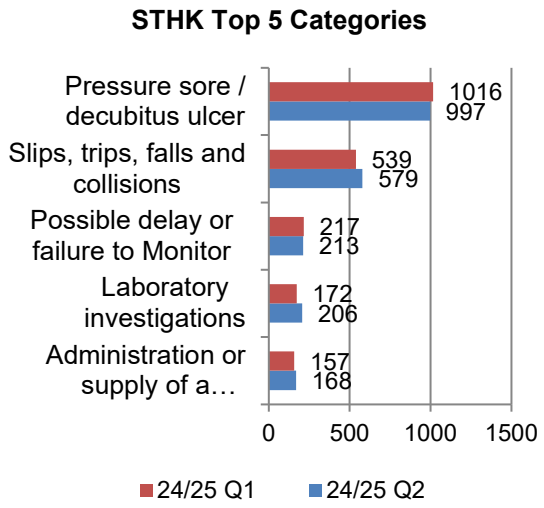
1. Introduction

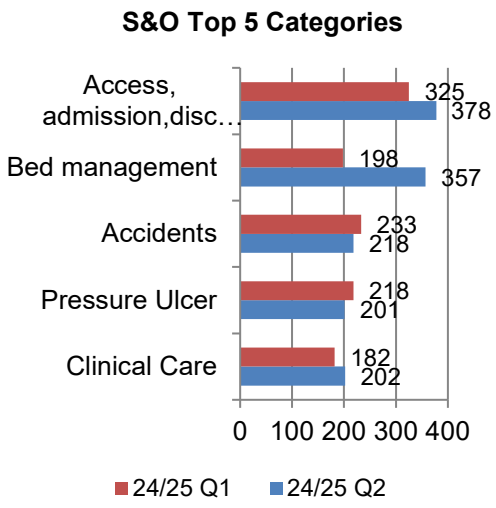
This paper includes reported incidents, complaints, PALS concerns, claims and inquests during quarter 1 and 2 2024-25, highlighting any trends, areas of concern and the learning that has taken place. The Trust uses Datix to record incidents, complaints, PALS and claims, with two different Datix systems in use from legacy organisations. The Trust IS currently undergoing a project to migrate to the new incident reporting system, InPhase, with an estimated launch date of January 2025. This new system will incorporate both legacy organisations' data into the new MWL amalgamated reporting system. InPhase is compatible with Patient Safety Incident Response Framework (PSIRF) reporting and will ensure we meet the NHS England requirements by the end of 2024-25.

2. Incidents



STHK Q1	STHK Q2	S&O Q1	S&O Q2	
4236	4311	2100	2360	Incidents affecting patients
424	442	303	303	Incidents affecting staff
856	924	293	384	Incidents affecting the Trust or other organisation
40	30	22	8	Incidents affecting visitors, contractors or members of the public





- STHK sites recorded a slight rise in total incidents during Q1 and Q2 2024-25. This is due to the number of reported pressure ulcers/decubitus ulcers, which was the top category in Q1 and Q2. Processes are now in place with a slight reduction of these incidents noted in Q2. Key themes identified through investigation are in relation of completion of contemporaneous care records, especially repositioning charts and early implementation of prevention devices. The Tissue Viability Nursing (TVN) team continue to identify areas of concern, deliver ward education and provide ongoing quality improvement to ensure the sustained reduction in the amount of avoidable harm that occurs from pressure ulcers.
- Slips, trips and falls remain one of the highest reported categories on STHK sites in Q1 (539) and Q2 (579).
- Access, admissions, discharge etc incidents are the highest reported incidents at S&O for Q1 and Q2, which includes sub-categories such as 12 hours breaches, delay transfer to wards & lost to follow up.
- The StEIS framework was closed at the end of Q2 2023-24 and Patient Safety Incident Response Framework (PSIRF) was launched on 1st October 2023. Both STHK and S&O sites now report to PSIRF as a combined service.

2.1 Patient Safety Incident Investigations (PSII) and Learning Reviews/ Expanded Learning Reviews

The management of patient safety includes not only identification, reporting and investigation of each incident, but also the implementation of any recommendations following investigation, dissemination of learning to prevent recurrence and implementation of changes in practice when required. Please see table below for Q1 and Q2 activity.

Q1 & Q2 2024-25	Total
Learning Reviews	37
Expanded Learning Reviews	13
Number of PSIIs commissioned	7
MDT	3

STHK	2023-24 Q1	2023-24 Q2	2023-24 Q3	2023-24 Q4	2024-25 Q1	2024-25 Q2
Moderate	25	20	32	18	19	13
Severe	5	10	8	8	8	8
Death	3	8	6	6	0	1
Total	33	38	46	32	27	22
S&O	Q1	Q2	Q3	Q4	Q1	Q2
Moderate	11	11	21	17	18	22
Severe	2	8	1	2	7	1
Death	1	0	0	0	0	1
Total	14	19	22	19	25	24

2.2 Duty of Candour

Duty of candour was completed for all cases reported during Q1 and Q2. Duty of candour is completed for all patient safety incidents graded as moderate or above harm.

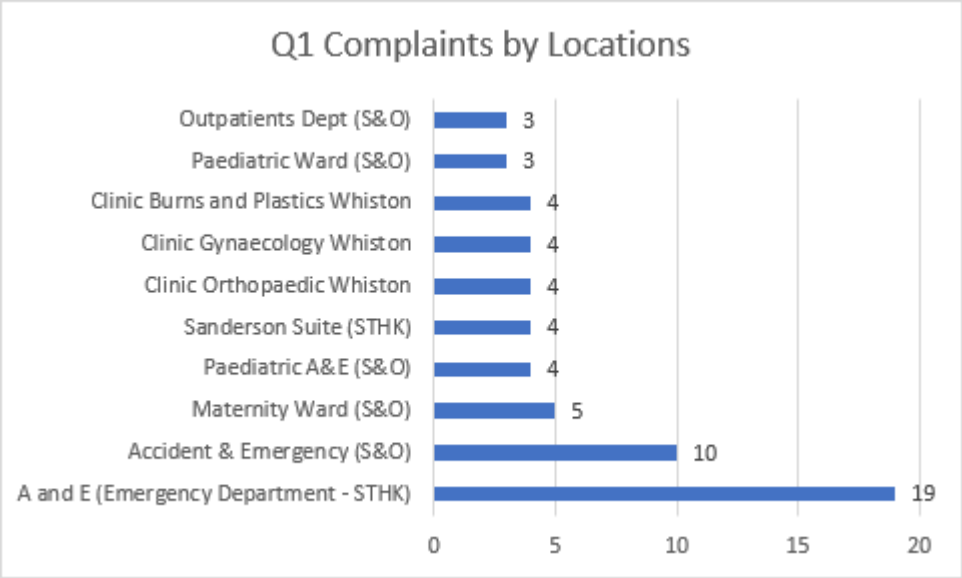
3. Complaints

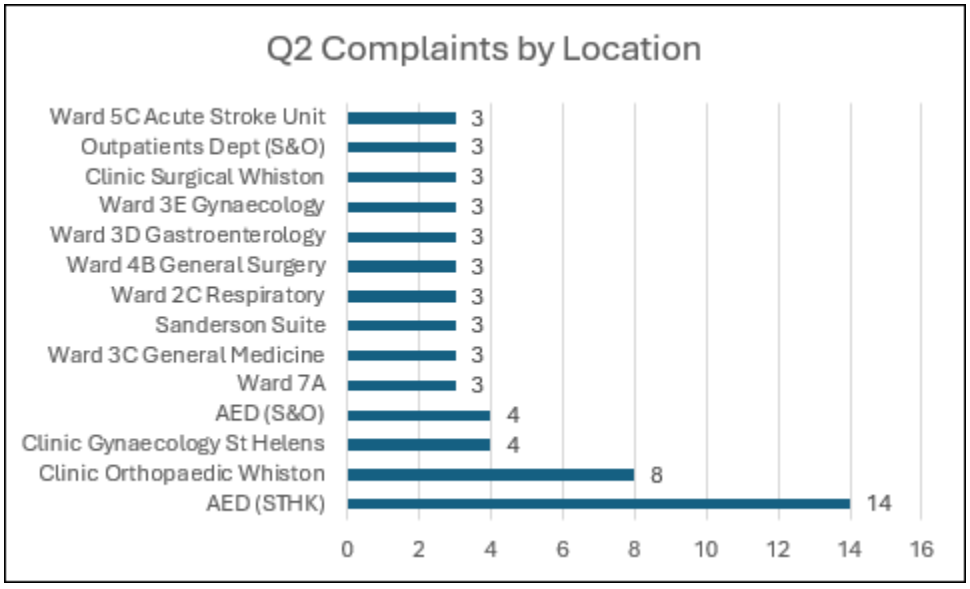
Indicator	22-23	23-24	23-24	23-24	23-24	24-25	24-25
Quarter	**Year**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Total number of new complaints	213 (247)	54 (39)	101	96	130	109	122
Second stage complaints Target <12 per Q	38	9 (3)	16	8	12	14	13
Response to first stage complaints within 60 working days. Target 80%	75% (51%)	72% (55%)	75%	60.3%	53.5%	74.76%	57.44%

NB Figures in brackets represent S&O site

Closed Complaints	Q3 2023-24	Q4 2023-24	Q1 2024-25	Q2 2024-25
Not Upheld	37	20	35	44
Partially Upheld	57	64	80	94
Upheld	22	15	24	18
Total	116	99	139	156

Top 5 Themes	Q3 2023-24	Q4 2023-24	Q1 2024-25	Q2 2024-25
Clinical Treatment	54	69	84	68
Patient Care (Nursing)	11	17	10	11
Values & Behaviours	7	13	12	12
Communication	12	15	1	19
Admission & Discharge	9	5	6	8





The number of complaints being made is increasing across all Trust sites, with the exception of month 6. The varying complexity of some of these complaints has also increased. Staff are continuing to make every effort to improve the Trust's performance against the 60 day timescale within this current financial year and the green shoots of this work show promise and progress will be reported on in the next reporting round.

Work has begun, led by the Head of Complaints, around defining responsibilities and expectations with Corporate and Directorate Leads within the new and developing divisions around improving response times and quality of statements.

A targeted and focussed drive to reduce the number of breached complaints was successful during late August/September and thanks offered to colleagues for their support.

Some examples of lessons learned during this reporting window are:

- A noise reduction checklist is to be added to the induction checklist for bank staff new to the ward.

- Staff to take thought before giving patients up to date information on their clinical tests in the middle of the night.

- Staff to ensure requests are actioned pre-discharge.

- That pharmacy will review with colleagues whether amendment of antibiotic guidance regarding nitrofurantoin in patients who have swallowing difficulties would be useful.

- That pharmacy will provide a Lessons Learnt bulletin for dispensary staff to escalate items which are out of stock to pharmacist at the earliest opportunity.

- That pharmacy will review with a view to expand ward based pharmacy technician service to support with discharges.

- Staff to ensure that they cross reference appointment to identify if a referred patient is new so that they appear on the 18-week pathway.

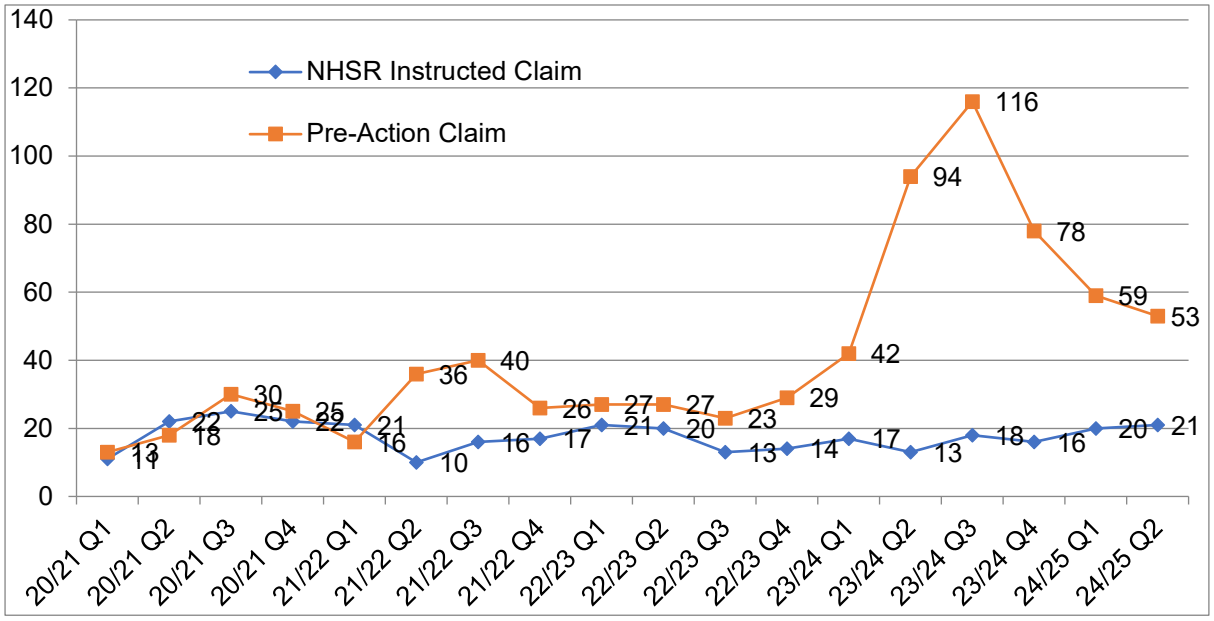
4. PALS Contacts for MWL

PALS	Q3 2023-24	Q4 2023-24	Q1 2024-25	Q2 2024-25
Number received	1099	1077	1167	1117

	Top five PALS themes
2023-24 Q3 STHK	1. Communications 2. Admissions and discharges 3. Clinical treatment 4. Appointments 5. Waiting Times
2023-24 Q4 S&O	1. Clinical Care 2. Communication 3. Values/behaviours and attitude 4. Length of waiting time for appointments 5. Patient property
2024-25 Q1 STHK	1. Communication 2. Clinical treatment 3. Admissions 4. Appointments 5. Nursing Care
2024-25 Q1 S&O	1. Clinical Care 2. Communication 3. Values/behaviours and attitude 4. Length of waiting time for appointments 5. Discharge

2024-25 Q2 STHK	1. Communication 2. Clinical Treatment 3. Admissions and Discharges 4. Appointments 5. Values and Behaviours
2024-25 Q2 S&O	1. Clinical Care 2. Communications 3. Values/Behaviours/Attitude 4. Appointment Waiting Times 5. Patient Property

5. New Clinical Negligence Claims

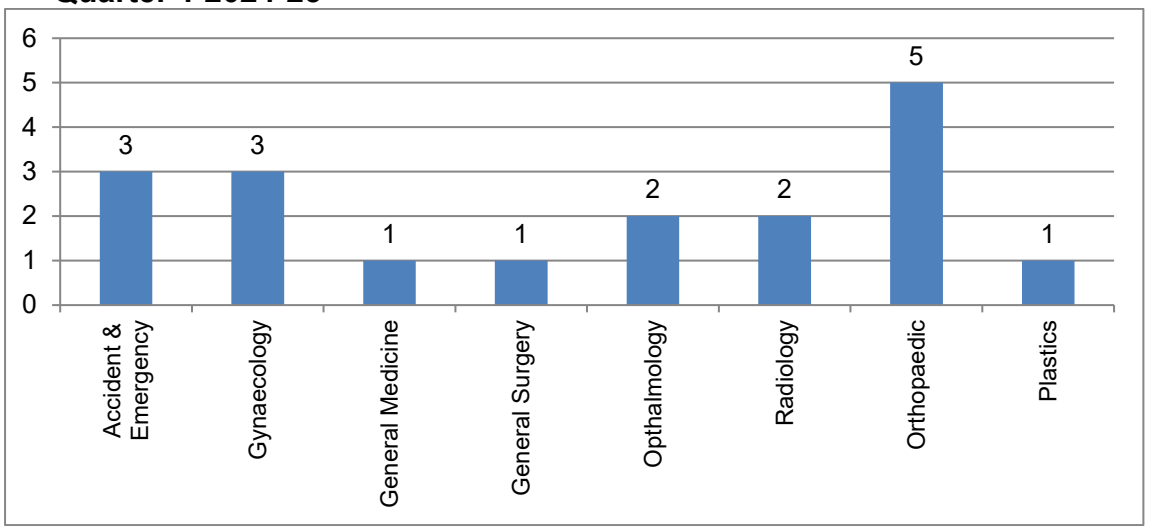


*Combined data for MWL is included from Q1 2023/24

Requests for records appear to be returning to an expected level, as the new fixed costs regime commences for lower value clinical negligence cases. We will continue to monitor whether this leads to an increase is formal claims (the blue line). We are aware there are still a number of cases where limitation was extended during COVID, meaning that the claimant has longer than 3 years to formally commence the claim.

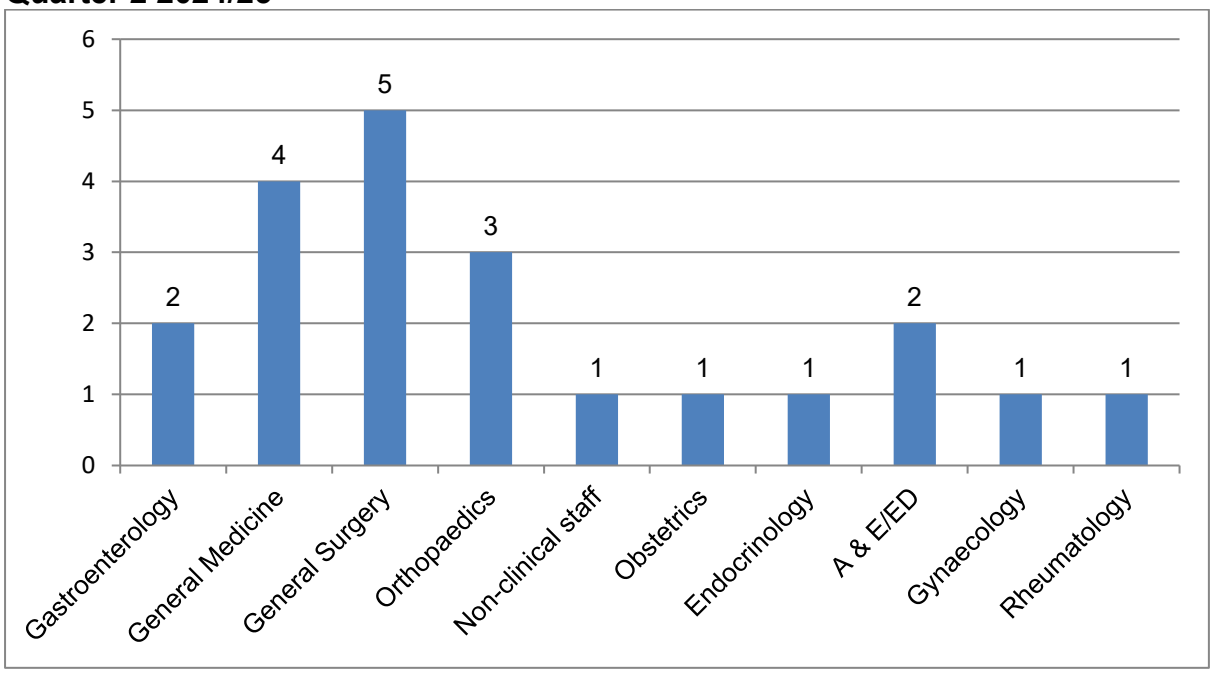
5.1 New claims by speciality

Quarter 1 2024-25



In Q1 there were 5 new claims involving orthopaedic care. This reflects an increased number of claims in previous quarters. There is no consistent pattern, and 1 and 4 are potentially mis-classified as Orthopaedic claims. 3 of the claims relate to delays in appropriate treatment, and 2 are that the surgery itself was not the expected standard.

Quarter 2 2024/25



In Q2 general medicine and general surgery received the most claims, despite only having 1 each in the previous quarter. The higher number of Orthopaedic claims has not persisted from Q1.

1.2 Closed Claims

The Trust closed 42 claims in Q1 and 65 in Q2. The majority of these were closed following a file review.

In Q2 judgment was handed down in two matters where the Trust had chosen to defend the allegations to trial. In both matters the court determined that the claimant had been fundamentally dishonest in claiming inflated damages for things that were either not true, or not attributable to anything the Trust was alleged to have done. The Trust continues to vigorously defend claims where we do not think they have merit, or where we believe the claimant has been dishonest.

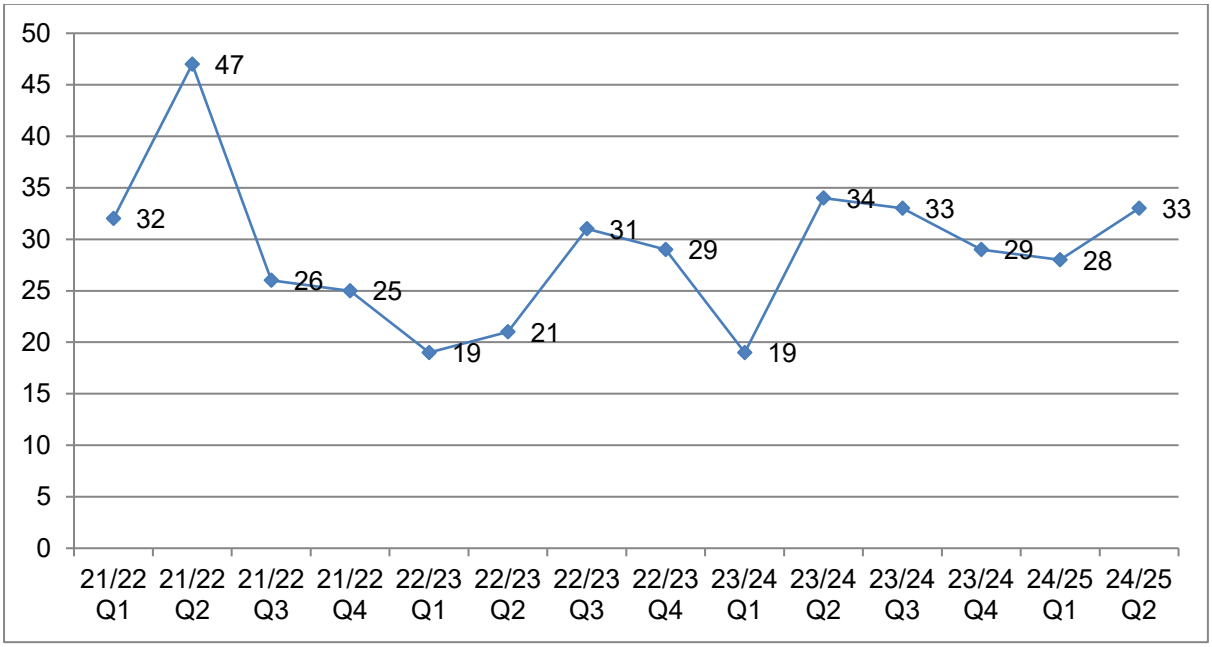
1.3 Lessons Learned from Claims

The case below is an example of a case where new learning and actions resulted from the claim itself, as opposed to any previous internal investigation:

The claimant underwent a below knee amputation case as a result (in part) of delays in the diabetic podiatry service receiving and accepting a referral. A new electronic referral system between ourselves and podiatry has been put in place to reduce the risk of this happening.

6. Inquests

6.1. New Inquests



*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.

6.2. Closed inquests

The Trust closed 35 inquests during Q1 and 31 in Q2. No Prevention of Future Death notices from the Coroner were received during that period.

The Coroner did seek, and was provided with, additional assurance around our ability to ensure that pathology requests are marked in a way that guarantees they are dealt with on an urgent basis. The Divisional Director for Surgery wrote to the Coroner to explain the complexity of the tests in this case, and to offer assurance that the Trust had robust processes in place to ensure timely diagnosis. This specifically covered work to be done about correctly marking requests. The Coroner was satisfied following this.

7. Recommendations

It is recommended that the Board note the report and the actions taken as a result of inquests and claims.

Title of Meeting	**Trust Board**		**Date**	30 October 2024
Agenda Item	**TB24/077 (12.1)**			
Report Title	Workforce Race Equality Standard Report (WRES)			
Executive Lead	Malise Szpakowska, Acting Director of Human Resources			
Presenting Officer	Malise Szpakowska, Acting Director of Human Resources			
Action Required	X	**To Approve**		**To Note**

Purpose

This report provides an overview and analysis of the Trust's Workforce Race Equality Standard (WRES) for 2023/2024 (March 2024).

This report provides an overview and analysis of the Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) with relevant trended data from MWL, legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and Southport and Ormskirk Hospital NHS Trust (S&O) and national data where available.

Executive Summary

Summary: The following is an overview of the WRES Highlights for 2023/2024.

The Trust has taken steps to start its journey to become a truly Anti-Racist organisation. Activity is in the early stages of development to apply for the Northwest Anti-Racism Framework accreditation with the intention to apply in the next application round. We completed a ward engagement activity with Black, Asian and Minority Ethnic (BME) staff to understand their experiences and launched a programme of Career Development Workshops for Band 5 BME Nurses. We have continued to review options to develop a reverse mentoring programme and implement EDI SMART targets for the Trust leaders, both of which will support future progress in this area.

Overall, the Trust continues to improve of key race equality metrics, including the proportion of BME staff within the workforce, and at key unrepresented bands, as well as improvements in most staff survey results. However key issues remain with the higher proportions of BME staff reporting more negative experiences than White staff in the staff survey.

We intend to complete a lessons learned exercise following the response to the Southport incident to ensure that we have effective mechanism to support staff in future race related social disturbances.

Going forward, we will be looking to engage with all members of staff to listen, learning and collectively understand the challenges faced by BME individual in the workplace and community, and to take effective and meaningful action.

Overall, key metrics from the WRES assessment are:

Workforce data metrics:

- An increase in the proportion of total BME staff to 15.1%; non-clinical staff to 3.5%; Clinical Non-Medical staff to 15.6%; and Clinical Medical & Dental staff to 49.3%
- There was an increase in the proportion of BME Non-Clinical staff on Bands 2 to 6 and 8c. There were no declared BME staff on Bands 8d, 9 or VSM.
- There was an increase in the proportion of Clinical Non-Medical BME staff on Bands 2 to 8c. There were no declared BME staff on Bands 8d, 9 or Very Senior Manager (VSM).

- There was an increase in the proportion of all Clinical Medical & Dental bands,
- BME applicants as a population are less likely to be appointed from shortlisting compared to White applicants.
- BME staff less likely to enter disciplinary process than White staff.
- BME staff are more likely than White staff to access non-mandatory training or continuing professional development (CPD).

Staff survey data:

- 25.8% BME staff state they have experienced bullying and harassment from a patient, family member or member of the public (27.8% nationally), compared to 21.4% of White staff, a difference of 4.4 points.
- 17.7% BME staff state they have experienced bullying and harassment from a colleague or manager (24.9% nationally), a difference of 0.0 points with White staff.
- 52.2% BME staff state they believe the Trust offers equality of opportunity in career progression (48.9% nationally), compared to 61.4% of White staff, a difference of 9.2 points
- 12% BME staff state they has experience discrimination from a manager or other colleague (15.5% nationally), compared to 4.3% of White staff, a difference of 7.7 points.
- 4.2% of the Trust Board is BME, lower than the workforce, but comparable with the local population, and higher than the non-clinical workforce.

Financial Implications

None

Quality and/or Equality Impact

This report is a regulatory requirement under the NHS Contract. It forms part of the Trust's work to promote race equality in line with the Equality Act 2010.

Recommendations

The Board is asked to note the Workforce Race Equality Standard Report (WRES) and approve the Action Plan.

Strategic Objectives

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

Workforce Race Equality Standard Report
Data Summary

April 2023 – March 2024

1. Executive Summary

This report provides the Trust Executive with the Annual Workforce Race Equality Standard (WRES) data for the Mersey & West Lancashire Teaching Hospitals Trust for the first time following its creation in 2023. The publication of this report is for the period 2023-2024 in line with the NHS Standard Contract requirements to publish the WRES indicators.

2. Introduction

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

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

3. A year in review: 2023-2024

The Trust has worked to implement anti-racism actions agreed within the 2023 WRES report, as well as the EDI Operational Plan 2022-2025, activity to support the implementation of the NHS EDI High Impact Actions[1] (HIA), the Equality Delivery System[2] (EDS) and our commitment to join the NW Anti-Racism Framework[3].

Key activities that have taken place between November 2023-October 2024 include:

- **Our Southport Response**: In response to the race-related tension and violence that erupted following the attack on school children in Southport on the 29th of July 2024, the Trust took a number of steps to support our colleagues who were directly and indirectly impacted by the incident, as well as the subsequent racial violence. Actions taken included critical incident response support by Health Work and Wellbeing, a series of EDI and HR drop ins across all Trust sites for those staff wanting support, a listening exercise

[1] NHS EDI Improvement Plan High Impact Actions
[2] NHS Equality Delivery System
[3] NHS North West BAME Assembly

with our BME colleagues and allies, as well as a series of HR support options, such as travel to and from work, lone working, and personal safety support.

- **EDI SMART Targets (HIA1)**: The Trust Executive agreed to develop personal EDI SMART Targets during their appraisal, as well as for their direct reports. In addition, from 2025, an EDI Target will be added into the appraisal form for all members of staff. A key outcome of this has been the appointment of Rob Cooper (Chief Executive elect) as the Trusts Senior Race Champion

- **Ethnicity Pay Gap (HIA3)**: Having completed the Ethnicity Pay Gap since 2022, this year the Trust will publish its results in line with the requirements of the NHS High Impact Actions. Furthermore, the Trust has completed additional levels of analysis (not included in the published report) for the different ethnic groups, as well as intersectional data by sex and ethnicity. Overall, the Trust and Agenda for Change Ethnicity Pay Gaps are in favour of our BME staff, with the pay gap for Medical & Dental staff in favour of our White medics.

- **Widening Recruitment (HIA4):** Following the creation of MWL in 2023, work has been ongoing to standardise the Trusts Work Experience, Volunteering, Outreach offer, and approach to Apprenticeships. A number of relationships have been formed with High Schools/Colleges to provide visit days, guest speakers and work experience, as well as taster days hosted onsite. Work is ongoing to create career progression resources

- **North West Anti-Racism Framework**: Following the launch of the new format of the North West Anti-Racism Framework, the Trust has committed to apply for the Bronze award level in 2025. Preliminary work has begun scoping out the activities and evidence of the assessment, as well as developing our understanding of the application and marking process from the NW BAME Assembly and lessons learned from the most recent application rounds. Rob Cooper (Chief Executive elect) is now the Trusts Anti-Racism champion, with anti-racism round table events taking place in October 2024 as a springboard for the generation of the Trusts anti-racism activity.

- **Online Resources**: The EDI (Workforce) Team has continued to expand the online resource available to staff, including extending all materials to Southport & Ormskirk colleagues. Resources now include an Anti-racism Hub which provides recommended reading and watching lists, key terminology definitions, sign posting to NHS, local and national groups and resources, and information on being an anti-racism ally. Furthermore, information on cultural awareness, bullying and harassment, and hate crimes has continued to be expanded and refined.

- **Cultural Awareness**: The Trust has worked to raise awareness of race equality topics by engaging in events including Black History Month and Wear

Red Day; as well as promoting/marking dates such as South Asian History Month, Ramadan, Eid, and Diwali. Through our Anti-Racism Pledge, we have engaged with hundreds of staff to commit to being an anti-racist ally.

- **Staff Training**: The trust piloted a career development workshop for Band 5 BME nurses and midwives following the results of the 2022 staff survey and an engagement exercise with BME clinical colleagues. The aim of the session was to support Band 5 BME staff to understand and reflect on progressing to a Band 6 role, as well as the application/TRAC processes, and application/interview key skills (actions support HIA3 & 5). Furthermore, the Trust continued to offer training on Unconscious Bias, Harassment & Discrimination, and Conflict Resolution, as well as Violence & Abuse drop ins with the security team; and zero tolerance posters are now available across the Trust (actions support HIA6).

Actions from the previous year which continue to be ongoing in their development include the reverse mentoring proposals, the online bullying and harassment reporting portal, and a Anti-Racism training offer. All of these project continue to be live and papers developed in due course for consideration.

4. The 9 WRES indicators

The WRES is an analysis of the following 9 data indicators, relating to workforce, recruitment, disciplinary, staff satisfaction, and board diversity:

1. **Staff Population**: Percentage of White and BME staff who are Non-Clinical, Clinical Non-Medical, by Agender for Change (AfC) pay bands, and Clinical Medical & Dental roles.
2. **Recruitment & Selection**: Relative likelihood of staff being appointed from shortlisting across all posts.
3. **Disciplinary**: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. **Training**: Relative likelihood of staff accessing non-mandatory training and Continuing Professional Development (CPD).
5. **Harassment from Patients**: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months,
6. **Harassment from Staff:** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months,
7. **Equality in Career Progression**: Percentage of staff believing that the trust provides equal opportunities for career progression or promotion,
8. **Discrimination**: In the last 12 months have you personally experienced discrimination at work from any of the following, a manager/team leader, or other colleagues,
9. **Board Representation**: Percentage difference between the organisations' Board membership and its overall workforce disaggregated: By voting membership of the Board; By executive membership of the Board.

4.1. Data and Methodology

Before reading the report, please familiarise yourself with the following information which provides a summary of the data sources and limitations. The time periods for the data sets are as follows:

- **Indicators 1 and 9**: snapshot date of the 31st March,
- **Indicators 2-4**: period from the 1st April to 31st March,
- **Indicators 5-8:** the relevant staff survey that took place between the 1st April to 31st March, usually in November/December.

The Trust collates data for Indicators 1-4 and 9 directly from Employee Staff Record (ESR), the TRAC recruitment system and HR Business Partners to create a final data set.

Benchmarking data has been sourced from the national staff survey website and Trust Staff Survey data[4] (2021-2023), Model Health system[5] (2020-2024), and the 2023 national WRES report[6]. Where 2024 data is not available, 2023 data has been provided.

4.1.1. MWL Trended Data

The previous years reports were provided for both legacy Trusts. Where it has been possible to do so, data from the legacy trusts has been combined to create a MWL data set for previous years. Where this has not been possible the legacy data has been provided.

4.1.2. Scope of reported population

The following data principles are applied to the WRES data:

- Data relates to the total substantive workforce on the relevant snapshot date with the exception of Indicator 1 which disaggregates the data by Non-Clinical, Clinical Non-Medical and Clinical-Medical, and by Pay Band.
- Medical staff are included, and the Medical WRES pilot was not repeated this year.
- Bank staff are not included and the Bank WRES pilot was not repeated this year.
- WRES data is only reported on the broad ethnicity categories of Black and Minority Ethnic (BME), White, and Unknown.

The WRES submission does not provide an in-depth analysis of the different demographics of the NHS workforce or the different source population and talent pipelines that make up the career groups, for example staff group is not analysed, nor data disaggregated by UK/Overseas domiciled or educated.

[4] NHS Staff Survey
[5] Model Health System (log in required)
[6] NHS WRES 2023 Data

4.1.3. Note on terminology

The report uses the term Black & Minority Ethnic (BME) to refer to all staff from a non-white ethnic minority group. This would include all staff who have identified as Asian, Black, Mixed/Dual Heritage, and Other. The term is comparable with Black, Asian & Minority Ethnic (BAME), People of Colour (PoC), Global Majority, Ethnic Minority, and Minority Ethnic.

5. Workforce WRES Data

5.1. Staff Profile Workforce Overview

In the snapshot date of 31st March 2024, Mersey & West Lancashire Teaching Hospitals Trust (MWL) employed 10,733 staff which consisted of:

- 15.1% Black and Minority Ethnic staff (BME)
- 81.2% White staff
- 3.7% Not Stated/ unspecified / prefer not to answer.

Over the past 5 years (2020 v 2024), MWL has seen a year-on-year increase in the number and proportion of BME staff in the total workforce (834/9.0% to 1623/15.1%), Non-Clinical (65/2.3% to 106/3.5%), Clinical Non-Medical (501/8.1% to 1052/15.6%) and Clinical Medical & Dental (M&D) (355/43.4% to 465/49.3%) (Figure 1). Further details for each category are set out below.

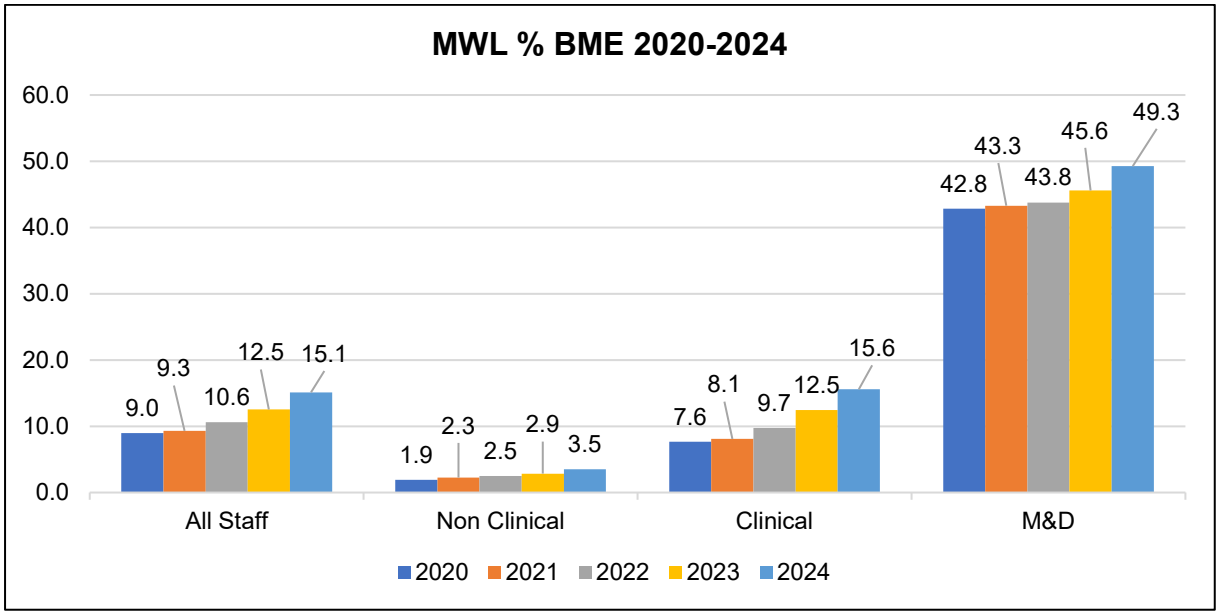


Figure 1

5.2. Indicator 1: Non-Clinical and Clinical Workforce

Indicator 1 is a review of the staff population by Non-Clinical Workforce by Agenda for Change (AfC) pay bands; Clinical Workforce not Medical by AfC pay bands; and Clinical Workforce Medical and Dental.

From March 2023 to March 2024, there was an increase in the number and proportion of BME staff:

- The total workforce from 1109 (11.8%) to 1623 (15.1%).
- Non-Clinical staff from 85 (2.9%) to 106 (3.5%)
- Clinical Non-Medical roles from 621 (11.3%) to 1052 (15.6%)
- Clinical Medical & Dental roles from 403 (45.6%) to 465 (49.3%)

Overall, the proportion of BME staff in non-clinical roles is 3.5% (Table 1), slightly lower than the local BME population of Sefton and Knowsley, but higher than West Lancashire (Table 2). The proportion of BME staff in clinical roles is significantly higher than the local population and reflects national trends in nursing and medicine specifically, as well as overseas recruitment activities.

Table 1: Staff Headcount

Staff Headcount March 2024	White	BME	Unk	%BME MWL (2024)	%BME National (2023)
Total	8713	1623	397	15.1%	26.4%
Non-Clinical Workforce (AfC)	2818	106	113	3.5%	17.3%
Clinical Non-Medical Workforce (AfC)	5481	1052	219	15.6%	26.9%
Medical and Dental Workforce	414	465	65	49.3%	46.8%

Table 2: Population Benchmarks

Benchmarks	%White	%BME	%Unk
MWL Total	81.2%	15.1%	3.7%
National (2023)	69.1%	26.4%	4.4%
North West (2023)	78.9%	17.1%	3.9%
National Census: Sefton	95.8%	4.2%	-
National Census: St Helens	96.5%	3.5%	-
National Census: Knowsley	95.3%	4.7%	-
National Census: West Lancashire	96.9%	3.1%	-
National Census: C&M ICB Area	93.0	7.0%	-
National Census: Liverpool City Region	91.7	7.3%	-

5.2.1. Indicator 1a: Non-Clinical workforce

The Non-Clinical workforce includes staff in administration, clerical and estates type of roles. Key observations:

- The total number of BME Non-Clinical staff increased from 85 to 106, with an increase in the number and proportion of BME staff on bands 2-6, and 8c (Table 3).
- There were no declared BME staff on Bands 8d, 9 or VSM.
- Compared to the lowest local population, the proportion of BME staff are underrepresented on Bands 4 and 8b, with the remaining bands within the range of 3.1%-4.7%.

Table 3: Staff Headcount Non-Clinical Workforce

MWL	2023		2024	
	% White	% BME	% White	% BME
Band 1	87.0%	0.0%	100.0%	0.0%
Band 2	88.9%	3.8%	90.3%	4.4%
Band 3	91.4%	3.3%	92.3%	4.4%
Band 4	95.8%	1.2%	96.4%	1.6%
Band 5	89.8%	3.8%	91.9%	4.5%
Band 6	93.4%	1.3%	91.9%	3.1%
Band 7	92.2%	3.3%	95.5%	3.2%
Band 8A	82.8%	4.7%	92.2%	3.1%
Band 8B	96.0%	2.7%	93.1%	1.4%
Band 8C	88.9%	0.0%	88.5%	3.9%
Band 8D	88.9%	0.0%	100.0%	0.0%
Band 9	100.0%	0.0%	100.0%	0.0%
VSM	91.7%	0.0%	91.7%	0.0%
Total	91.3%	2.9%	92.8%	3.5%

5.2.1.1. Race Disparity Ratio Non-Clinical Staff

The WRES report calculates a “race disparity ratio” which is difference between the proportion of BME Non-Clinical staff in AfC bands Lower v Middle, Middle v Upper, and Lower v Upper; where Lower means bands 1-5, Middle bands 6-7, and Upper bands 8+. A ratio value of 1 means that there is no difference, a ratio of <1 means BME staff are more represented in the higher band, and a ratio of >1 means that White staff are more represented in the higher band.

Overall, the Trust has a low race disparity between the AfC band groups comparing favourably to benchmarks indicating that BME staff are able to progress up the pay bands at the Trust (Table 4).

Table 4: Non-Clinical Staff Race Disparity Ratio

	MWL	C&M ICB (2023)	Peer Median (2023)	National Median (2023)
Lower (bands 1-5)	0.6	0.9	1.1	1.0

Middle (bands 6-7)	1.2	1.0	1.6	1.5
Upper (band 8+)	0.8	0.9	1.6	1.5

5.2.2. Indicator 1b: Clinical workforce: Non-Medical

The Clinical Non-Medical workforce includes all allied health professionals, nursing and midwifery staff and relevant support staff. Key observations:

- The total number of BME Clinical Non-Medical staff increased from 818 (12.5%) to 1052 (15.6%), with an increase in the number and proportion of BME staff on bands 2 to 8c (Table 5)
- There were no declared BME staff on Bands 8d, 9 or VSM.
- Compared to the local population, the proportion of BME staff is equal to or exceeds the Knowsley census population of 4.7%, with the proportion of BME staff on Bands 2, 4-6 and 8A exceeding the population of the Liverpool City Region.

Table 5: Staff Headcount Clinical Non-Medical Workforce

MWL	2023		2024	
	% White	% BME	% White	% BME
Band 1	100.0%	0.0%	100.0%	0.0%
Band 2	88.5%	6.0%	85.2%	10.2%
Band 3	89.5%	4.5%	92.0%	4.7%
Band 4	90.4%	7.1%	88.5%	9.7%
Band 5	63.8%	27.2%	63.1%	33.3%
Band 6	87.2%	7.9%	86.8%	10.8%
Band 7	91.2%	5.1%	92.0%	5.7%
Band 8A	86.8%	8.5%	89.0%	8.9%
Band 8B	95.5%	0.00%	90.9%	4.6%
Band 8C	88.9%	5.6%	94.1%	5.9%
Band 8D	100.0%	0.0%	100.0%	0.0%
Band 9	100.0%	0.0%	100.0%	0.0%
VSM	0.0%	0.0%	100.0%	0.0%
Total	81.4%	12.5%	81.2%	15.6%

5.2.2.1. Race Disparity Ratio Non-Clinical Staff

Overall, the Trust has a mixed-race disparity (Table 6) between the Clinical AfC band groups:

- For the Lower Bands, the Trust places in the 3rd quartile of trusts nationally, along with C&M ICB.
- For the Middle Bands, the Trust places in the 1st quartile (best) of trusts nationally, along with the C&M ICB,
- For the Upper bands, the Trust places in the 2nd quartile of trusts nationally, along with the C&M ICB.

As our data shows, 33% of Band 5 Clinical AfC staff are BME, which is a reflection of the Trust nursing population, specifically overseas recruited nurses. There is a drop off between band 5 and 6 reflected in the lower ratio calculation. Although there is no BME staff on band 8d+, the proportion of BME individual on Bands 6-8c have all increased, working to reduce the race disparity.

Table 6: Non-Clinical Staff Race Disparity Ratio

	MWL	C&M ICB (2023)	Peer Median (2023)	National Median (2023)
Lower (bands 1-5)	2.7	2.6	2.5	2.3
Middle (bands 6-7)	1.1	1.2	1.8	1.6
Upper (band 8+)	2.9	3.1	4.3	3.5

5.2.3. Indicator 1c: Clinical workforce: Medical & Dental

The Clinical Medical & Dental workforce includes all staff on a medical and dental terms and conditions and includes Foundation and Specialist Doctors and Consultants. Key observations:

- The total number of BME Clinical Medical & Dental staff has increased from 403 (45.6%) to 465 (49.3%) and the total number of White staff has increased from 395 to 414 (Table 7).
- The main increase of BME staff was for Trainee Grades (121 to 166), and Consultants (174 to 194).
- Compared to the local population, the medical workforce is significantly overrepresented by BME individuals. This is a reflection of national trends on the medical workforce, as well as overseas recruitment into the NHS.

The WRES data does not calculate a race disparity ratio for medical and dental roles and is therefore not reported.

Table 7: Staff Headcount Clinical Medical & Dental Workforce

MWL	2023		2024	
	% White	% BME	% White	% BME
Consultants	52.0%	40.9%	52.8%	42.4%
Consultants also Senior medical manager	100.0%	0.0%	100.0%	0.0%
Non-consultant	23.2%	60.5%	22.8%	69.1%
Trainees	44.6%	45.3%	39.4%	51.9%
Other	93.3%	6.7%	70.6%	11.8%
Total MWL	44.7%	45.6%	43.9%	49.3%
Total National[7]	45.0%	50.4%	42.9%	52.8%

[7] Source: Model Hospital, Medical & Dental staff in post: Demographic

Medical data does not include Lead Employer doctors in training, including those who are on placement within the Trust.

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

Indicator 2 is an assessment of the Trusts recruitment and selection practices, and whether BME applicants are as likely as White applicants to be successfully shortlisted and appointed.

This indicator is assessed at “whole organisation” level and does not disaggregate the recruitment trends by job group or department where BME individual may be more or less likely to form part of the talent pool e.g., BME people are overrepresented in the medical and dental profession.

Table 8: Percentage of candidates appointed from shortlisting

MWL	White	BME	Unknown
2022-2023	34.19%	21.09%	56.05%
2023-2024	36.33%	20.35%	75.29%

Table 9: Relative likelihood of appointment from shortlisting

MWL	White	BME	Unknown
2022-2023	0.34	0.21	0.56
2023-2024	0.36	0.20	0.75

Table 10: Relative likelihood of White candidate being appointed from shortlisting compared to a BME candidate

MWL	Ratio	Peer Median	National	North West	Target Benchmark
2022-2023	1.62	1.44	1.59	1.58	0.8-1.25
2023-2024	1.79	tbc	tbc	tbc	tbc

A value <1 means that BME applicants are more likely to be appointed, and value >1 means they are less likely to be appointed. For example, a value of "2.0" would indicate that White candidates were twice as likely as BME candidates to be appointed from shortlisting, whilst a value of "0.5" would indicate that White candidates were half as likely as BME candidates to be appointed from shortlisting.

Key observations:

- White applicants who are shortlisted are more likely to be offered a post compared to BME applicants (Table 8, 9)
- The relative likelihood of white applicant being appointed compared to BME applicant stands at 1.8 times more likely than a BME applicant (Table 10).

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

Indicator 3 is an assessment of whether BME staff are more likely to face formal disciplinaries compared to White staff. There are relatively few formal disciplinaries each year, with 71 in 2021/2022, and 130 in 2022/2023 (Table 11).

Table 11: Likelihood of staff entering the formal disciplinary process

YES		STHK	S&O	MWL
2021-2022	White	1.06%	0.13%	
	BME	1.06%	0.00%	
	Unknown	1.11%	0.17%	
2022-2023	White	1.98%	0.16%	
	BME	1.33%	0.25%	
	Unknown	0.00%	0.25%	
2023-2024	White			1.81%
	BME			0.98%
	Unknown			0.00%

In 2023/2024 the relative likelihood measure for this indicator was 0.67 (Table 12), meaning that White staff were more likely than BME staff to enter formal disciplinary processes. This was a reduction from a likelihood of 1 in 2021/2022 which meant there was an equal likelihood.

A value <1 means that BME staff are less likely to enter formal disciplinary processes, and value >1 means they are more likely to enter formal disciplinary processes. For example, a value of "2.0" would indicate that BME staff were twice as likely as White staff to enter a formal disciplinary process, whilst a value of "0.5" would indicate that BME staff were half as likely as White staff to enter a formal disciplinary process.

Table 12: Relative likelihood of BME staff entering the formal disciplinary process compared to White staff

	MWL	STHK	S&O	Peer Median	National	North West	Target Benchmark
2021-2022		1.00	0.00	1.06	1.14	1.20	0.8-1.25
2022-2023		0.67	1.55	1.20	1.03	1.11	0.8-1.25
2023-2024	0.54			tbc	tbc	tbc	tbc

Table 13: Proportion of staff entering a Disciplinary process, %BME

	MWL	STHK	S&O	Peer Median	Provider Median
2021-2022		11.3%	9.2%	11.6%	18.6%
2022-2023		13.0%	11.7%	14.4%	21.0%
2023-2024	9.0%			tbc	tbc

Overall BME staff are less likely that White staff to enter a formal disciplinary process (Table 12, 13)

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

Indicator 4 is an assessment of whether BME staff have the same access to non-mandatory training and development as White staff.

Non-mandatory training refers to any learning, education, training, or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement or mandated by the organisation. All training and development recorded on ESR that is not classed as mandatory training has been included in this data.

The relative likelihood measure for this indicator was 0.78 (Table 14), meaning that BME staff were more likely than White staff to access non-mandatory training and CPD in the reporting period.

Table 14: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.

	MWL	STHK	S&O	Peer Median	National	North West	Target B'mark
2021-2022		1.03	0.97	1.00	1.12	1.18	0.8-1.25
2022-2023		1.00	0.96	1.00	1.12	1.14	0.8-1.25
2023-2024	0.78			tbc	tbc	tbc	tbc

6. Staff Survey Questions

The 2023 NHS Staff Survey was conducted between October and December 2023 and completed by 3928 staff (34% response rate).

For the purposes of this report, the 2023-2024 staff survey results have been sourced from the Trusts staff survey reports, with benchmarking data being sourced from the National Staff Survey results portal and Model Health.

6.1. Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months (Staff Survey)

Table 15: Harassment by patients

		21-22	22-23	23-24	Change
MWL	BME		30.2%	25.8%	-4.4
	White		26.4%	21.4%	-5.0
	All		26.9%	21.9%	-5.0
STHK	BME	29.7%	29.1%		
	White	25.5%	25.9%		
	All	25.9%	26.2%		
S&O	BME	28.8%	32.3%		
	White	26.1%	27.9%		
	All	28.3%	29.4%		
National	BME	29.3%	30.4%	27.8%	-2.6
	White	27.0%	26.8%	24.1%	-2.7
	All	27.6%	27.7%	25.2%	-2.5
North West	BME	26.4%	26.9%	tbc	tbc
	White	24.2%	24.2%	tbc	tbc
	All	24.9%	24.9%	22.3%	-2.6
C&M ICB	BME	-	-	25.4%	-
	White	-	-	19.3%	-
	All	24.3%	24.9%	21.2%	-3.7
Acute & Community	BME	16.1%	30.4%	27.6%	-2.8
	White	13.2%	26.7%	23.8%	-2.9
	All	27.4%	27.7%	25.0%	-2.7

Overall, there was a decrease in the proportion of staff reporting that they had experienced bullying and harassment from a patient, visitor, family member or member of the public (Table 15); although a higher proportion of BME staff (who are more likely to work in a patient facing role than white staff) is higher than that for white staff. Specifically, there was a:

- 5.0 point decrease in the proportion of staff reporting experiencing bullying and harassment from a patient et al,
- 5.0 point decrease in the proportion of White staff reporting experiencing bullying and harassment from a patient et al,
- 4.4 point decrease in the proportion of BME staff reporting experiencing bullying and harassment from a patient et al,

6.2. Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (Staff Survey)

Table 16: Harassment from Staff (Managers and Colleagues)

Yes		21-22	22-23	23-24	Change
MWL	BME			17.6%	-
	White			17.6%	-
STHK	BME	26.6%	24.2%		
	White	19.1%	17.2%		
S&O	BME	31.1%	35.4%		
	White	24.2%	26.8%		
National	BME	27.6%	27.7%	24.9%	-2.8
	White	22.5%	22.0%	20.7%	-1.3

Overall, the proportion of staff reporting that they have experienced bullying and harassment from another member of staff (manager or colleague) decreased for BME staff when compared to Legacy STHK and SOTH (Table 16). The Trusts response rate is lower than the National average. Specifically, there was a:

- 6.6 point decrease (STHK v MWL) and a 17.8 point decrease (SOTH v MWL) in the proportion of staff reporting experiencing bullying and harassment from another member of staff,
- 0.4 point increase (STHK v MWL) and a 9.2 point decrease (SOTH v MWL) in the proportion of White staff reporting experiencing bullying and harassment

6.3. Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (Staff Survey)

This staff survey question asks; *"Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?"* with the options to answer; Yes, No or Don't Know.

Table 17: Equal Opportunities in Career Progression

YES		21-22	22-23	23-24	Change
MWL	BME		46.5%	52.2%	+5.7
	White		61.3%	61.4%	+0.1
	All		59.5%	59.9%	+0.4
STHK	BME	48.3%	48.3%		
	White	64.5%	65.5%		
	All	62.5%	63.6%		
S&O	BME	48.5%	43.0%		
	White	50.9%	50.7%		
	All	50.3	49.5		
National	BME	44.4%	46.4%	48.9%	+2.5
	White	58.7%	59.1%	59.4%	+0.3
	All	55.6%	56.0%	56.4%	+0.4
North West	BME	45.3%	46.1%	tbc	-
	White	59.1%	59.5%	tbc	-
	All	56.7%	56.9%	56.9%	0.0
C&M ICB	BME	44.6%	44.9%	45.9%	+1.0
	White	-	-	-	
	All	57.3%	57.6%	57.3%	-0.3
Acute & Community	BME	43.9%	46.1%	48.6%	+2.5
	White	58.5%	58.7%	59.0%	+0.3
	All	55.1%	55.4%	55.8%	+0.4

Overall, the proportion of staff reporting that they believed the Trust provides equality of opportunity in career progression improved, although a lower proportion of BME staff were likely to say so (Table 17). The Trusts response rates were higher than the National, C&M ICB, and Acute & Community averages. Specifically:

- 0.4 point increase in the proportion of staff reporting Yes,
- 0.1 point increase in the proportion of White staff reporting Yes,
- 5.7 point increase in the proportion of BME staff reporting Yes,
- 5.6 point decrease in the difference between White v BME in 2022 (14.8 points) to 2023 (9.2 points).

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

Table 18: Discrimination from Manager or Colleague

YES		21-22	22-23	23-24	Change
MWL	BME		18.0%	12.0%	-6.0
	White		4.5%	4.3%	-0.2
	All		5.9%	5.4%	-0.5
STHK	BME	17.1%	22.2%		
	White	5.8%	3.9%		
	All	6.7%	5.1%		
S&O	BME	25.4%	22.2%		
	White	6.2%	6.0%		
	All	8.5%	8.7%		
National	BME	17.0%	16.6%	15.5%	-1.1
	White	6.8%	6.7%	6.7%	0.0
	All	9.1%	9.0%	9.1%	+0.1
North West	BME	17.2%	17.0%	tbc	-
	White	6.2%	6.3%	tbc	-
	All	7.7%	7.9%	7.8%	-0.1
C&M ICB	BME	15.1%	16.4%	15.1%	-1.3
	White	-	-	-	-
	All	6.9%	6.9%	6.9%	0.0
Acute & Community	BME	19.1%	17.2%	16.0%	-1.2
	White	4.5%	6.8%	6.8%	0.0
	All	9.4%	9.4%	9.5%	+0.1

Overall, the proportion of staff reporting that that had experience discrimination from a manager or colleague decreased for BME and White staff, although BME staff and 3 times more likely to report experiencing discrimination (Table 18). The Trusts response rates were lower than the National, C&M ICB, and Acute & Community averages. Specifically:

- 0.5 point decrease in the proportion of staff reporting Yes
- 0.2 point decrease in the proportion of White staff reporting Yes
- 6.0 point decrease in the proportion of BME staff reporting Yes
- 5.8 point decrease in the difference between White v BME in 2022 (13.5 points) to 2023 (7.7 points)

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

Overall, 4.2% of Board Members or 5.3% of Non-Executive Board Members are BME (Table 20). This equates to a 11 point and 15 point difference between the Workforce and the Board. However, this is comparable with the local population and non-clinical workforce diversity. Due to the small sample size, single individual changes in board membership will significantly change the percentages,

In 2022 (most current benchmark data), nationally 13.2% of Board Members of NHS Trusts were from an ethnic minority background.

Table 19: Board Membership 2022-2023

		BME	White	Unknown
STHK	Board Member	6.3%	93.8%	0.0%
	Workforce	13.0%	85.6%	1.4%
	Difference Total Board v Workforce	-6.7	+8.1	+1.4
S&O	Board Member	0.0%	78.6%	21.4%
	Workforce	11.6%	71.9%	16.5%
	Difference Total Board v Workforce	-11.6	+6.8	+4.9

Table 20: Board Membership 2023-2024

	BME	White	Unknown
Total Board	4.2%	79.2%	16.7%
Of which Voting Board Members	0.0%	100%	0.0%
Non-Votiong Board Members	5.3%	73.7%	21.1%
Of which Executive Board Members	0.0%	100%	0.0%
Non-Executive Board Members	5.3%	73.7%	21.1%
Difference Total Board v Workforce	-11	-2	+13
Difference Voting Members v Workforce	-15	+19	-4
Difference Execuitve Members v Workforce	-15	+19	-4

7. Conclusion

The Trust has taken steps to start its journey to become a truly Anti-Racist organisation. Activity is in the early stages of development to apply for the Northwest Anti-Racism Framework accreditation with the intention to apply in the next application round. We completed a ward engagement activity with BME staff to understand their experiences and launched a programme of Career Development Workshops for Band 5 BME Nurses. We have continued to review options to develop a reverse mentoring programme and implement EDI SMART targets for the Trust leaders, both of which will support future progress in this area.

Overall, the Trust continues to improve of key race equality metrics, including the proportion of BME staff within the workforce, and at key unrepresented bands, as well as improvements in most staff survey results. However key issues remain with

the higher proportions of BME staff reporting more negative experiences than White staff in the staff survey.

We intend to complete a lessons learned exercise following the response to the Southport incident to ensure that we have effective mechanism to support staff in future race related social disturbances.

Going forward, we will be looking to engage with all members of staff to listen, learning and collectively understand the challenges faced by BME individual in the workplace and community, and to take effective and meaningful action (see action plan).

Overall, the WRES indicators show the following:

- An increase in the proportion of total BME staff to 15.1%; Non-Clinical staff to 3.5%; Clinical Non-Medical staff to 15.6%; and Clinical Medical & Dental staff to 49.3%
- There was an increase in the proportion of BME Non-Clinical staff on Bands 2 to 6 and 8c. There were no declared BME staff on Bands 8d, 9 or VSM.
- There was an increase in the proportion of Clinical Non-Medical BME staff on Bands 2 to 8c. There were no declared BME staff on Bands 8d, 9 or VSM.
- There was an increase in the proportion of all Clinical Medical & Dental bands, with the exception of the Medical Director.
- BME applicants as a population are less likely to be appointed from shortlisting compared to White applicants.
- BME staff less likely to enter disciplinary process than White staff.
- BME staff are more likely than White staff to access non-mandatory training or CPD
- 25.8% BME staff state they have experienced bullying and harassment from a patient, family member or member of the public (27.8% nationally), compared to 21.4% of White staff, a difference of 4.4 points.
- 17.7% BME staff state they have experienced bullying and harassment from a colleague or manager (24.9% nationally), a difference of 0.0 points with White staff.
- 52.2% BME staff state they believe the Trust offers equality of opportunity in career progression (48.9% nationally), compared to 61.4% of White staff, a difference of 9.2 points
- 12% BME staff state they has experience discrimination from a manager or other colleague (15.5% nationally), compared to 4.3% of White staff, a difference of 7.7 points.
- 4.2% of the Trust Board is BME, lower than the workforce, but comparable with the local population, and higher than the Non-Clinical workforce.

8. Action Plan

From our assessment, the priority areas of activity are:

- An inclusive and Anti-Racist MWL,
- The Underrepresentation of BME staff in Non-Clinical roles compared to the local population,
- The Underrepresentation of BME staff in Clinical Non-Medical roles compared to the Staff Group average, in particular at Band 6,
- The Underrepresentation of BME Senior Leaders (Band 8+),
- The everyday experience of racism, reducing instances of race related harassment, discrimination and hate crimes.

To address the issues identified within the WRES data analysis, the Trust is committed to delivering the following actions:

Table 21: Action Plan

The Trust will be developing a new EDI Strategy 2025-2028 in the coming months, as well as an operational action plan for the implementation of the NW Anti-Racism Framework.

Priority Area of Activity	Main Action	Success Measures	To be in effective from:
An inclusive and Anti-Racist MWL	**Race Competence and Confidence:** To create a programme of race and anti-racism conversations, to build up race allyship, and confident conversations about race issues.	• Deliver a series of conversations with leaders, and teams on anti-racism and race equality • To engage all staff on the development of our anti-racism approach • To facilitate listening and learning sessions with staff across the trust	October 2025
	NW Anti-Racism Framework - To submit an application for the Northwest Anti-Racism Framework Bronze. To develop an accompanying action plan that will provide operational anti-racism actions.	Application successful Action plan	March 2025
	Community Engagement – to be actively involved in the Liverpool City Regional Race Equality Hub Network, sharing best practice and resources.	Ongoing engagement and best practice development	Ongoing
	To encourage Senior Leaders (Band 8a+) to develop Anti-Racism SMART Targets	Identified targets	December 2024
	Cultural Awareness - To develop a cultural awareness training offer for staff to help develop their cultural competence	50 staff completed each course	December 2025
	To continue to develop and expand resources on the Anti-Racism Hub	Resources and toolkits published	Ongoing
	Awareness Raising	• To promote anti-racism and race equality through events, news, and social media	Ongoing

Priority Area of Activity	Main Action	Success Measures	To be in effective from:
		• To mark Black History Month, Show Racism the Red Card, South Asian History Month	
	To add a personal EDI SMART target into the Appraisal form for all members of staff	80% of staff have EDI target by end of 2025 appraisal round	November 2025
	To investigate options to develop a MWL Anti-Racist training programme or eLearning offer	Review completed and options presented to HRSLT	March 2025
Underrepresentation of BME staff in Non-Clinical Roles	Outreach – we will review all outreach events and assess their engagement with local BME communities including events and engagement with colleges, schools, and universities.	Review completed	April 2025
	Volunteering - Identify opportunities to work in partnership with local voluntary, community, faith, and social enterprises to increase employability opportunities and support across the local boroughs	Review completed	April 2025
	Work Experience – we will review our work experience offer and uptake by BME communities	Review completed	May 2025
	Recruitment – improve the information available to applicants on the recruitment process and making the most of the application form. We will enhance the information on our external web pages to promote the benefits of working at MWL	• Website Update and resources published. • Easy to find and clearer information on work experience, apprenticeships and volunteering opportunities at MWL	April 2025
Underrepresentation of BME staff in Clinical Non-Medical (Band 6+)	To review the BME Band 5 Career Workshops for lessons learned, and plan future delivery options	Review completed, identification of next steps, development of common resources for staff to use	March 2025
	To promote L&OD career development offer to BME staff to ensure equal access	Cohort representative of the target workforce profile	Ongoing

Priority Area of Activity	Main Action	Success Measures	To be in effective from:
Underrepresentation of BME Senior Leaders (Band 8+)	Engaged with the NHS NExT Director Scheme	Relationship re-established, and first cohort engaged	October 2025
	Development of a series of board related EDI training and development programmes, including anti-racism, cultural competence	Development identified and Board engagement with sessions / resources	October 2025
BME Medical Workforce	To implement a medical workforce race equality working group to investigate any racial disparities specifically effecting the medical workforce.	Group established	June 2025
Data and Metrics	To develop an EDI Dashboard to ensure that EDI / Ethnicity data is readily available to decision makers in a timely manner	Dashboard launched	October 2025
Ethnicity Pay Gap	To complete the Ethnicity, Pay Gap, and conduct additional deep dive analysis to identify possible areas of concern	Analysis completed	December 2025
Everyday Experience of Racism	To develop and launch a bullying and harassment reporting tool using DATIX	• System live and in use. • 50 cases in Yr1 • Reduction in reported Harassment from colleagues / managers	December 2025
	To complete a deep dive into the staff survey bullying and harassment results to understand which areas have proportionally higher reported instances and taken action to address	• Deep drive complete • Priority areas identified • Conversations completed with area managers	February 2025
	Listening Workshops – to implement a programme of listening workshops where staff can raise concerns about race related topics, working in collaboration with H&S/Security, EDI/HR/HWWB	X3 sessions delivered by end of year	October 2025
	To create a “racial unrest response plan” to provide clear process and toolkits for the Trust to	• Lessons learned completed • Protocol and toolkits developed	June 2025

Priority Area of Activity	Main Action	Success Measures	To be in effective from:
	quickly identify and respond to future race or religious based disturbances and social unrest.	• Key staff briefed/trained	

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	30 October 2024
Agenda Item	**TB24/077 (12.2)**			
Report Title	Workforce Disability Equality Standard Report (WDES)			
Executive Lead	Malise Szpakowska, Acting Director of Human Resources			
Presenting Officer	Malise Szpakowska, Acting Director of Human Resources			
Action Required	X	**To Approve**		**To Note**

Purpose

This report provides an overview and analysis of the Trust's Workforce Disability Equality Standard (WDES) for 2023/2024 (March 2024).

This report provides an overview and analysis of the Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) with relevant trended data from MWL, legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and Southport and Ormskirk Hospital NHS Trust (S&O) and national data where available.

Executive Summary

The following is an overview of the WDES Highlights for 2023/2024.

Workforce data metrics:

- An increase in the proportion of total disabled staff reported to 5.6%; non-clinical staff to 6.9%; Clinical Non-Medical staff to 5.4%; and Clinical Medical & Dental staff to 2.9%
- An increase in the number and proportion of non-clinical disabled staff on bands 2 -7 and 8b.
- An increase in the number and proportion of Clinical Non-Medical disabled staff on bands 2-8b.
- Disabled applicants are slightly less likely to be appointed than non-disabled applicants.
- The proportion of disabled individual on the Trust Board match the overall workforce population.

Staff survey data:

- 26.5% of disabled staff reported experiencing harassment from patients et al, compared to 20% of non-disabled staff,
- 11.4% of disabled staff reported experiencing harassment from a manager, compared to 6.5% of non-disabled staff,
- 20.5% of disabled staff reported experiencing harassment from colleagues, compared to 12.2% of non-disabled staff,
- Disabled and Non-Disabled staff were nearly as likely to report harassment if they had experienced it,
- 57.7% of disabled staff believe the Trust provide equality in career progression, compared to 60.9% of non-disabled staff,
- 26.2% of disabled staff reported feeling pressured to come to work when ill, significantly higher than non-disabled staff at 16.2%
- 37.7% of disabled staff reported feeling that the trust valued their work, compared to 48% of non-disabled staff.
- 73.2% of disabled staff that require workplace adjustments reported being provided with them

Financial Implications

None

Quality and/or Equality Impact
This report is a regulatory requirement under the NHS Contract. It forms part of the Trust's work to promote race equality in line with the Equality Act 2010.

Recommendations
The Board is asked to note the Workforce Disability Equality Standard Report (WDES) and approve the WDES Action Plan.

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

Workforce Disability Equality Standard Report
Data Summary

April 2023 – March 2024

1. Executive Summary

This report provides the Trust Executive with the Annual Workforce Disability Equality Standard (WDES) data for the Mersey & West Lancashire Teaching Hospitals Trust for the first time following its creation in 2023. The publication of this report is for the period 2023-2024 in line with the NHS Standard Contract requirements to publish the WDES indicators.

2. Introduction

NHS England introduced the Workforce Disability Equality Standard (WDES) in 2019. The WDES exists to highlight any differences between the experiences and treatment of disabled staff and non-disabled staff in the NHS and places an onus on NHS organisations to develop and implement actions to bring about continuous improvements. The main purpose of the WDES is:

- to help NHS organisations to review performance on disability equality, based on the ten WDES indicators.
- to produce action plans to close any gaps in workplace experience between disabled and non-disabled staff.
- to improve the disabled representation at the Board level of the organisation.

3. A year in review: 2023-2024

The Trust has worked to implement disability inclusion actions agreed within the 2023 WDES report, as well as the EDI Operational Plan 2022-2025, activity to support the implementation of the NHS EDI High Impact Actions[1] (HIA), the Equality Delivery System[2] (EDS) and our work as a Disability Confident Leader[3].

Key actions that have been achieved between November 2023-October 2024 include:

- **Disability Advice Service**: The EDI (Workforce) team have provided information and advice on workplace reasonable adjustments to staff, managers, OH and HR Business Partners on 141 instances. This value-added service is helping to increase disability disclosure and ensure staff are provided with reasonable adjustments and completed passports.

[1] NHS EDI Improvement Plan High Impact Actions
[2] NHS Equality Delivery System
[3] Disability Confident

- **Charter Mark Renewal**: The Trust successful renewed its Disability Confident Leader recognition as MWL (2023), joined the Dying to Work Charter, was reaccredited as MWL with the Veterans Aware Charter (2023) and the Defence Employers Recognition Scheme (2024).

- **New Policies**: The Trust has introduced the new Carers Leave entitlement, and updated its Menopause Policy, Equality Impact Assessment SOP, and Reasonable Adjustment Passport. The Guaranteed Interview Scheme was extended to include Veterans and Reservists, and the Disability Reasonable Adjustments Policy is undergoing a review with the intention to implement in early 2025.

- **Disability Pay Gap (HIA3)**: Having completed the Disability Pay Gap since 2022, this year the Trust will publish its results in line with the requirements of the NHS High Impact Actions. Furthermore, the Trust has completed additional levels of analysis (not included in the published report) including by staff group and banding. Overall, the Disability Pay Gaps are in favour of Non-Disabled staff.

- **Widening Recruitment (HIA4):** Following the creation of MWL in 2023, work has been ongoing to standardise the Trusts Work Experience, Volunteering, Outreach offer, and approach to Apprenticeships. A number of relationships have been formed with High Schools/Colleges to provide visit days, guest speakers and work experience, as well as taster days hosted onsite. Work is ongoing to ensure that reasonable adjustment processes are effective in these instances.

- **Online Resources**: The EDI (Workforce) Team has continued to expand the online resource available to staff, including extending all materials to Southport & Ormskirk colleagues. New disability resources include guidance on accessible documents, common disability fact sheets, alternative formats, neurodiversity, and building access features.

- **Cultural Awareness**: The Trust has worked to raise awareness of disability equality topics by engaging in events including Disability History Month, Neurodiversity Week, Carers Week, and Menopause Awareness Week.

- **Staff Training**: The trust continued to implement training courses on Disability Reasonable Adjustments for Managers, Designing an Inclusive Event, Unconscious Bias, and Equality Impact Assessments, Harassment & Discrimination (actions support HIA6); and introduced a new course on Disability Reasonable Adjustment for Disabled Staff. Multiple departments have also commissioned Neurodiversity training from external providers as part of local reasonable adjustment support arrangements.

4. The 10 WDES indicators

The WDES is an analysis of the following 10 data indicators, relating to workforce, recruitment, capability, staff satisfaction, and board diversity:

1. **Staff Population**: Percentage of Disabled/Non-Disabled staff who are Non-Clinical, Clinical Non-Medical, and Clinical Medical by Agender for Change (AfC) pay bands or grade codes.
2. **Recruitment & Selection**: Relative likelihood of staff being appointed from shortlisting across all posts.
3. **Capability**: Relative likelihood of staff entering the formal capability process, as measured by entry into a capability process.
4. **Harassment**: Percentage of staff experiencing harassment, bullying or abuse from patients et al, managers, colleagues
5. **Equality in Career Progression**: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion
6. **Presenteeism**: Percentage of staff stating that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties
7. **Being valued**: Percentage of staff reporting that they are satisfied with the extent to which their organisation values their work.
8. **Reasonable Adjustments**: Percentage of staff reporting that reasonable adjustments have been provided.
9. **Disabled staff voice**: activities to engage disabled staff and facilitate staff voice
10. **Board Representation**: Percentage difference between the organisations' Board membership and its overall workforce disaggregated: By voting membership of the Board; By executive membership of the Board.

4.1. Data and Methodology

Before reading the report, please familiarise yourself with the following information which provides a summary of the data sources and limitations. The time periods for the data sets are as follows:

- **Indicators 1 and 10**: snapshot date of the 31st March,
- **Indicators 2-3**: period from the 1st April to 31st March,
- **Indicators 4-9:** the relevant staff survey that took place between the 1st April to 31st March, usually in the November/December.

The Trust collates data for Indicators 1-3 and 10 directly from the Employee Staff Record (ESR), the TRAC recruitment system and HR Business Partners to create a final data set.

Benchmarking data has been sourced from the national staff survey website and Trust Staff Survey data[4] (2021-2023), Model Health system[5] (2020-2024), and the 2023 national WRES report[6]. Where 2024 data is not available, 2023 data has been provided.

4.1.1. MWL Trended Data

The previous years reports were provided for both legacy Trusts. Where it has been possible to do so, data from the legacy trusts has been combined to create a MWL data set for previous years. Where this has not been possible the legacy data has been provided.

4.1.2. Scope of reported population

The following data principles are applied to the WDES data:

- Data relates to the total substantive workforce on the relevant snapshot date with the exception of Indicator 1 which disaggregates the data by Non-Clinical, Clinical Non-Medical and Clinical-Medical, and by Pay Band.
- Medical staff are included
- WDES data is only reported on the broad categories of Disabled, this being where ESR has a disability flag, No Disability, this being where ESR has No Known Disability fag; and Unknown, where ESR has a black, unknown or decline flag.

The WDES submission does not provide an in-depth analysis of the different demographics of the NHS workforce or the different source population and talent pipelines that make up the career groups.

4.1.3. Note on terminology

In data derived from ESR and HR processes, the term Disability is a reference to an employee that has disclosed and been recorded in ESR as having a disability (Yes), which is taken to mean “a physical or mental impairment, which has a substantial, adverse effect, on a persons ability to carry out normal day-to-day activities” (Equality Act 2010).

In data derived from the Staff Survey, the term Disability is a reference to respondents who stated YES to the question “Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?”.

[4] NHS Staff Survey
[5] Model Health System (log in required)
[6] NHS WRES 2023 Data

5. WDES Indicators

5.1. Staff Profile Workforce Overview

In the snapshot date of 31st March 2024, Mersey & West Lancashire Teaching Hospitals Trust (MWL) employed 10,733 staff which consisted of:

- 5.6% Known Disability,
- 84.2% No Known Disability,
- 10.2% Not Stated/ unspecified / prefer not to answer.

Over the past 5 years (2020 v 2024) (Figure 1), MWL has seen a year-on-year increase in the total number and in the proportion (%) of known disabled staff in the total workforce (250/2.7% to 573/5.6%), Non-Clinical (93/3.3% to 209/6.9%), Clinical Non-Medical (181/2.8% to 364/5.4%) and Clinical Medical & Dental (M&D) (11/0.6% to 27/2.9%) (Table 1).

Further details for each category are set out below.

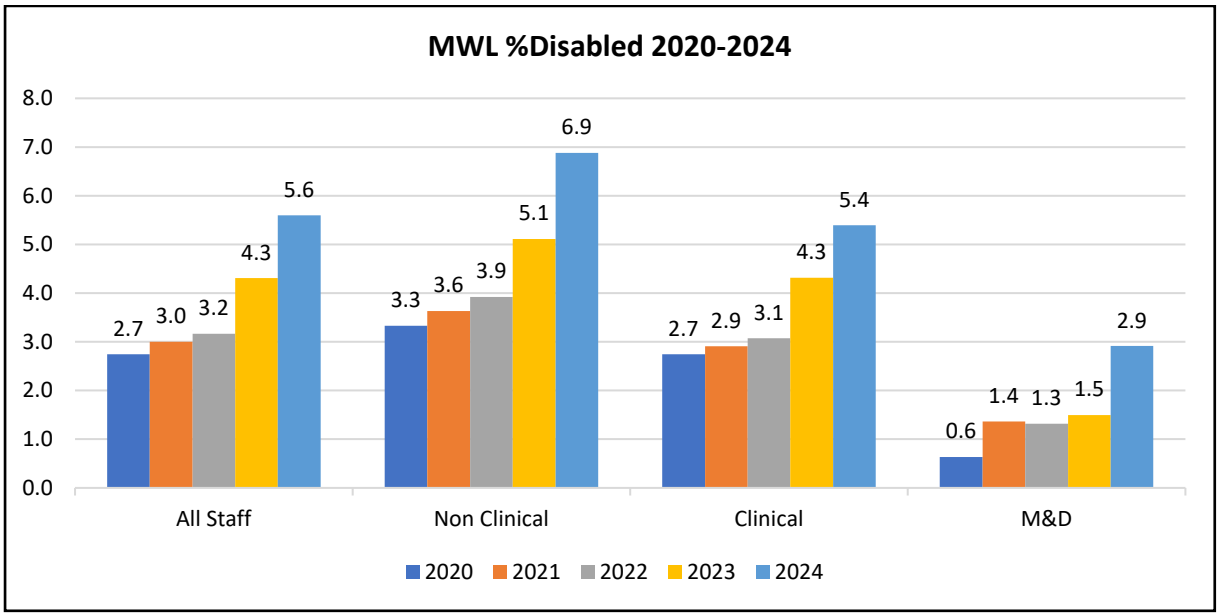


Figure 1

Table 1: 5-year trend and benchmarking

	2019	2020	2021	2022	2023	2024
% MWL	3.0%	2.7%	3.0%	3.2%	4.3%	5.6%
% National	3.1%	3.4%	3.7%	4.2%	4.9%	tbc
% North West	3.2%	3.5%	3.8%	4.2%	4.9%	tbc
% Acute	3.1%	3.0%	3.2%	3.6%	-	tbc

5.2. Indicator 1: Workforce Staff Data

Indicator 1 is a review of the staff population by Non-Clinical by Agenda for Change (AfC) pay bands; Clinical Non-Medical by AfC pay bands; and Clinical Medical & Dental.

From March 2023 to March 2024, there was an increase in the number and proportion of known disabled staff (Table 2) as follows:

- The total workforce from 448 (4.3%) to 600 (5.6%).
- Non-Clinical staff from 152 (5.1%) to 209 (6.9%)
- Clinical Non-Medical roles from 283 (4.3%) to 364 (5.4%)
- Clinical Medical & Dental roles from 13 (1.5%) to 27 (2.9%)

Overall, the local populations (Table 3) are far more likely to report having a disability and long-term medical condition than the Trusts workforce, both for the total population and the working age population.

Table 2: % Disabled by Staff Group

Staff Headcount March 2024	Dis	No Dis	Unk	% Dis	% Dis National (2023)
Total Workforce	573	8226	990	5.6%	4.9%
Non-Clinical AfC Workforce	209	2464	364	6.9%	5.8%
Clinical AfC Workforce	364	5762	626	5.4%	5.0%
Medical and Dental Workforce	27	794	106	2.9%	2.2%

Table 3: Census Population Benchmarks

Benchmarks %Disabled	Total Population (16+)	Working Age Population (16-64)
National Census: Sefton	20.6%	18.8%
National Census: St Helens	22.1%	19.9%
National Census: Knowsley	23.7%	20.8%
National Census: West Lancashire	18.7%	16.3%
National Census: C&M ICB Area	20.5%	18.1%
National Census: Liverpool City Region	20.7%	19.9%

5.2.1. Indicator 1a: Non-Clinical workforce

The Non-Clinical workforce includes staff in administration, clerical and estates type of roles. Key observations

- The total number of Disabled Non-Clinical staff increased from 152 (5.1%) to 209 (6.9%), with an increase in the number and proportion of Disabled staff on bands 2 -7 and 8b (Table 4).
- There were no known disabled staff on Band 9 or VSM.
- A larger proportion of Band 1, 6 and 8D staff are known to have a disability compared to the Non-Clinical average.
- 2024 Benchmarking data is not currently available; however, the proportion of disabled staff now exceeds the 2023 regional and national comparators (Table 5).

Table 4: % Disabled Non-Clinical Workforce

MWL	2023		2024	
	% Disabled	% No Dis	% Disabled	% No Dis
Band 1	4.7%	74.5%	9.8%	58.8%
Band 2	7.1%	83.3%	6.5%	75.6%
Band 3	4.6%	80.4%	8.4%	83.6%
Band 4	3.8%	86.0%	6.6%	83.6%
Band 5	5.8%	82.5%	4.9%	87.8%
Band 6	4.0%	84.2%	9.4%	81.3%
Band 7	6.3%	84.4%	6.4%	84.1%
Band 8A	0.0%	84.0%	6.3%	89.1%
Band 8B	5.6%	88.9%	2.8%	80.6%
Band 8C	11.1%	77.8%	3.9%	96.2%
Band 8D	0.0%	100.0%	11.8%	76.5%
Band 9	0.0%	88.9%	0.0%	91.7%
VSM	4.7%	74.5%	0.0%	91.7%
Total	5.1%	79.7%	6.9%	81.1%

Table 5: % Disabled Non-Clinical Workforce National Comparators

% Disabled	2019	2020	2021	2022	2023	2024
MWL	3.3	3.3	3.6	3.9	5.1	6.9
National	3.6	4.0	4.3	4.9	5.8	tbc
North West	3.6	4.0	4.2	4.7	4.9	tbc
Acute	3.6	3.6	3.9	4.4	-	tbc

5.2.2. Indicator 1b: Clinical workforce: Non-Medical

The Clinical Non-Medical workforce includes all allied health professionals, nursing and midwifery staff and relevant support staff. Key observations:

- The total number of Disabled Clinical Non-Medical staff increased from 283 (4.3%) to 364 (5.3%), with an increase in the number and proportion of disabled staff on bands 2-8b (Table 6).
- There were no known disabled staff on Bands 8c-9 and VSM.
- 2024 Benchmarking data is not currently available; however, the proportion of disabled staff now exceeds the 2023 national comparator (Table 7).

Table 6: % Disabled Clinical Non-Medical Workforce

MWL	2023		2024	
	% Disabled	% No Dis	% Disabled	% No Dis
Band 1	0.0%	0.0%	0.0%	0.0%
Band 2	3.9%	85.6%	5.1%	85.5%
Band 3	4.7%	81.2%	6.0%	81.9%
Band 4	4.6%	84.0%	6.9%	83.3%
Band 5	4.5%	86.4%	4.9%	88.0%
Band 6	4.8%	81.9%	6.5%	83.7%
Band 7	4.2%	82.7%	5.5%	84.0%
Band 8A	3.2%	83.6%	3.6%	87.2%
Band 8B	1.5%	75.8%	3.0%	77.3%
Band 8C	0.0%	100.0%	0.0%	100.0%
Band 8D	20.0%	80.0%	0.0%	100.0%
Band 9	0.0%	100.0%	0.0%	100.0%
VSM	0.0%	0.0%	0.0%	100.0%
Total	4.3%	84.1%	5.4%	85.3%

Table 7: % Disabled Clinical Non-Medical Workforce National Comparators

	2019	2020	2021	2022	2023	2024
MWL	3.2%	2.8%	2.9%	3.1%	4.3%	5.4%
National	3.2%	3.6%	3.9%	4.3%	5.0%	tbc
North West	3.3%	3.6%	3.9%	4.3%	-	tbc
Acute	3.1%	3.0%	3.3%	3.6%	-	tbc

5.2.3. Indicator 1c: Clinical workforce: Medical & Dental

The Clinical Medical & Dental workforce includes all staff on a medical and dental terms and conditions and includes Foundation and Specialist Doctors and Consultants. Key observations:

- The proportion of Clinical Medical & Dental staff has increased from 13 (1.5%) to 24 (2.9%) (Table 8).
- By career stage, trainee doctors are far more likely to have disclosed a disability (4.7%) compared to Consultants (1.5%).
- Compared to the known population of disabled people in the population, workforce, and in medical and dental education, there remains either a significant underreporting or issues with recruitment/retention of medics with a disability, both at the Trust and nationally.
- 2024 Benchmarking data is not currently available; however, the proportion of disabled staff now exceeds the 2023 national comparator (Table 9).

Table 8: % Disabled Clinical Medical & Dental Workforce

	2023		2024	
	% Disabled	% No Dis	% Disabled	% No Dis
Consultants	1.2%	80.5%	1.5%	82.1%
Non-consultant	2.3%	80.8%	3.4%	84.6%
Trainees	1.5%	92.1%	4.7%	91.3%
Total	1.5%	84.1%	2.9%	85.7%

Table 9: % Disabled Clinical Medical & Dental Workforce National Comparators

	2019	2020	2021	2022	2023	2024
MWL	0.5%	0.6%	1.4%	1.3%	1.5%	2.9%
National	1.3%	1.3%	1.5%	1.7%	2.2%	tbc
North West	1.1%	1.1%	1.4%	1.4%	-	tbc
Acute	1.2%	1.2%	1.4%	1.6%	-	tbc

5.3. Indicator 2: Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Indicator 2 is an assessment of the Trusts recruitment and selection practices, and whether disabled applicants are as likely as non-Disabled applicants to be successfully shortlisted and appointed.

This indicator is assessed at “whole organisation” level and does not disaggregate the recruitment trends by job group or department.

Table 10: Relative likelihood of being appointed from interview

MWL	Disabled	No Disability	Unknown
2021-2022	18.5%	21.3%	21.1%
2022-2023	21.7%	24.0%	70.1%
2023-2024	28.9%	31.5%	69.3%

Table 11: Relative likelihood of a non-Disabled staff being appointed from shortlisting compared to disabled staff

	MWL	National	C&M ICB
2021-2022	1.2	1.1	0.9
2022-2023	1.1	1.0	0.9
2023-2024	1.1	tbc	tbc

A value below <1 means that Disabled candidates are more likely than Non-Disabled candidates to be appointed from shortlisting.

The data suggests that there is no statistical evidence to suggest that there is a difference in likelihood of disabled or non-disabled individuals being offered a post.

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

Indicator 3 is an assessment of whether disabled staff are more likely to be subject to formal capability processes compared to non-disabled staff for non-health related reasons. The data used for this indicated is the average number of cases over a 2-year period e.g. 2021/22 + 2022/23 average, and 2022/23 + 2023/24 average.

There are no known disabled staff who gone through a formal capability process in the last 2 years (Table 12).

Table 12: Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff

	STHK	S&O	National Average
2020/21 + 2021/22	9.96	0.00	-
2021/22 + 2022/23	4.97	0.00	2.17
2022/23 + 2023/24	0.00		tbc

A figure above 1.00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.

6. Staff Survey Questions

The 2023 NHS Staff Survey was conducted between October and December 2023 and completed by 3928 staff (34% response rate). For the purposes of this report, the 2023-2024 staff survey results have been sourced from the national staff survey website and the Trusts staff survey data, with benchmarking data being sourced from the National Staff Survey results portal and Model Health.

6.1. Indicator 4a: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public (Staff Survey, Q14a)

Table 13: Harassment by Patients et al

		21-22	22-23	23-24	Change
MWL	Disabled		33.7%	26.5%	-7.2
	No Dis		24.6%	20.0%	-4.6
	All		26.9%	21.9%	-5.0
STHK	Disabled	35.6%	33.6%		
	No Dis	22.6%	23.6%		
	All	25.9%	26.2%		
S&O	Disabled	35.2%	33.9%		
	No Dis	24.2%	26.8%		
	All	28.3%	29.4%		
National	Disabled	33.0%	33.1%	30.0%	-3.1
	No Dis	25.8%	25.9%	23.3%	-2.6
	All	27.6%	27.7%	25.2%	-2.5
Acute & Community	Disabled	32.6%	32.9%	29.6%	-3.3
	No Dis	25.6%	26.0%	23.3%	-2.7
	All	27.2%	27.7%	25.0%	-2.7

Overall, there was a decrease in the proportion of staff reporting that they had experienced bullying and harassment from a patient, visitor, family member or member of the public (Table 13); although a higher proportion of Disabled staff reported this than Non-Disabled staff. Specifically, there was a:

- 5.0 point decrease in the proportion of staff reporting experiencing bullying and harassment from a patient et al,
- 7.2 point decrease in the proportion of Disabled staff reporting experiencing bullying and harassment from a patient et al,
- 4.6 point decrease in the proportion of Non-Disabled staff reporting experiencing bullying and harassment from a patient et al
- The proportion of disabled staff reporting experiencing bullying was lower than the National and Acute & Community disability averages.

6.2. Indicator 4b: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers (Staff Survey)

Table 14: Harassment by Managers

		21-22	22-23	23-24	Change
MWL	Disabled		13.4%	11.4%	-2.0
	No Dis		7.9%	6.5%	-1.4
	All		9.3%	7.8%	-1.5
STHK	Disabled	18.1%	12.0%		
	No Dis	7.5%	6.0%		
	All	10.3%	7.9%		
S&O	Disabled	18.4%	17.4%		
	No Dis	11.3%	12.3%		
	All	13.4%	14.0%		
National	Disabled	17.2%	16.4%	14.6%	-1.8
	No Dis	9.8%	9.4%	8.3%	-1.1
	All	11.6%	11.1%	9.9%	-1.2
Acute & Community	Disabled	18.1%	17.4%	15.2%	-2.2
	No Dis	10.3%	9.9%	8.7%	-1.2
	All	12.1%	10.6%	10.4%	-0.2

Overall, there was a decrease in the proportion of staff reporting that they had experienced bullying and harassment from a manager although a higher proportion of Disabled staff reported this than Non-Disabled staff (Table 14). Specifically, there was a:

- 1.5 point decrease in the proportion of staff reporting experiencing bullying and harassment from a manager,
- 2.0 point decrease in the proportion of Disabled staff reporting experiencing bullying and harassment from a manager,
- 1.4 point decrease in the proportion of Non-Disabled staff reporting experiencing bullying and harassment from a manager,
- The proportion of disabled staff reporting experiencing bullying was lower than the National and Acute & Community disability averages.

6.3. Indicator 4c: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Colleagues (Staff Survey)

Table 15: Harassment by Colleagues

		21-22	22-23	23-24	Change
MWL	Disabled		23.6%	20.5%	-3.1
	No Dis		14.8%	12.2%	-2.6
	All		17.0%	14.5%	-2.5
STHK	Disabled	22.8%	22.3%		
	No Dis	12.4%	12.0%		
	All	15.0%	14.7%		
S&O	Disabled	29.6%	27.2%		
	No Dis	16.9%	21.5%		
	All	21.1%	22.7%		
National	Disabled	25.3%	25.1%	23.8%	-1.3
	No Dis	16.6%	16.6%	15.4%	-1.2
	All	18.7%	18.7%	17.7%	-1.0
Acute & Community	Disabled	27.1%	27.0%	25.5%	-1.5
	No Dis	17.7%	17.9%	16.5%	-1.4
	All	19.9%	20.0%	18.8%	-1.2

Overall, there was a decrease in the proportion of staff reporting that they had experienced bullying and harassment from a colleague although a higher proportion of Disabled staff reported this than Non-Disabled staff (Table 15). Specifically, there was a:

- 2.5 point decrease in the proportion of staff reporting experiencing bullying and harassment from a colleague,
- 3.1 point decrease in the proportion of Disabled staff reporting experiencing bullying and harassment from a colleague,
- 2.6 point decrease in the proportion of Non-Disabled staff reporting experiencing bullying and harassment from a colleague,
- The proportion of disabled staff reporting experiencing bullying was lower than the National and Acute & Community disability averages.

6.4. Indicator 4d: Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it (Staff Survey)

Table 16: Reporting Harassment

		21-22	22-23	23-24	Change
MWL	Disabled		52.3%	49.3%	-3.0
	No Dis		48.8%	51.9%	+3.1
	All		49.8%	51.0%	+1.2
STHK	Disabled	51.4%	54.6%		
	No Dis	49.4%	51.2%		
	All	50.1%	52.2%		
S&O	Disabled	51.1%	46.4%		
	No Dis	42.6%	44.9%		
	All	43.3%	44.0%		
National	Disabled	47.6%	51.0%	52.5%	+1.5
	No Dis	46.1%	49.2%	51.4%	+2.2
	All	46.5%	47.6%	49.6%	+2.0
Acute & Community	Disabled	42.8%	46.5%	48.6%	+2.1
	No Dis	40.6%	44.5%	47.2%	+2.7
	All	41.2%	45.1%	47.7%	+2.6

Overall, there was an increase in the proportion of staff stating that they had reported bullying and harassment when they had experienced it, although a higher proportion of Non-Disabled staff reported this than Disabled staff (Table 16). Specifically:

- The percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it was similar for Disabled staff (49.3%) and for Non-Disabled staff (51.9%).
- The proportion of disabled staff reporting this decreased by 3.0 points compared to a and increase of 3.1 points for non-disabled staff.
- Trust staff were more likely to state that the bullying have been reported than the national and Acute & Community averages,

6.5. Indicator 5: Percentage of Disabled staff compared to non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion. (Staff Survey)

Table 17: Career Opportunities

		21-22	22-23	23-24	Change
MWL	Disabled		54.4%	57.7%	+3.3
	No Dis		61.3%	60.9%	-0.4
	All		59.5%	59.9%	+0.4
STHK	Disabled	54.5%	58.9%		
	No Dis	65.4%	65.4%		
	All	62.5%	63.6%		
S&O	Disabled	43.0%	41.6%		
	No Dis	52.6%	51.9%		
	All	50.3%	49.5%		
National	Disabled	51.0%	51.7%	52.2%	+0.5
	No Dis	57.0%	57.5%	58.1%	+0.6
	All	55.6%	56.0%	56.4%	+0.4
Acute & Community	Disabled	50.5%	50.9%	51.3%	+0.4
	No Dis	56.4%	56.8%	57.4%	+0.6
	All	55.0%	53.3%	55.8%	+2.5

Overall, the proportion of staff reporting that they believed the Trust provides equality of opportunity in career progression improved, although a lower proportion of Disabled staff were likely to say so (Table 17). Specifically:

- 0.4 point increase in the proportion of staff reporting Yes,
- 3.3 point increase in the proportion of Disabled staff reporting Yes,
- 0.4 point decrease in the proportion of Non Disabled staff reporting Yes,
- 3.7 point decrease in the difference between Disabled v Non Disabled responses in 2022 (6.9 points) to 2023 (3.2 points).
- The Trusts response rates were higher than the National and Acute & Community averages.

6.6. Indicator 6: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (presenteeism)(Staff Survey, Q11e)

Presenteeism refers to where employees come to work despite being physically or mentally unwell, underperforming due to illness, stress, or other issues that affect their ability to function effectively. Unlike absenteeism, where an employee is absent from work, presenteeism is characterised by being present but not fully productive.

Table 18: Presenteeism

		21-22	22-23	23-24	Change
MWL	Disabled		26.4%	26.2%	-0.2
	No Dis		18.6%	16.2%	-2.4
	All		21.2%	19.7%	-1.5
STHK	Disabled	34.5%	26.2%		
	No Dis	22.2%	17.9%		
	All	26.4%	20.8%		
S&O	Disabled	34.1%	26.9%		
	No Dis	21.0%	20.4%		
	All	25.5%	22.0%		
National	Disabled	30.2%	28.0%	26.6%	-1.4
	No Dis	22.2%	20.1%	18.5%	-1.6
	All	24.7%	23.8%	21.8%	-2.0
Acute & Community	Disabled	32.2%	29.9%	28.3%	-1.6
	No Dis	23.4%	21.2%	19.5%	-1.7
	All	23.9%	23.8%	22.3%	-1.5

Overall, the proportion of staff reporting that they felt pressured to come into work when they were not well decreased, although Disabled staff were far more likely to experience this (Table 18). Specifically:

- 1.5 point decrease in the proportion of staff stating they felt pressure to come to work when ill
- 0.2 point decrease in the proportion of Disabled staff stating that they felt pressured to come to work when ill
- 2.4 point decrease in the proportion of Non-Disabled staff stating that they felt pressure to come to work when ill.
- The difference between disabled and Non-Disabled staff response increased from 7.8 points (2022) to 10 points (2023).
- The Trusts response rates better than the National and Acute & Community averages.

6.7. Indicator 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work (Staff Survey, Q4b)

Table 19: Feeling Valued

		21-22	22-23	23-24	Change
MWL	Disabled		32.9%	37.7%	+4.8
	No Dis		45.4%	48.0%	+2.6
	All		42.2%	45.2%	+3.0
STHK	Disabled	34.5%	26.2%		
	No Dis	22.2%	17.9%		
	All	45.4%	44.1%		
S&O	Disabled	30.0%	27.7%		
	No Dis	40.5%	40.7%		
	All	37.8%	37.5%		
National	Disabled	34.7%	34.7%	36.9%	+2.2
	No Dis	44.6%	44.6%	47.8%	+3.2
	All	42.1%	40.5%	43.7%	+3.2
Acute & Community	Disabled	32.6%	32.4%	34.7%	+2.3
	No Dis	43.2%	43.0%	46.5%	+3.5
	All	40.7%	40.5%	43.6%	+3.1

Overall, the proportion of staff reporting that they felt that the Trust valued their work increased, although Disabled staff were far less likely to state this (Table 19). Specifically:

- 3.0 point increase in the proportion of staff that they felt valued
- 4.8 point increase in the proportion of Disabled staff stating that they felt valued
- 2.6 point increase in the proportion of Non-Disabled staff stating that they felt valued
- The difference between disabled and Non-Disabled staff responses decreased from 12.5 points (2022) to 10.3 points (2023).
- The Trusts response rates better than the National and Acute & Community averages.

6.8. Indicator 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. (Staff Survey)

The reported figured for this question are only based on those staff that stated that they had a long-term medical condition, and that they required workplace reasonable adjustments

Table 20: Reasonable Adjustments

%YES	21-22	22-23	23-24	Change
MWL		71.3%	73.2%	+1.9
STHK	69.0%	70.9%		
S&O	74.5%	72.3%		
National	72.2%	71.0%	72.4%	+1.4
North West	70.2%	72.0%	73.4%	+1.4
C&M ICB	71.9%	71.8%	73.1%	+1.3
Acute & Community	70.7%	71.4%	73.0%	+1.6

Overall, there was a 1.9 point increase in the proportion of disabled staff who stated that there had been provided with adequate reasonable adjustments (Table 20). The Trusts response rate slightly outperformed the National, C&M ICB and Acute & Community averages for this question.

If it worth noting that the NHS Staff Survey disclosure rate of staff with a long-term medical condition is significantly larger (26.8%) than the official data held in ESR (5.6%). This may be because of a number of reasons including the anonymity of the survey, as well as the difference in the wording of the question which is broader in the survey (see 4.1.3, p6).

6.9. Indicator 9a: The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation

The score for the staff engagement theme is derived from the nine questions (Q2a, Q2b, Q2c, Q3c, Q3d, Q3f, Q23a, Q23c and Q23d), grouped into three themes: motivation; involvement; and advocacy (Table 21).

Table 21: Staff Engagement

	Disabled		No Dis			
	STHK Disabled	S&O Disabled	STHK No Dis	S&O No Dis	National Disabled	National No Dis
2021	6.8	6.2	7.2	6.9	6.5	7.0
2022	6.9	6.1	7.3	6.9	6.4	6.9
2023	tbc		tbc		tbc	tbc

NB: The Disabled Staff Engagement score is provided by NHSE as part of the WDES data return. Therefore the 2023 results are currently unavailable.

6.10. Indicator 9b: Has your Organisation taken action to facilitate the voices of Disabled staff in your organisation to be heard (yes or no)?

Indicator 9b is an open question asking how the Trust has engaged disabled staff.

The Trust reported doing the following:

- The Trust supports the Building Abilities Network staff network, which is open to disabled staff and allies.
- The network is represented on a number of groups including a regular Staff Network Chair meeting with the Equality, Diversity & Inclusion Team and membership of the Equality, Diversity & Inclusion Steering Group.
- The network has been actively consulted on a number of projects including the Trusts Reasonable Adjustments Policy, all business tabled at the ED&I Steering Group, the development of an annual calendar of events, and events/comms to support the aims of the staff network.

6.11. Indicator 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated

Overall, the proportion of the Trust Board with a known disability is now equal to that of the overall workforce population (Table 23). The difference therefore now 0%. The principal difference being that no members of the Trust Executive who are members of the board are known to have a disability. In this metric the difference is -6%.

Table 22: Trust Board Trend

	STHK Disabled	S&O Disabled	National Disabled
2022	0.0%	0.0%	4.6%
2023	6.3%	7.1%	5.7%
2024	5.6%		tbc

Table 23: Trust Board 2024

	Dis	No Dis	Unknown
Total Board	5.6%	88.9%	5.6%
Of which Voting Board Members	11.1%	88.9%	0.0%
Non-Voting Board Members	0.0%	88.9%	11.1%
Of which Executive Board Members	0.0%	100%	0.0%
Non-Executive Board Members	11.1%	77.8%	11.1%
Difference Total Board v Workforce	0	+5	-5
Difference Voting Members v Workforce	+6	+5	-10
Difference Execuitve Members v Workforce	-6	+16	-10

7. Conclusion

Overall, the proportion of known disabled staff at the Trust continues to improve, including a reduction in the gap between the national average, and the total disclosure within the medical workforce continues to be comparatively low.

Disabled staff overall are less satisfied that non-disabled staff in the staff survey responses, though several improvements have been made in staff responses.

Overall, the WDES indicators show the following:

- An increase in the proportion of total disabled staff reported to 5.6%
- The proportion of disabled individual on the Trust Board match the overall workforce population.
- Disabled and Non-Disabled staff were nearly as likely to report harassment if they had experienced it,
- A higher percentage of disabled staff reported experiencing harassment whether that be from patients et al, managers or colleagues compared to Non-Disabled staff.
- 57.7% of disabled staff believe the Trust provide equality in career progression, compared to 60.9% of Non-Disabled staff,
- 26.2% of disabled staff reported feeling pressured to come to work when ill, significantly higher than non-disabled staff at 16.2%
- 37.7% of disabled staff reported feeling that the trust valued their work, compared to 48% of non-disabled staff.
- 73.2% of disabled staff that require workplace adjustments reported being provided with them

8. Action Plan

From our assessment, the priority areas of activity for the next 12 months are:

1. Encourage and enable disability disclosure at all levels but specifically
    - Capturing staff early during onboarding,
    - Empowering staff and managers
    - Clear alignment with HR processes
    - Embedding organisational level adjustments
2. The Underrepresentation of Disabled Senior Leaders (Band 8+),
3. The Underrepresentation of Disabled Medical & Dental roles,
4. To streamlining reasonable adjustments
5. The differential experiences and satisfaction of disabled staff compared to non-disabled staff

To address the issues identified within the WDES data analysis, the Trust is committed to delivering the following actions:

Priority Areas of Activity	Main Action	Success Measures	Success Measure Achievement
Enabling disclosure and supportive culture	**Disability Disclosure:** To increase the disability disclosure rate of the workforce by identifying disclosure routes, improving processes, and self-declaration.	• All: 8% • Non-Clinical: 9% • Clinical Non-Medical: 8% • Clinical M&D: 5%	October 2025
	Disclosure Band 8+: To increase the disability disclosure rates at Band 8+	• >0%	March 2026
	Onboarding: To reinforce and enhance the current provision of ensuring that new onboarded staff have multiple opportunities to disclosure a disability pre-arrival, and within their induction period.	Disability disclosure of new starters Staff Survey: Reasonable Adjustments: 77% Yes	June 2025
Underrepresentation of Disabled Medical & Dental roles	Review causes of the drop-in disclosure rates between Medical Schools and the workforce and agree actions were relevant.	Review completed and action identified	October 2025
	Review M&D induction to ensure disability disclosure processes are clear and line managers understand their responsibility	Review completed and action identified	June 2025
Streamlining Reasonable Adjustments	**RA Policy:** To support the embedding of the Reasonable Adjustments policy and provide support and training to managers across the Trust to apply the policy meaningfully. To review the RA process for Volunteers, Work Experience and Apprentices	• Policy approved • Processes published • Staff Survey: Reasonable Adjustments: 77% Yes	June 2025
	IT and Assistive Software: To identify commonly recommended and used assistive software and ensure they can be accessed via the Trust IT systems	• IT system / IG allows software to be installed / used. • Staff Survey: Reasonable Adjustments: 77% Yes	June 2025

	Changing Places: To open the Trust first Changing Places Toilet, and agree a commitment to expand provision across the Trust in the future	Changing Place Open Future Vision agreed	December 2024 October 2025
	Recruitment & Selection: To ensure that it is clear to the applicant how to request reasonable adjustments, that managers know how to respond, and guidance/training is easily accessible.	• Increase is proportion of applicants disclosing a disability • Increase in proportion of successful disabled new starters	October 2025
Training	To develop and introduce a training session on Neurodiversity	• Cause launched • 50 attendees in yr 1	From April 2025
Neurodiverse Inclusive Workplaces	To conduct a review of best practice in creating neurodiverse workplaces and identify best practice and recommendations.	Review complete	June 2025
Disabled Staff Network	To renew the disabled staff network (Building Abilities Network)	Increasing membership and engagement	December 2025
To support partners to become disability confident	To offer information, advice and guidance on becoming disability confident to partner organisations who have not yet started their disability confident journey/would like to progress	X4 relationships completed	Annual Rolling Target
Sickness, attendance, and Presenteeism	To develop a new Sickness Absence Policy, embedding disability sickness absence and disability leave process upfront.	Policy approved and implemented	June 2025
	To develop new guidance and resources on the use of Disability Leave and to empower managers and staff to use their leave when appropriate.	Guidance published and promoted to managers, embedded in disability training.	March 2025

	To review leadership and management training and resources, to ensure managers understand the importance of supporting disabled staff, to create a supportive culture, and not apply undue pressure on staff to attend work when ill.	• Updated guidance and training content • Comms Strategy implemented by HRBP's on effective management of disabled staff • Updated RA guidance to include in RA Passport	May 2025

Title of Meeting	**Trust Board**		**Date**	30 October 2024
Agenda Item	**TB24/078**			
Report Title	Infection, Prevention and Control Annual Report 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 present the 2023/24 Infection Prevention and Control Annual Report, to provide assurance that the Trust is taking the necessary action to monitor and prevent hospital acquired infections.

Executive Summary

This is the first Infection Prevention and Control (IPC) Annual report for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). The annual reports for legacy STHK and S&O were previously reported to Trust Board in October 2023.

The Infection Prevention Annual Report is a two-part document, Part 1 outlines the developments and performance related to Infection Prevention (IP) activities during 2023/24 and Part 2 (Appendix 2) is the annual work plan for 2024/25 which aims to reduce the risk of healthcare associated infections (HCAIs). The report identifies the achievements and challenges faced in-year and the Trust's approach to reducing the risk of HCAI for patients.

The IPC programme is based around compliance with:

- The Health and Social Care Act 2008 (amended 2015) – Code of Practice on the
- prevention and control of infections and related guidance also known as the Hygiene Code,
- Antimicrobial Stewardship:
- NHS England IPC BAF August 2023
- Infection Prevention & Control Board Assurance Framework (October 2023 V1.8)

Key highlights

- Infection prevention and control is a statutory duty of the Trust Board, and an annual report must be made annually on performance in the previous year.
- Health care acquired infections (HCAIs) are reported every month via the Corporate Performance Report (CPR) and the Board, via the Quality Committee, also gains assurance via regular in-depth reports of the actions taken and lessons learnt.
- The Trust has remained registered with the Care Quality Committee (CQC) and is rated as Outstanding.
- The Trust continues to have appropriate arrangements in place for the prevention and control of infections in accordance with Health and Social Care Act 2008.
- The legacy trusts reported separately in 2023/24 with MWL combined HCAI objectives only being established the following financial year. At the end of the financial year 2023/24, the legacy reporting sites have exceeded the thresholds as set out in the NHS Standard Contract 2023/24. This reflects the national picture across acute trusts, with all adult acute trusts in the region exceeding the thresholds for Clostridioides difficile (C.diff), Escherichia coli (E. coli) and Klebsiella. However, MWL was an outlier for rates of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia, with six cases in year.
- Extremely disappointingly there were six cases of MRSA hospital onset. There were four cases at Whiston Hospital and two cases at Southport Hospital. Four of the cases were identified as

avoidable peripheral IV cannula (PIVC) associated infections following post infection review.

- An MWL PIVC Improvement Plan was developed and implemented in 2023/24 and will continue into 2024/25. This includes the development of a single Trust system and process for Aseptic Non-Touch Technique (ANTT), cannula insertion and ongoing PIVC monitoring documentation, and the development of effective audit processes to support sustainable improvement. Task and Finish Groups were used to implement these actions.
- A zero-tolerance approach to MRSA bacteraemia and reduction in avoidable health care associated infections will remain a Trust priority within the Quality Account 2024/25.
- Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia - there is no national objective set for MSSA bacteraemia, however the Trust participates in the national mandatory surveillance of MSSA bacteraemia.
- There were 59 healthcare associated cases which is a reduction at both legacy sites compared to the previous financial year. Surveillance is undertaken on all healthcare-associated cases and the main source of infection is from skin and soft tissue e.g. leg ulcers. Cases have also been linked to vascular access devices and improvements will be supported by the PIVC Improvement Plan.
- C.diff - in 2023-24, the Trust exceeded the NHSE standard contract threshold (as have all other adult acute trusts in the region) by 29 cases and an improvement plan was developed in response to this. The combined MWL Trust threshold was for no more than 85 cases in 2023/24. There were 114 cases in year.
- E. coli - both sites were above the E. coli bloodstream infection threshold in 2023/24, an improvement plan was developed in response to this with an improved position in Q3 & 4.
- Klebsiella - the combined Trust objective is no more than 32 cases in 2023/24. There were 49 cases in year cases (28 HOHAs and 21 HOHA). The majority of cases to have been identified as urinary sources of infection or hepatobiliary in complex patients, with limited opportunity for learning following reviews of cases.
- Carbapenemase Producing Enterobacteriaceae (CPE) - there was no CPE bacteraemia cases in 2023/24 (hospital or community acquired).
- Hand hygiene continues to be strongly promoted throughout the Trust. Monthly audits of hand hygiene were undertaken on all wards throughout the year. Covert hand hygiene surveillance has also been undertaken.
- Orthopaedic Surgical site infections (SSI) surveillance - there were six surgical site infections (SSI) for Whiston Hospital and none at Ormskirk Hospital. The infections related to:
  - five hip infections out of 291 procedures which equates to 1.7% rate of infection, which is above the national expected rate of 1%
  - one knee infection out of 349 procedures which equates to 0.3% rate of infection, which is below the national expected rate of 1%.
- Outbreaks - there were a total of 107 outbreaks across MWL sites, the vast majority of these were due to SARS-CoV.

Part 2 - the MWL IPC forward plan for 2024/25.

Financial Implications

None as a direct consequence of this paper.

Quality and/or Equality Impact

Not applicable

Recommendations	
The Board is asked to approve the Infection Prevention Control Annual Report 2023/24.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Mersey and West Lancashire Teaching Hospitals

Infection Prevention
Annual Report

2023-2024

CONTENTS

1. Introduction

Mersey and West Lancashire Teaching Hospitals Trust is committed to leading on and supporting initiatives to reduce HCAI. Good IPC practice is essential to ensure that people who use the Trust's services receive safe and effective care. Effective IPC practices require the hard work and diligence of all grades of staff, clinical and non-clinical. Good practice must be applied consistently by everyone. The publication of the Trust's annual report is a requirement to demonstrate good governance and public accountability. In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention Team (IPT).

A zero-tolerance approach continues to be taken by the Trust towards all avoidable Healthcare Associated Infections (HCAIs). The publication of the IP Annual Report, is a requirement in accordance with The Health and Social Care Act (2008), will be publicly available on the Trust website to demonstrate effective governance and public accountability.

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

This report consists of two parts: the performance related to Infection Prevention and Control (IPC) and exception reporting during 2023/24, and the broad plan of work for 2024/25 to reduce the risk of HCAIs.

There are national contractual reduction objectives for Clostridioides difficile (C. difficile) infections and gram-negative blood steam infections (GNBSIs). Zero tolerance to MRSA bacteraemia remains in place. These are included in the six infections that are subject to mandatory reporting to United Kingdom Health and Security Agency (UKSHA) listed below:

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

2. Context 2023/24

During 2023/24, on July 1st the integration of St Helens and Knowsley Teaching Hospitals and Southport and Ormskirk Hospitals was transacted. This single larger organisation is committed to providing reliable standardised care for its acute, intermediate, community and primary care services.

Despite the organisation's commitment to deliver clean safe care, it is relevant to note the context of working within the current NHS system of high bed occupancy, staffing pressures, and overcrowding in the Emergency Departments. This has remained as a continuing pressure both to the delivery of clinical care and to the ability to minimise the risk of healthcare associated infection.

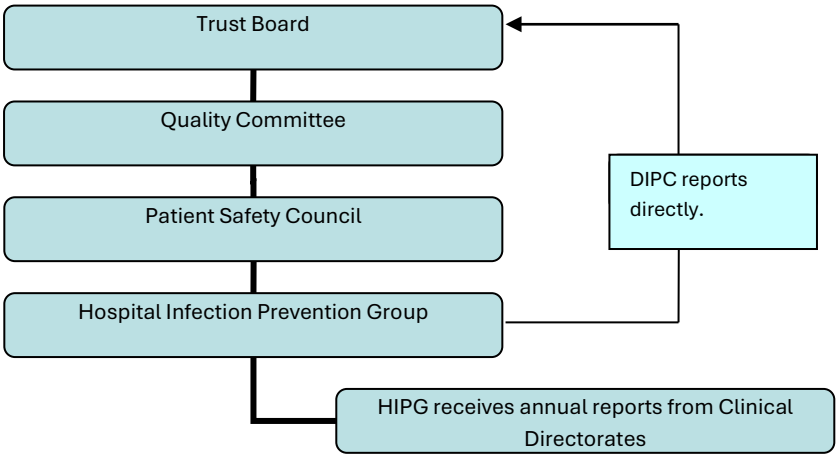
3. Governance and Monitoring

The Board of Directors has collective responsibility for keeping the risk of infection to a minimum and recognises its responsibility for overseeing IPC arrangements in the Trust. The

DIPC delivers the annual HCAI reduction report and annual plan to the Board of Directors based on the national and local quality goals.

The Hospital Infection Prevention Group (HIPG) provides a strategic meeting to support the delivery of a zero-tolerance approach to avoidable HCAIs, whilst the divisional management teams are responsible for the delivery. Figure 1 outlines the reporting structure at MWL.

Figure 1. IPC Governance



In August 2023, NHS England updated the IPC Board Assurance framework (BAF)[1], which was developed to support healthcare providers to effectively self-assess their compliance with the National Infection Prevention and Control Manual (NIPCM)[2] and other related infection prevention and control guidance. The BAF is structured around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection[3] which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[4]. The BAF has been aligned across the new organisation to provide assurance against these requirements.

Colleagues from the Integrated Care System (ICS) are members of HIPG and are also invited to IPC outbreak/incident meetings. The ICS also receives quarterly reports as part of the Quality Schedule reporting.

4. Infection Prevention Team

The IPT is led by Sue Redfern as the Director of Nursing, Midwifery and Governance, Director of Infection Prevention and Control (DIPC) who is supported by a Consultant Nurse and a Consultant Microbiologist Infection Control Doctor at STHK sites. The IPT works primarily on a site-based model with matrix working responsibilities across the sites. The IPT consists of:

- 1 x Nurse Consultant
- 1 x Lead Nurse
- 1 x Matron
- 4.8 x IP Nurse Specialists (Band 7)
- 2 x IP Nurses (Band 5)

[1] NHS England » National infection prevention and control
[2] NHS England » National infection prevention and control
[3] Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk)
[4] Regulation 12: Safe care and treatment - Care Quality Commission (cqc.org.uk)

- 1.6 x Support Workers (Band 3)
- 2.0 x Administrators (Band 4)

The IPT provides a clinical support service during weekdays from 8.30am to 5pm, with on-call provision at Southport and Ormskirk sites at weekends. Out of hours there is an on-call service provided by medical microbiologists for urgent IPC advice.

5. Surveillance

The IPCT undertakes continuous surveillance of target organisms and alert conditions. Pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The IPCT advises on the appropriate use of infection control precautions for each case and monitors overall trends.

These alerts include positive Clostridioides difficile, new CPE colonisations, bloodstream infections and MRSA colonised patients; additionally test results which indicate potential for cross infection and a need to alert ward staff and conduct follow up visits are highlighted. All inpatients identified for follow up are visited and records are reviewed by the team.

The Trust has the ICNet surveillance system, and it has been used at the legacy sites for many years. In addition to submitting data to support the national HCAI objectives for C. difficile infection, MRSA bacteraemia and gram-negative bacteraemia (GNBSIs) including E. coli, Klebsiella spp. and Pseudomonas aeruginosa, the Trust also submits data to the UK Health Security Agency (UKSHA) on MSSA. The data is submitted by the 15th day of each month to UKSHA via an online Health Care Associated Infection Data Capture System (DCS).

5.1 Achievements against the national HCAI thresholds

The NHS Standard Contract 2023/24 includes quality requirements for NHS trusts to minimise rates of both C. difficile and GNBSIs to threshold levels set by NHS England[5]. They are inclusive of all healthcare associated infections (community onset healthcare associated, and hospital onset healthcare associated).

- Hospital-onset healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)

- Community-onset healthcare associated (COHA) - Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

The legacy Trusts reported separately in 2023/24 with MWL combined HCAI objectives only being established the following financial year. At the end of the financial year 2023/24, the legacy reporting sites have exceeded the thresholds as set out in the NHS Standard Contract 2023/24, as outlined in Table 2. This reflects the national picture across acute Trusts, with all adult acute Trusts in the region exceeding the thresholds for C. difficile, E. coli and Klebsiella. However, MWL was an outlier for rates of MRSA bacteraemia, with six cases in year.

[5] https://www.england.nhs.uk/wp-content/uploads/2021/08/PRN00150-NHS-Standard-Contract-202324-Minimising-Clostridioides-difficile-and-Gram-negative-bloodstream-infect-1.pdf

Table 2. HCAI performance against NHSE thresholds 2023/24

	STHK Threshold	STHK Actual	S&O Threshold	S&O Actual	Combined Threshold	Total cases in Year
MRSA	0	4	0	2	0	**6**
MSSA	N/A	38	N/A	21	N/A	**59**
C. difficile	46	75	39	40	85	**115**
E. coli	73	112	48	59	121	**171**
Klebsiella	19	31	13	18	32	**49**
Pseudomonas	6	10	5	7	11	**17**
VRE	N/A	4	N/A	0	N/A	**0**

5.2 Mandatory Reporting

5.2.1 MRSA bacteraemia

A zero-tolerance approach is still in place to support no MRSA bacteraemia. In 2023-24, extremely disappointingly 6 MRSA bacteraemia's were reported at MWL. There were 4 cases at Whiston site and 2 cases at Southport site. Four of the cases were identified as avoidable peripheral IV cannula (PIVC) associated infections following post infection review.

An MWL PIVC Improvement Plan was developed and implemented in 2023/24 and will continue into 2024/25. This includes the development of a single Trust system and process for ANTT, cannula insertion and ongoing PIVC monitoring documentation, and the development of effective audit processes to support sustainable improvement. Task and Finish Groups were used to implement these actions.

In Q4 an external audit of PIVC care was performed at Whiston Site, with results shared with the senior nursing team and across the MDT. A similar audit was undertaken at Southport and Ormskirk Sites at the end of 2022-23. A regular PIVC spot check audit is now included in the IPCT audit plan, and will be undertaken by the IP Team at Whiston, Southport and Ormskirk sites, with timely feedback to clinical and divisional teams, to support improvement. Ward managers and matrons also undertake monthly Nursing Care Indicator audits to provide assurance regarding cannula care.

A zero-tolerance approach to MRSA bacteraemia will remain a Trust priority within the Quality Account 2024/25. The measures that will be used to support this ambition are.

1) Deliver the agreed Peripheral Intravenous Cannula (PIVC) Improvement plan.
2) Achieve minimum aseptic non-touch technique compliance of 85% for Level 1 (theory) and Level 2 (practical).
3) 90% compliance with visual infusion phlebitis (VIP) monitoring
4) Align ANTT training and competencies across MWL and achieve 85% compliance for Level 1 (theory) and Level 2 (practical).

5.2.2 MRSA screening compliance

Although there is a focus on reporting MRSA bacteraemia there is the potential for patients to become colonised with MRSA whilst in hospital, without infection. The IPT reviews all MRSA positive patients to advise regarding actions currently in place and additional actions required to reduce the risk of bacteraemia and onward transmission.

The Trust continues to use a robust approach to screening the majority of patients, either pre operatively or on admission and patients who have a length of stay for 30 days or more are also screened. MRSA admission screening compliance is monitored on a monthly basis. The target for MRSA screening is 95% of eligible patients requiring screening. MRSA screening compliance at the legacy STHK sites was least 98% throughout 2023-24 and 92% at Southport and Ormskirk sites. Compliance with preoperative screening at Southport and Ormskirk was above 95%, screening of emergencies was an area of focus for the IPT and Emergency Department at the Southport site.

The MRSA Policy was harmonised across the Trust in Q4, aligning best practice for MRSA screening and suppression guidance, following Trust wide consultation. This will be implemented in 2024/25.

5.2.3 MSSA bacteraemia

There is no national objective set for MSSA bacteraemia, however the Trust participates in the national mandatory surveillance of MSSA bacteraemia. A total of 59 cases across MWL. There were 38 healthcare associated cases (26 HOHA, 12 COHA) at STHK sites, which is a reduction of 6 cases when compared to 2022-23.

There were 21 cases at Southport and Ormskirk sites (18 HOHA, 3 COHA), which is a reduction of 12 cases compared to the previous financial year.

UKHSA Cheshire and Merseyside HCAI data indicates that for 3 out of 4 Quarters Southport and Ormskirk sites were below the Cheshire and Merseyside rate for MSSA, while STHK legacy sites were below the C&M rate for the first two Quarters of 2023-24. From January to March 2024, the rate of MSSA bacteraemia at STHK was 21.7 per 100,000 bed days and Southport and Ormskirk was 14.2 per 100,000 bed days compared to the Northwest rate of 15.8.

Surveillance is undertaken on all healthcare-associated cases and the most common source of infection is from skin and soft tissue, with cases also linked to vascular access devices. Improvements in vascular access care will continue to be supported by the PIVC Improvement Plan which was implemented in 2023-24. Patients known to be colonised with MSSA in wounds or devices are managed by the IPT and are treated with suppression therapy as required (the same as for MRSA colonisation) to reduce the risk of invasive infection.

5.2.4 Clostridioides difficile

Both legacy sites have exceeded the NHS Standard Contract thresholds for CDI, as have all other adult acute Trusts in the region. The MWL combined Trust objective for the legacy Trusts was for no more than 85 cases in 2023/24. There were 114 cases in year.

To the end of March 2024, Whiston and St Helens sites had 74 healthcare-associated cases (46 HOHA 28 COHA) against a threshold of no more than 46 cases (Figure 3). This was a notable increase when compared to the previous two financial years (Figure 5).

During the same period Southport and Ormskirk had just one case above the threshold with 40 healthcare-associated cases (31 HOHA 9 COHA) against a threshold of no more than 39 cases for the financial year (Figure 4). This represents a reduction of 9 cases when compared to 2022-23.

In 2023-24 the proportion of C difficile hospital-onset healthcare associated (HOHA) and community onset healthcare associated (COHA) cases is as follows for the legacy Trusts.

- STHK sites 62% HOHA/38% COHA
- Southport & Ormskirk sites 77.5% HOHA/22.5% COHA

As the combined MWL Trust threshold was exceeded by 29 cases an improvement plan was developed in response to this for 2024-25.

Figure 3. STHK healthcare-associated C. difficile April 23-March 24

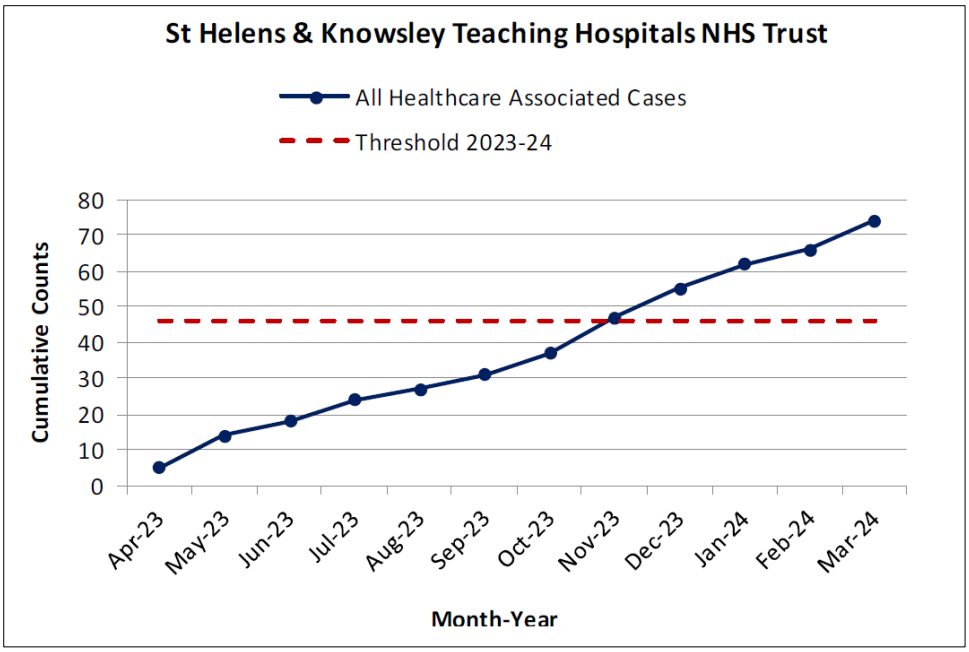


Figure 4. S&O healthcare-associated C. difficile April 23-March 24

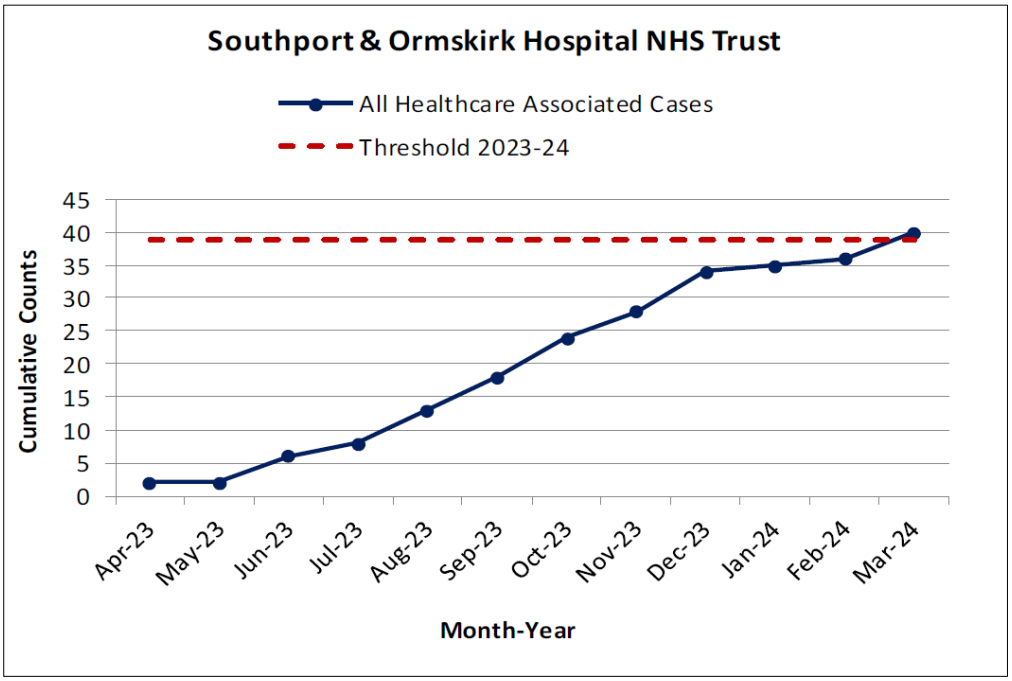


Figure 5 outlines the legacy Trust C difficile performance for the last three financial years. When taken together this shows a trend of increasing cases year on year.

Figure 5.

Financial Year	STHK Threshold	STHK Actual	S&O Threshold	S&O Actual	Combined Threshold	Total cases
2021-22	54	54	27	43	NA	97
2022-23	56	57	49	48	NA	105
2023-24	46	74	39	40	85	114

UKHSA data indicates that in Q2 and Q3 Southport and Ormskirk sites were above the Cheshire and Merseyside rate for C. difficile, while STHK legacy sites were above the C&M rate in one quarter, Q3 of 2023-24.

However, in Q4, from January–March 2024 all sites were below the C&M rate (Figure 6). S&O sites had improved to a rate of 17.1 per 100,000 bed days compared to a rate of 45.5 in the previous reporting period. S&O was noted to be a low outlier by UKHSA for this period. STHK sites had reduced to 27.5 per 100,000 bed days from a rate of 34.8 per 100,000 bed days in October-December 2023.

Figure 6. Clostridium difficile rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 2023	Jul-Sep 2023	Oct-Dec 2023	Jan-March 2024
Cheshire & Merseyside	26.7	29.4	29.2	33.8
STHK Sites	26.4	18.8	34.8	27.5
S&O Sites	17.3	34.1	45.5	17.1

The improvement plan was developed and focuses on the key areas of environmental and equipment cleanliness, robust diarrhoea management, antimicrobial stewardship and improved awareness among clinical staff. This improvement plan will be monitored through the Hospital Infection Prevention Group with Director of Infection Prevention and Control (DIPC) oversight, while providing assurance to Quality Committee.

Themes from learning reviews (previously RCA) remain largely unchanged from previous years. The most common learning is regarding compliance with the SIGHT mnemonic protocol, which relates to timely stool testing, isolation, appropriate PPE use and hand hygiene. In some cases, there was also a lack of assurance in relation to environmental cleaning and antimicrobial prescribing. Approximately a quarter of hospital-associated cases had no lapses in care identified.

In Q4 there was a cross-site review of the legacy RCA processes following cases of HCAIs, with a new MWL process aligned to the Patient Safety Incident Response Framework (PSIRF) and an improvement focus, while maintaining ownership within clinical and divisional teams. The new process is similar to the existing incident review mechanisms within divisions, with support by IPCT, microbiology and pharmacy. This new Infection Prevention Learning Review (IPLR) process will apply to CDI and HOHA bloodstream infections from April 2024 onwards, with revised documentation to optimise the IPLR process. This will assist with thematic review across MWL, to identify further areas for improvement regarding healthcare-associated infections.

5.2.5 E. coli bacteraemia

E. coli bloodstream infections represent approximately 55% of all GNBSIs. The majority of cases continue to be from a urinary source and are in older people 80+ years old. Less common sources include hepatobiliary, respiratory, and skin and soft tissue. It was also noted that patients were more likely to have had recent hospital admission, with comorbidities and frailty.

In 2023/24 the Trust reported 169 healthcare associated cases against a combined trajectory of ≤121. The legacy sites exceeded these thresholds for 2023-24 (Figures 7 & 8), and at the year end of March 2024, Southport and Ormskirk sites had 59 healthcare-associated cases (31 HOHA, 28 COHA) against a threshold of no more than 48 cases. This is an increase of 10 cases from 2023-24.

During the same period, at Whiston and St Helens sites, there were 110 healthcare-associated cases (54 HOHA 56 COHA) against a threshold of no more than 73 cases. This is an increase of 19 cases compared to 2022-23. However, it should be noted that this reflects the national picture across acute Trusts, with all adult acute Trusts in the region exceeding the E coli threshold.

Figure 7. STHK healthcare-associated E. coli BSI April 23-March 24

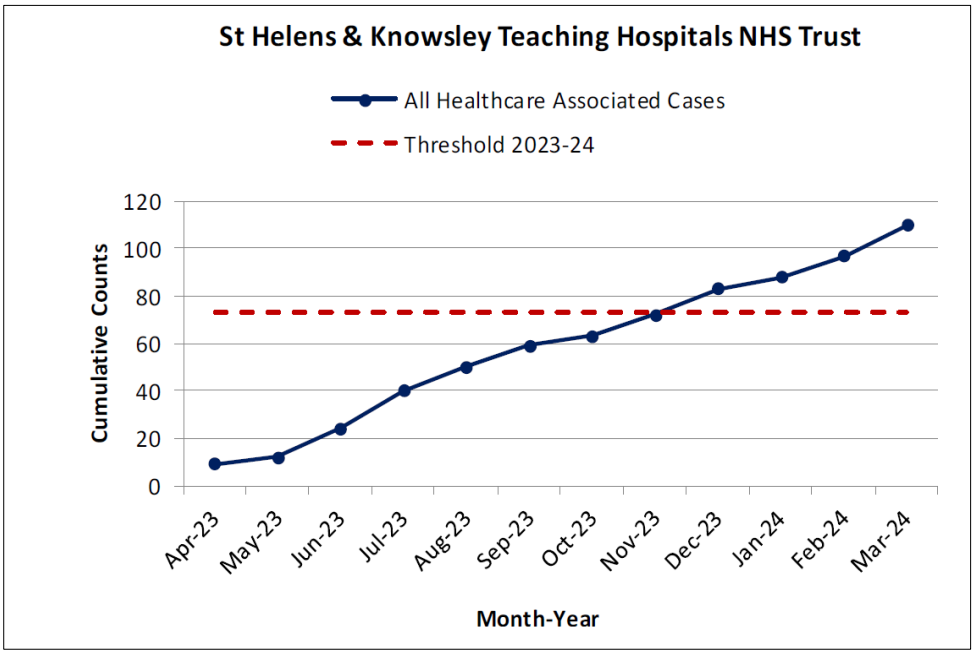
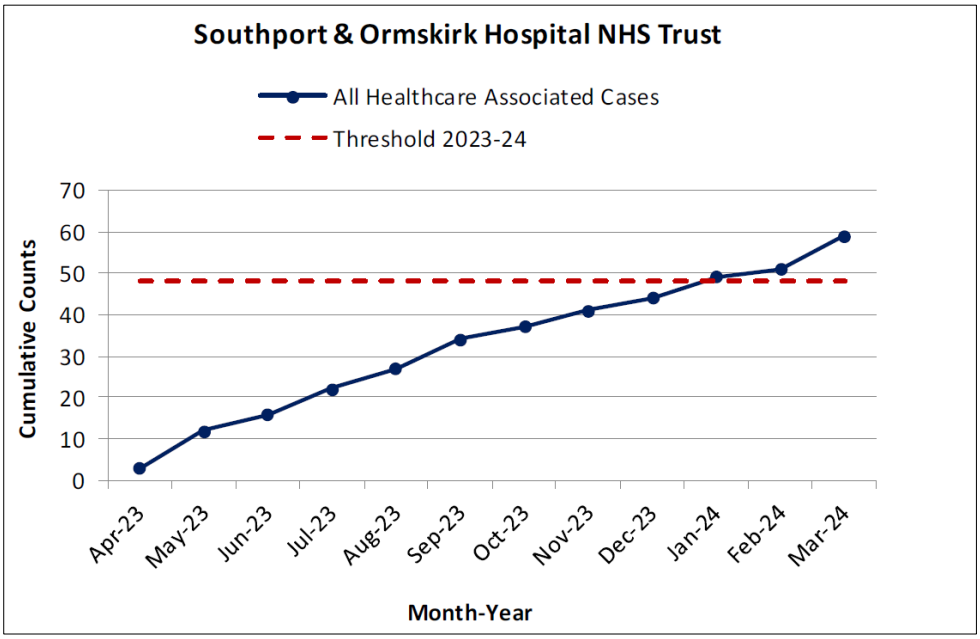


Figure 8. S&O healthcare-associated E. coli BSI April 23-March 24



As both legacy sites were above the Cheshire and Merseyside rate in the period July-September 2023 and an E. coli Improvement Plan was developed in response to this, in November 2023. However, from Oct–Dec 2023 S&O Sites had improved to a rate of 28.5 per 100,000 bed days compared to a rate of 51.2 in the previous reporting period. STHK Sites had reduced to 34.8 per 100,000 bed days from a rate of 50.7 per 100,000 bed days in July-Sept 2023.

STHK sites has remained below the Cheshire and Merseyside rate to the end of 2023-24 (Figure 9). However, S&O sites is above the regional rate, but was still in an improved position compared to the same period last year.

Figure 9. E coli rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 2023	Jul-Sep 2023	Oct-Dec 2023	Jan-Mar 2024
Cheshire & Merseyside	44.5	44.5	35.4	39.7
STHK Sites	35.2	50.7	34.8	39.1
S&O Sites	46.0	51.2	28.5	42.7

The Trust has also committed to reducing E.coli infections by 15% in 2024-25 and the approach is outlined in the E coli Improvement Plan. As these are also the patients who may benefit most from the Trust priority of improving hydration, to reduce the incidence of dehydration, UTI, and systemic infection the improvement plan dovetails with the Nutrition and Hydration Strategy. This includes a staff listening event, the MIAA audit of fluid balance charts, a review of the Fluid Balance SOP, implementation of Hydration Heroes Campaign at S&O Sites, and the development of patient information leaflets and coloured jug lids to identify patients at risk of dehydration. The Lead Nurse IP is a key member of the Fluid balance Focus Group and the Nutrition & Hydration Group. A food and drink strategy is under development with key stakeholders to support the need for improvement. Findings from the external fluid balance audit has resulted in a regular focus on nutrition and hydration on senior nurse walkarounds and other senior nursing fora.

5.2.6 Health Economy Engagement GNBSI/AMR

The Consultant Nurse IPC continues to attend the North Mersey Infection Prevention and Control and Antimicrobial Resistance (IPC and AMR) Group (previously GNBSI Group). The Group was established across the North Mersey health economy to drive forward the ambition to support a reduction in healthcare associated Gram-negative bloodstream infections (GNBSI) and a reduction in antimicrobial resistance to antibiotics.

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. The Lead Nurse Infection Prevention at STHK sites continues to attend the Halton and Warrington System-wide Collaborative, Infection Prevention Group, with GNBSI BSI reduction as a priority. The group aims to provide the opportunity for the Health and Local Authority partners across the North Mersey place to contribute to constructive dialogue with regards to the IPC and AMR improvement plan.

5.2.7 Klebsiella spp. bacteraemia

Klebsiella species are commonly associated with a range of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis.

The legacy sites have exceeded the NHS Standard Contract thresholds for Klebsiella, as have all other adult acute Trusts in the region. The MWL combined Trust objective is no more than 32 cases in 2023/24. There were 49 cases in year cases (28 HOHAs and 21 HOHA). Most cases to have been identified as urinary sources of infection or hepatobiliary in complex patients, with limited opportunity for learning following reviews of cases.

Figure 10. S&O healthcare-associated Klebsiella BSI April 23-March 24

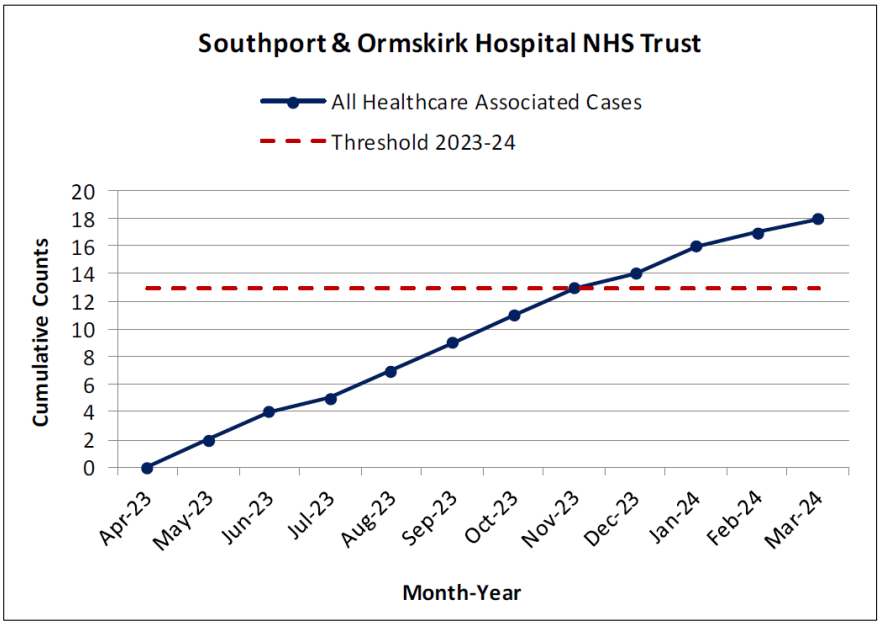


Figure 11. STHK healthcare-associated Klebsiella BSI April 23-March 24

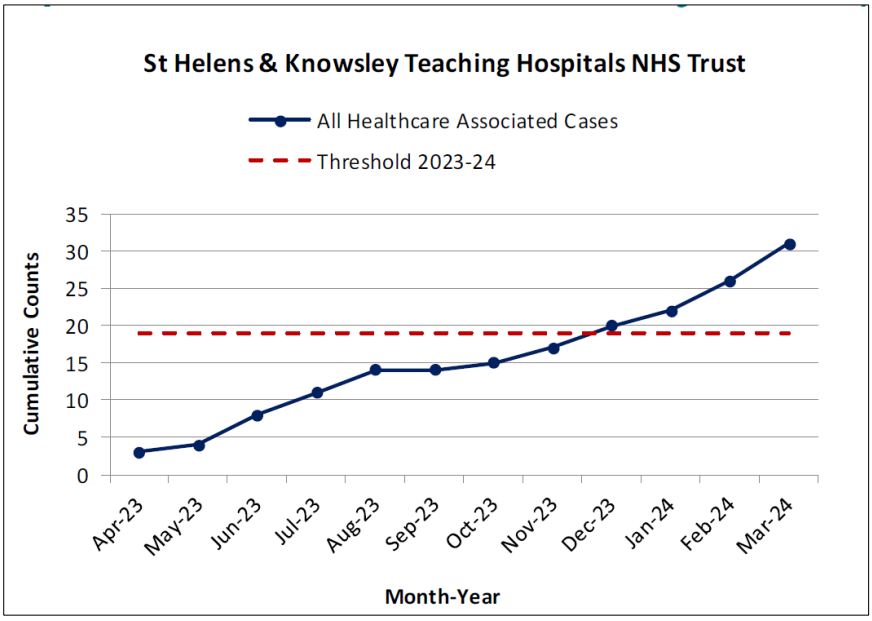


Figure 12 outlines the legacy sites quarterly Klebsiella rates compared to the Cheshire and Merseyside rate. STHK sites were well below the C&M rate in Q2 and Q3, while Southport and Ormskirk sites were below the Northwest rate for 3 out of 4 Quarters.

Figure 12. Klebsiella rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 2023	Jul-Sep 2023	Oct-Dec 2023	Jan-Mar 2024
Cheshire & Merseyside	11.6	12.1	15.6	14.8
STHK Sites	11.7	8.7	8.7	15.9
S&O Sites	11.5	14.2	14.2	11.4

5.2.8 Pseudomonas aeruginosa

Pseudomonas is a type of bacteria that is found commonly in the environment, including soil and in water. Of the different types of Pseudomonas, the one that most often causes infections in humans is called Pseudomonas aeruginosa, which can cause several significant infections.

In 2023/24 at STHK sites there were 10 cases of Pseudomonas bacteraemia against a threshold of 6 cases (Figure 13). These included 7 HOHA and 3 COHA cases. At Southport and Ormskirk there were 7 cases (2 HOHA and 5 COHA) in year against a threshold of ≤ 5 cases (Figure 14). This is an increase of 3 cases compared to 2022-23. The Cheshire and Merseyside comparative data is outlined in Figure 15.

Figure 13. STHK healthcare-associated Pseudomonas BSI April 23-March 24

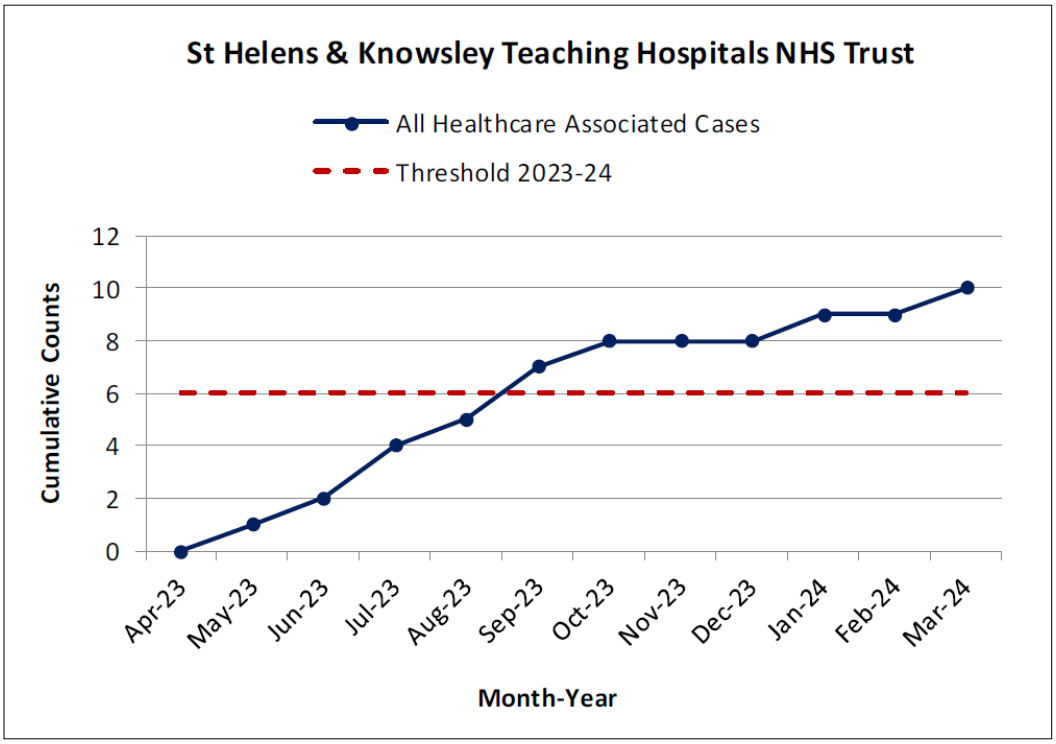


Figure 14. Southport and Ormskirk healthcare-associated Pseudomonas BSI April 23-March 24

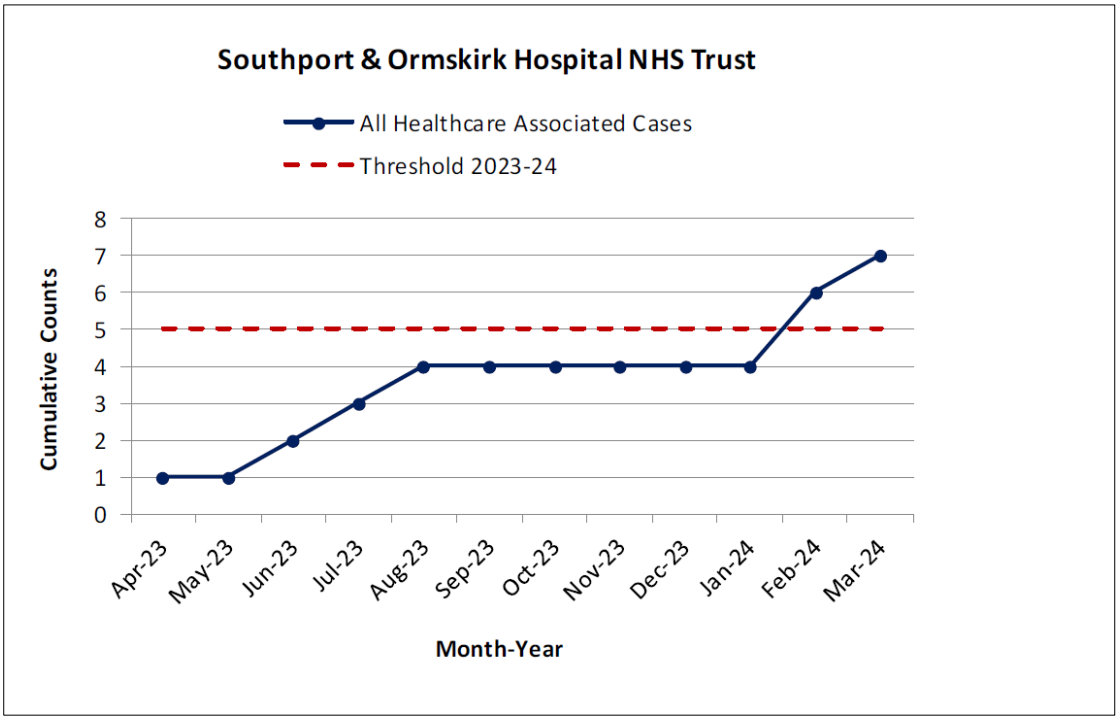


Figure 15. Pseudomonas rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 2023	Jul-Sep 2023	Oct-Dec 2023	Jan-Mar 2024
Cheshire & Merseyside	3.5	4.7	7.0	4.1
STHK Sites	2.9	7.2	1.4	2.9
S&O Sites	5.8	5.7	0.0	8.5

6. Carbapenemase Producing Enterobacteriaceae (CPE)

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

There were 5 CPE acquisitions at the Southport site and 6 at the Whiston sites in 2023-24. There was no CPE bacteraemia in 2023/24 (hospital or community acquired).

Patients are screened for CPE on admission to MWL following transfer from certain high prevalence Trusts. The IPT is currently reviewing CPE policy against the national CPE toolkit and will have a revised MWL policy in 2023-24.

7. Covid -19

The Covid-19 pandemic, cause by the SARS-CoV2 virus, was recognised in December 2019. Like previous pandemics the SARS-CoV2 pandemic has continued to present in waves of infection. Throughout the pandemic the legacy Trusts implemented national guidance both on

PPE (to ensure the safety of staff) and infection control to reduce the risk of transmission in the hospital.

In 2023-24 there was a total of 1976 patients with Covid-19, including patients who are defined as community or hospital onset cases. This included 1272 cases diagnosed at St Helens and Knowsley sites and 674 cases at Southport and Ormskirk sites. Figure 16 outlines the attribution of these cases. The majority are community cases diagnosed within two days of hospital admission. 22% of the total cases at STHK sites were classed as definite or probable healthcare associated, while 33% of cases at Southport and Ormskirk sites were healthcare associated.

UKHSA definitions of HCAI Covid are as follows.

- COVID-CO: Community Onset - First positive specimen date ≤ 2 days after admission to Trust
- COVID-HOIHA: Hospital Onset - Indeterminate Healthcare Associated - First positive specimen date 3-7 days after admission.
- COVID-HOPHA: Hospital Onset - Probable Healthcare Associated - First positive specimen date 8-14 days after admission.
- COVID-HODHA: Hospital Onset - Definite Healthcare Associated - First positive specimen date 15 or more days after admission

Figure 16 Covid cases 2023-24

	Hospital onset definitive	Hospital onset probable	Hospital onset indeterminate	Community onset
STHK sites	13%	9%	12%	66%
S&O sites	18%	15%	20%	47%

8. Measles

During 2023 there was a resurgence of measles in England with a rapid escalation of activity from October. Most cases have been in the West Midlands and London and most cases have been in children under 10 years of age.

To prevent and control potential measles outbreaks the trust established a measles preparedness group, which focused on the patient pathway, patient testing, infection control precautions, staff vaccination and staff face fit testing. Measles guidance was developed and is available for staff on the intranet. At MWL the IPT managed 4 cases of measles in 2023-24, including contact tracing and issuing warn and inform letters as per UKHSA guidance.

9. Outbreaks

The IPT detected and supported with the HCAI outbreaks in 2023-24 as outlined in Table 15, and in line with the Trust's Outbreak Policy and UKHSA guidance.

Figure 17. Outbreaks by legacy Trust 2023-24

Organism	Outbreaks STHK sites	Patients affected	Outbreaks S&O sites	Patients
COVID	55	274	24	300
Flu A	3	23	8	74
Parainfluenza	-	-	1	5
CDT PII	2	7	3	11
Norovirus	4	34	4	46
MRSA colonisation	1	5	1	2
Group A Strep	1	5	-	-
Total	66	348	41	438

10. Surgical Site Surveillance (SSI)

It is mandated by UKSHA that organisations must participate in orthopaedic surgical site surveillance. The Trust participates in this programme and submits data nationally and undertakes local surgical site infection surveillance for orthopaedic surgery.

The requirement is for each Trust to conduct surveillance for at least one orthopaedic category for one period in the financial year. The categories are:

- hip replacements
- knee replacements
- repair of neck of femur
- reduction of long bone fracture

The Trust participates in the mandatory UKSHA surveillance of elective orthopaedic surgery and submits data for hip and knee replacements for each quarter of the year.

At S&O sites in 2023-24 there were no infections reported following 174 knee replacements. 1 infection was reported following a total hip replacement, giving an SSI rate of 0.57 for the year (Table 18).

Table 18. Orthopaedic SSI Southport and Ormskirk sites 2023-24

Trust Overall 2022/2023	Patients	Primary Infections	Secondary Infections	Percentage Rates
TOTAL HIP REPLACEMENTS				
April 2023 – June 20223	**40**	**0**	**0**	**0%**
July 2023– September 2023	**32**	**0**	**0**	**0%**
October 2023 – December 2023	**64**	**1**	**0**	**1.56%**
January 2024 – March 2024	**37**	**0**	**0**	**0%**
TOTAL KNEE REPLACMENTS				
April 2023– June 2023	**40**	**0**	**0**	**0%**
July 2023 – September 2023	**24**	**0**	**0**	**0%**
October 2023– December 2023	**54**	**0**	**0**	**0%**
January 2024 – March 2024	**55**	**0**	**0**	**0%**
Trust Overall 2023/2024				
Total Hip Replacements	**174**	**1**	**0**	**0.57%**
Total Knee Replacements	**174**	**0**	**0**	**0%**

At STHK sites in 2023-24 there was 1 infection reported following 349 knee replacements giving an SSI rate of 0.3% for the year. However, 5 infections were reported following 291 total hip replacements, giving an SSI rate of 1.7% rate for the year. This resulted in the legacy Trust being identified as an outlier and the following actions were taken:

- RCA panels completed for all cases to check for themes.
- No themes were apparent during reviews – different consultants involved; no theatre issues noted.
- None occurred whilst on Ormskirk site.
- Dressing clinic continues to review all post operative wounds in designated room and designated staff.
- No changes in antibiotic usage.
- No other underlying ward infection issues.
- Complex patients being undertaken at Whiston site.

11. Audit

Audit is a key component of IPC to provide assurance that clean safe care is delivered at MWL. There is an extensive standardised IPC audit plan across all sites in the organisation. All audit tools and schedules have been reviewed and updated for the year both for inpatient and outpatient areas. Results are presented for monthly Hand Hygiene, Practice and Environment, and Nursing Care Indicator (cannula and catheter care and Bristol Stool Chart monitoring) audits.

12. Education & Training

All staff, including those employed by support services, must receive training in prevention and control of infection. Infection Prevention is included in induction programmes for new staff, including support services. There is also a programme of on-going education for existing staff, including update of policies, feedback of audit results, with examples of good practice and action required to correct deficiencies, and Root Cause Analysis (RCA) reviews and lessons learned from the process and findings. Records are kept of attendance of all staff who attend Infection Prevention training/teaching programmes.

Infection Prevention Mandatory Training is delivered by e-learning. Level 1 training must be undertaken by all staff and level 2 must be completed by clinical staff.

Other Training Sessions/Courses included:

- Trust Induction
- Junior Doctors Induction
- Rotational Doctors Induction
- Infection Prevention Mandatory Update
- The IPT provide training sessions on the Band 5 and HCA rolling education programme.
- The IPT provide training for Student, Cadet and Bank Nurses
- The Team also provides additional ad hoc education sessions held in seminar rooms in the clinical areas. These sessions address current HCAI problems identified within the Trust. Topics have included MRSA, CDI and CPE.

Link personnel meetings were held 2-3 monthly. Numerous topics were covered, including hand hygiene, CDI, MRSA, CPE, SARS- Cov2 etc. In addition, the link personnel have been encouraged to continue to undertake their own ward audits. Infection prevention audit Indicators are now embedded into the Tendable audit platform.

The IPT have attended national meetings remotely, e.g. Infection Prevention Society (IPS), various meetings/study days throughout the year, including meetings of Northwest Infection Control Group (NORWIC).

13. Aseptic Non-touch Technique (ANTT)

There is a requirement in the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections to ensure that staff undertaking invasive procedures have the required aseptic technique skills via training and demonstration of proficiency before being allowed to undertake these procedures independently. Legacy STHK has an established system and process for training and competency assessment for ANTT.

However, legacy Southport and Ormskirk was not compliant with the Code of Practice. Level 1 e-learning was available on ESR, and although competency assessments were undertaken

by practice educators, compliance was not monitored and ESR did not have the functionality to record Level 2 competency assessments.

The ANTT harmonisation project began in 2023-24 and will be completed in 2024-25, with the IPT and Learning and OD collaboration within the Mandatory Training Steering Group.

In 2023-24 Trust-wide ANTT compliance continues to be monitored, albeit only Level 1 compliance at Southport and Ormskirk sites. Actions in place to further improve compliance are:

- ANTT: Each ward and department have a key trainer who is responsible for cascading training to all staff in their areas. Responsibility for training has been undertaken by the nominated leads from the IPT and the Lead Nurse for IP.

- ANTT practical competencies - these competencies are mandatory assessed by the Key trainers on an annual basis and are monitored by the IPT.

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

14. Infection Prevention Policies

No new IP policies have been required during 2022/23. Extensive advice on SARS-CoV, Measles and mpox has been produced and is available on the Trust intranet.
An MWL policy harmonisation plan was developed in 2023-24, with a delivery plan to align more than thirty IPC policies across the new Trust.

15. Estates & Facilities

During the period April 2023 to July 2023 the two Estates and Facilities teams within the legacy Trusts worked closely together as part of the formal transaction process leading into the creation of one Estates and Facilities team under the new Mersey and West Lancashire teaching hospitals NHS Trust in July 2023. At the heart of the new team's objectives is ensuring safe, effective and efficient patient care. An integral part of the team's work is close liaison with the Infection prevention team teams across the organisation.

15.1 Training and Development

Each member of the Estates and Facilities team including service partners receive relevant and appropriate infection prevention and control training. This ranges from mandatory training, work specific training e.g. procedures for conducting deep cleans auditing or testing water outlets to elements of infection control embedded within specialist training for Authorised Persons or engineers who work on the Trusts infrastructure such as ventilation.

Compliance with training targets is monitored internal by the senior leadership team at the senior leadership operational meeting and assurance reported through the Estates and Facilities Governance Council in addition to the Trusts HR governance meetings and Infection Prevention Committee.

15.2 Leadership Culture

The Estates and Facilities Senior Leadership team objectives have strong links to the IPC agenda, developing partnership working with the IPC team across the new organisation. To strengthen this partnership working approach the Estates and Facilities Matron who reports

into the Assistant Director of Estates and Facilities from an operational perspective also reports into the Head of IPC for clinical professional development. Forging closer working relationships across the teams.

15.3 Estates and Facilities Matron

The E&F Matron works collaboratively with IPC colleagues to provide assurance around compliance with regulatory and internal standards, advocating for high standards of quality care for both patients and staff. This includes working closely with IPC colleagues to raise the cleanliness standards in conjunction with the National Standards of Cleanliness. Working together to introduce a clinical cleaning schedule and ensure the relevant training is provided to clinical colleagues. Key workstreams during the reporting period have been: -

Key National & Local Drivers - The E&F Matron and is working with the Dementia & Delirium, Capital Projects team and IPC to develop and standardise an MWL ward based dementia friendly template in conjunction with National and Local drivers and policies to enhance the patient experience whilst ensuring the Trust meets quality audits including CQC / PLACE and the Kings Fund.

Medical Device Service Provision - The Medical Equipment Library (MEL) team continue to swab bed frames, patient trolleys and foam mattress that are in the bed stores daily, Monday - Friday, using adenosine triphosphate- a molecule (ATP) monitoring. (Readings > 50 are classed as a fail). These results are reported to the IPC group. As a result of the high level of contamination on bed frames / mattresses a task and finish group has been established with IPC and clinical colleagues. The clinical element of bed / mattress cleaning is outlined in the 50 Elements of the National Standards of Cleanliness and embedded in the clinical cleaning schedules which are held at ward level.

Bed Frame / Foam Mattress decontamination - Working towards a best practice MEL decontamination unit as part of NSOC and IPC recommendations and best practice. A working group has been arranged with, The Heads of Nursing, IPC, Matrons to discuss a robust process for the clinical cleaning responsibilities of bed frames & foam mattress.

Ward level Deep Clean & Maintenance Programme - Meetings have been attended with senior nursing and divisional colleagues, to establish access for a ward deep clean and maintenance works to be carried out. Conversations around access, flooring, painting replacement programmes have taken place subject to approval.

Introduction of an E&F annual radiator & vent cleaning schedule for the Southport and Ormskirk Hospital sites.

Environmental Audits - The E&F Matron is introducing a digital daily environmental check list to address any immediate concerns with regards to the estates and cleanliness of the hospital corridors. Any actions (e.g. lift out of action) are fed back via the daily E&F morning huddles and completion data to be monitored via the E&F Operational Meetings. In addition to this the E&F Matron is implementing a digital E&F 15 Step Challenge Quality assessing the environment from a patient's perspective using the NHSE toolkit. The E&F team & Matron continue to support IPC colleagues with the Environmental audits. Action planning and escalating where required.

15.4 Hospital Ventilation

Pre-merger the ventilation systems were monitored on the Southport and Ormskirk Hospital sites through the Engineering Safety Group. This group reviewed on a quarterly basis; that the operation of all Engineering Services including ventilation within the hospitals was compliant with legislation, guidance, and best practice that the systems were designed to at the time of construction. At the St Helens and Whiston Hospital sites the ventilation group met monthly with a similar objective.

The new MWL Ventilation safety group now meets monthly covering all acute and community sites across the Trust. This group receives regular reports from key stakeholders that identifies any actions taken and results for any ventilation works or testing during the period. This provides assurance that the Trust is compliant with relevant legislation. Key workstreams during the period have been: -

Agreed operating theatre ventilation re-verification has been undertaken and is monitored with contracts in place to carry out planned preventative maintenance on all air conditioning systems. The Trust's in house team and Vinci FM maintain all ventilation systems including air handling units on the acute hospital sites.

A survey was completed in 2022/23 to determine what current ventilation flow rates are from all existing supply and extract grills. An engineering consultancy has been commissioned to carry out a full review of the ventilation at Southport and Ormskirk sites to determine the current level of ventilation and if it is in alignment with HTM03-01 identifying any shortfalls & noncompliance.

On the Whiston and St Helens Hospital sites Vinci on the Trusts behalf have completed a full gap analysis between the provision of systems currently within the hospital and the requirements of the revised HTM03-01. Work is underway to assess what if anything requires further alignment or derogation.

The group also discuss any construction projects that are ongoing withing the Trust taking a collaborative approach with IPC colleagues, authorising engineers and persons agreeing works needed or derogations that require logging within the organisation. Any items of concern raised by the groups are reported and discussed at the Estates and Facilities Governance Council with appropriate actions noted for assurance.

15.5 Water Safety

The Water Safety Groups across MWL are currently coming together as one group and will increase the frequency of meetings to monthly, compared to the legacy group who met quarterly on the Southport and Ormskirk sites. The water safety group receives regular reports from key stakeholders that identifies any actions taken and results for any water safety works. This provides assurance that the Trust is compliant with relevant legislation.

The flushing of underused outlets within all areas of the Southport and Ormskirk sites which is undertaken by Domestic and Estates teams and Operating theatre staff for their area and is monitored by the Estates and Facilities compliance Team on a weekly basis, with any issues escalated to the Water Safety Group members for immediate action. At the Whiston and St Helens Hospital sites the flushing of underused outlets is monitored by Vinci FM weekly and audited by the E&F team monthly and any failures are raised with the ward or department.

A Procurement exercise was undertaken to carry Water Safety Risk assessments at both Southport and Ormskirk sites, and contracts have been awarded for Water Safety risk assessments to be undertaken in 2023/24. These are in place on the Whiston and St Helens sites.

Written schemes of control have been produced for the Ormskirk site and are in progress for the Southport site all of which are expected to be completed in 2024.

The group also discuss any construction projects that are ongoing withing the Trust taking a collaborative approach with IPC colleagues, authorising engineers and persons agreeing works needed. Any items of concern raised by the groups are reported and discussed at the Estates and Facilities Governance Council with appropriate actions noted for assurance.

15.6 Cleaning Services

Cleaning is a top priority for the Trust and the team goal is to provide the cleanest and safest environment possible for patient's staff and visitors. Cleaning services are provided at the St Helens and Whiston Hospital sites as part of the PFI (Private Finance Initiative) partnership arrangement with New Hospitals through their service provider Medirest. On the Southport and Ormskirk Hospital site the in-house Domestic Services team provide the service with community properties providing this service through various landlords.

The teams across MWL have spent time reviewing cleaning standards and training staff in working methods and techniques keeping up to date in line with the clinical service requirements. The team continues to be involved with infection control meetings and audits to ensure the cleaning team is working in harmony with clinical staff to improve infection prevention and control. Trials of new equipment ranging from cleaning robots and new ultraviolet and hydrogen peroxide machines have been undertaken with significant investment in preferred products. The introduction of new cleaning material and products continues to be standardised across the Trust.

The National Standards of Cleanliness (NSOC) 2021 have been mainly implemented across MWL with a current business case being under review to implement additional resources where and if required based on internal recommendations to the functional risk ratings. This standardised framework for detailing the required cleaning service in all healthcare premises and how the technical and the efficacy audits of the cleaning process should be conducted.

The standards reflect changes in methods of cleaning, infection prevention and control and the move to a risk-based assessment of cleaning and governance frameworks to be followed. They also include learning for cleaning services from the Coronavirus pandemic. The standards cover all cleaning, including clinical and specialist equipment and not only environmental cleaning.

Together with the Health and Social Care Act 2008 and associated regulations these provide an assurance framework to support compliance with the core cleanliness standard and code of practice. Each ward or department have previously risk assessed in line with the NSOC guidance and allocated a Functional Risk rating which determines the % target score which should be achieved: -

2021 Risk rating and target
FR1 = 98%
FR2 = 95%
FR3 = 90%
FR4 = 85%
FR5 = 80%
FR6 = 75%

The graphs below show the average results of the NSOC audits undertaken by the Estates and Facilities team over the last 12 months.

Figure 19. STHK NSOC Scores per Functional Area

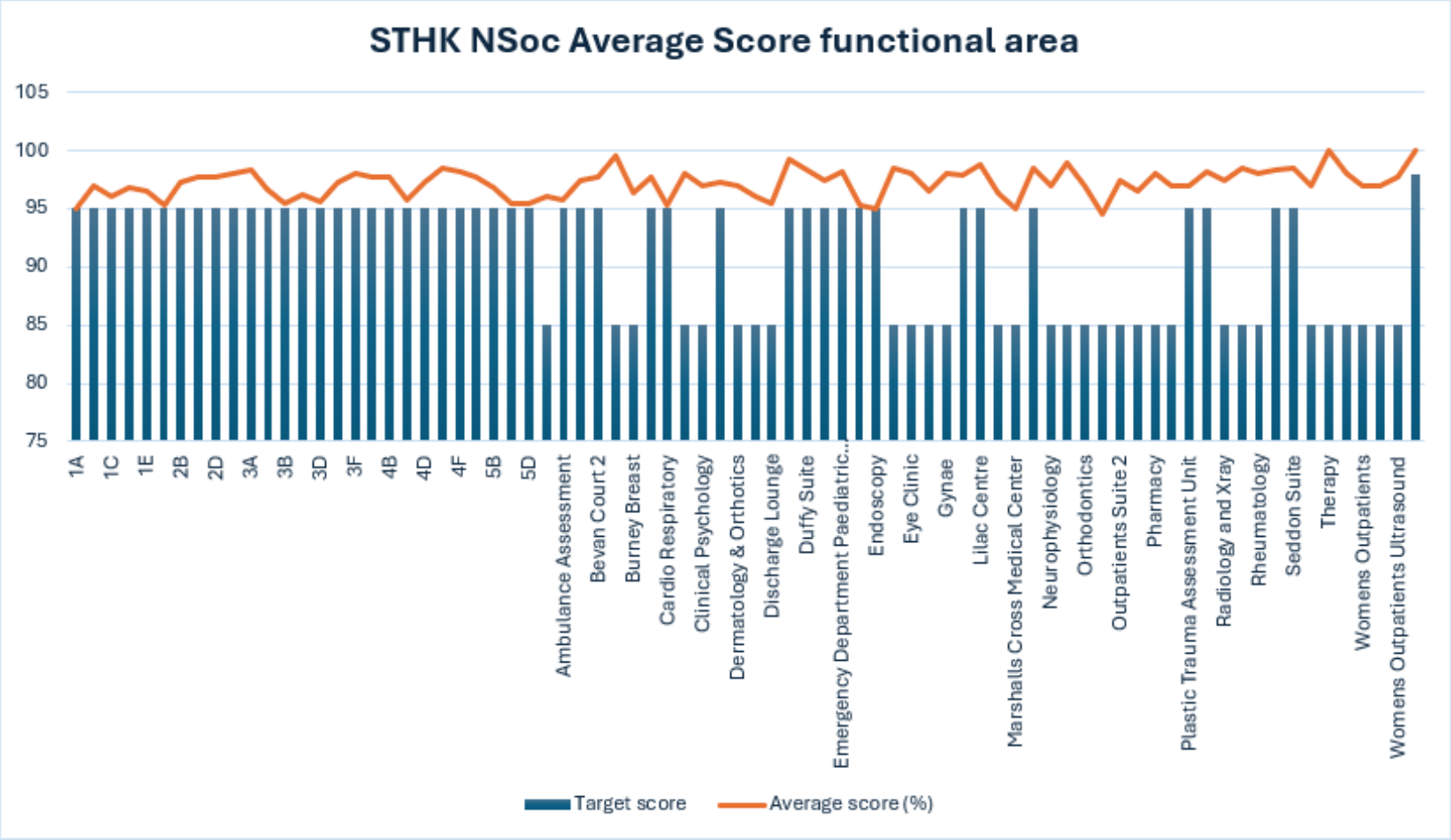
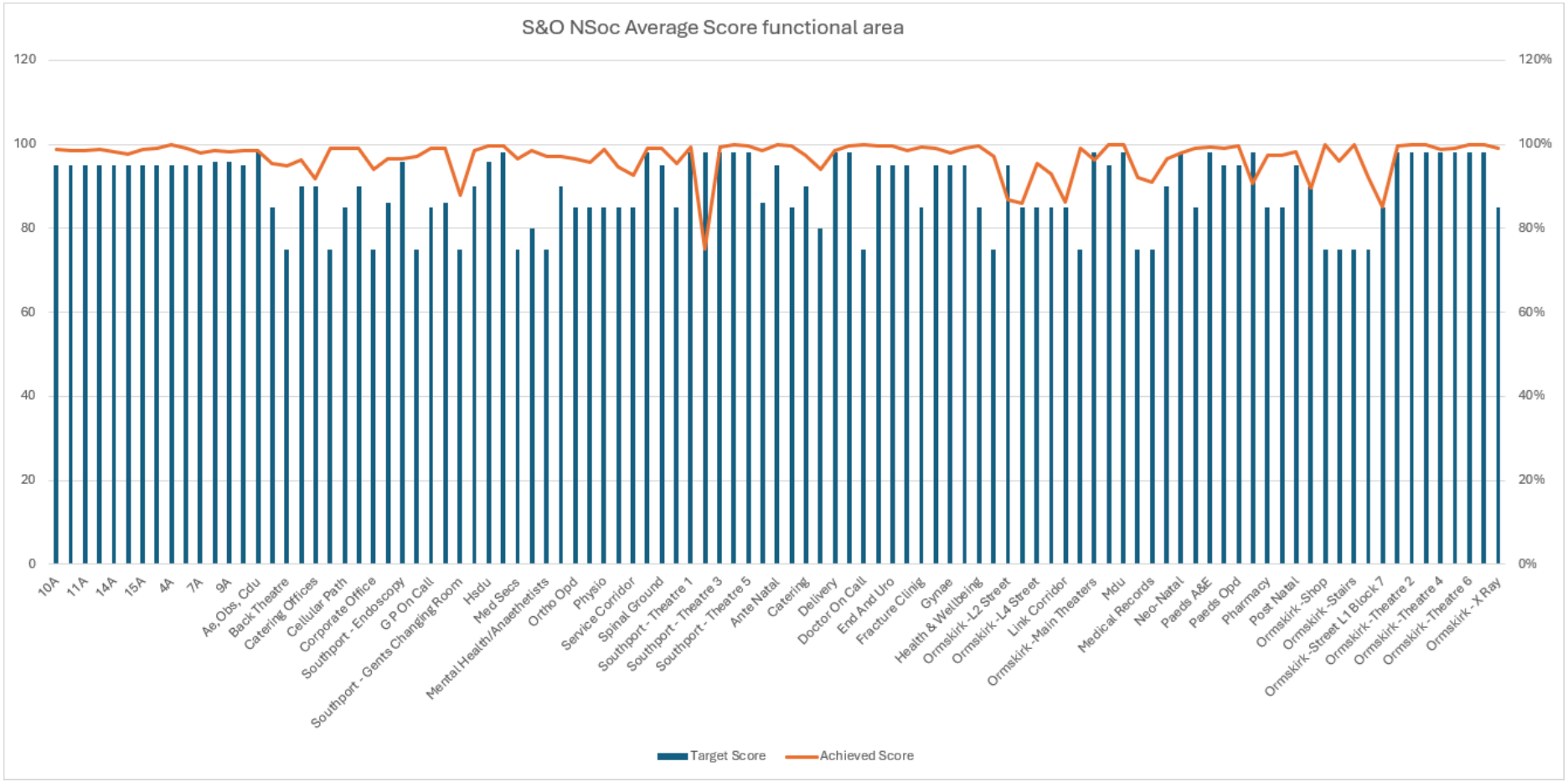


Figure 20. Southport and Ormskirk NSOC Scores per Functional Area



15.7 Waste Management

The Waste Group meets bimonthly and receives regular reports from key stakeholders that identifies any actions taken and results for any waste stream. This provides assurance that the Trust is compliant with relevant legislation. The group look at the options available to reduce our carbon footprint whist still maintain the correct waste streams.

Healthcare waste pre acceptance audits were completed in August 2024. Duty of care visits have been completed at Suez (recycling and recovery of general waste) and Tradebe (clinical waste) and Sharpsmart (sharps waste).

During the visit to Tradebe improvements were noted within full process with the disposal and cleaning of the clinical waste bins. This remains a concern that is being addressed from the waste contractor SRCL. The internal clinical waste service on all sites has been running at a normal level in the last twelve months from the service providers. Communications have continued with all parties directly and at quarterly meetings.

Staff Training - In House clinical waste disposal sessions are available through PowerPoint presentation for all staff. Training sessions explain the correct waste segregation and safe disposal of all types of waste.

The volume of waste disposed of is monitored monthly through the estates and facilities integrated performance report and any items for escalation are reported through to the estates and facilities governance council. The Trusts waste production and costs are monitored nationally through the organisations national estates returns.

16. Antimicrobial Stewardship

The AMS Pharmacy Team has provided antimicrobial stewardship ward rounds across multiple specialties at Whiston Hospital, although limited representation at Southport and Ormskirk sites due to AMS pharmacy vacancy. A new antimicrobial stewardship ward round has commenced on 3A to review plastic surgery patients on a weekly basis. In addition:

- Maintained one of the lowest levels of total consumption of ‘’watch’’ and ‘’reserve’’ antibiotics categories within the region.
- Continued to facilitate outpatient parenteral antibiotic therapy (OPAT) with the service formally launched in March 2023. Pharmacist and pharmacy technician, microbiologist seconded, and OPAT nurses recruited to launch the service in 2023. Since launching in March 2023, the OPAT service has saved on average 233 bed days per month. A business case has been submitted to Trust executives to secure permanent funding.
- Developed a SOP for the current OPAT service which encompasses multiple different community IV services offering different capacities and services.
- The AMT has continued to champion innovative antimicrobial drug therapy delivery systems such as 24-hour elastomeric infuser devices in the OPAT setting to promote Antimicrobial Stewardship (AMS) and allow patients to be discharged home on optimal therapy. The Trust is part of the Cheshire & Mersey regional elastomeric group project hosted by Cheshire & Mersey ICB to facilitate the use of these devices. Since the launch of the pilot in October 2023 43 patients have been successfully treated helping to save 707 bed days.
- Updated the Trust wide patient information leaflet for fluoroquinolones in line with the latest MHRA alerts.

- Published and maintained up to date patient group directives relating to the use of antimicrobials.
- Published and launched a new policy on appropriate dosing of antimicrobials in patients with renal disease and acute kidney injury (AKI).
- Developed an IV to Oral decision support tool to help prescribers to step down patients to oral antibiotics in a timely manner. The tool has been rolled out on AMU and has shown a 13% reduction in patients who were still receiving IV antibiotics past the point at which they meet the oral switch criteria.
- Completed and passed CQUIN03: Prompt switching of intravenous (IV) to oral antibiotics. The target set for the trust as per NHS England is to achieve 60% (or more) patients no longer receiving IV antibiotics past the point at which they meet switching criteria to switch to oral therapy. The Trust results are displayed below:

Figure 21. IVOS CQUIN Compliance STHK Sites

Specialty	Quarter 1 compliance	Quarter 2 compliance	Quarter 3 compliance	Quarter 4 compliance
Medical	75%	75%	81%	80.8%
Surgical	74%	62.5%	77%	75%
Total	75%	73%	80%	78%

Key challenges/issues:

- In the period of April 2023-March 2024 there has been an AMS pharmacist vacancy at Southport & Ormskirk sites, as well as two ongoing Consultant Microbiologist vacancies with only one Consultant Microbiologist on site. However, two speciality doctors have been appointed and are both working on site at Southport site.
- CQUIN data for Southport and Ormskirk sites was not completed in Q1 and Q2 due to shortages within the pharmacy department. Q3 and Q4 data was collected, and results are included. PPI data for all quarters will be collected for 24/25
- MicroGuide is being migrated to a new platform called Eolas. The MicroGuide platform will no longer be supported from 1st November 2024.
- OPAT continues to be challenging with the OPAT service growing since relaunching in late 2023.
- Increasing use of broad-spectrum antimicrobials for multi drug resistant infections coupled with increasing winter pressures and the demand for more community-based services.
- To continue to reduce suboptimal prescribing and therapeutic drug monitoring and missed doses of antimicrobials through guideline expansion and innovation with the increased use of EPMA, networking and informatics initiatives.
- Expanding the Pharmacy aseptic dispensing unit capacity to produce ready-made antimicrobials if capacity allows.
- EMIS is being rolled out in community services including the STHK OPAT team. This will allow us to review and manage patient in virtual ward setting.
- AMT ward round audit data is recorded in an Access database which is currently unsupported.

Actions taken to overcome challenges and issues:

- OPAT business case has been developed and awaiting approval for permanent funding.
- OPAT patient identification and tracking has been difficult the impact of EMIS to be evaluated.
- AMT continued to do targeted weekly antimicrobial stewardship ward rounds to tackle inappropriate antibiotic prescribing at ward level.
- Antimicrobial point prevalence audits to continue at least annually to look at areas of good practice and areas that require improvement regarding AMS.
- Development of EPMA data extraction reports to facilitate AMS initiatives.
- AMT ward round audit data is to be migrated from the Access database to a new custom designed Power Apps database.

Forward plan 2025/2026:

- To review and publish updated versions of paediatric and neonatal antibiotic policies.
- To facilitate the safe and seamless migration of the antibiotic policy from MicroGuide to Eolas.
- To work with antimicrobial colleagues at Southport & Ormskirk to merge the antibiotic policies and develop a Trust AMR strategy and audit program.
- To roll out the IV to oral decision support tool trust wide
- The AMT to work with EPMA team and the clinical informatics pharmacist to incorporate AMS strategies within EPMA and to continue to develop innovative automated crystal and CRD reporting.
- Work with Northwest Antibiotic Pharmacist Group and national AMS network to develop and deploy a region-wide gentamicin protocol and calculator.
- To continue to provide education to other healthcare professionals including junior doctors, pharmacists, and nurses.
- To continue to work in collaboration with other hospitals in the area to increase access and availability of antibiotic elastomeric infuser devices within the region. This will allow patients to be discharged home with narrow spectrum IV antimicrobials in a timely manner. This supports good antimicrobial stewardship in addition to bed day savings and improving patient experience. The group is also looking at setting up a regional aseptic Dispensing Unit to provide ready-made antibiotic elastomeric infuser devices in line with Lord Carter's review of pharmacy aseptic services.

17. Decontamination

17.1Sterile Services

All decontamination and sterilisation of reusable medical devices is carried out onsite at the Southport & Ormskirk Hospital sites, by the Trust's Sterile Services and Endoscopy Departments. All decontamination and sterilisation of reusable medical devises is out- sourced for St. Helens and Knowsley Hospital sites. All equipment is maintained, tested and validated in accordance with the relevant HTM's. This is audited by the independent Authorising Engineer for Decontamination AE(D). Both departments are ISO 13685:2016 & MDR production Quality Certification Assurance registered and are audited annually by an external notified body.

The governance and assurance are reported to the Trust Decontamination Steering Group quarterly meetings. The Group will assess decontamination requirements and consider what

aspects of Best Practice will be prioritised and should be implemented, based on improving patient outcomes, decontamination benefits, efficiencies, and risks.
The Trust Decontamination Policy has been reviewed and updated to ensure that it meets and interprets appropriately the guidance of Health Technical Memorandum (HTM) 01-01(2016).

17.2 Endoscopy Decontamination Services

Flexible endoscopes are complex reusable instruments that require unique consideration with respect to decontamination. In addition to the external surface of endoscopes, their internal channels for air, water, aspiration and accessories are exposed to body fluids and other contaminants. In contrast to rigid endoscopes and most reusable accessories, flexible endoscopes are deemed as 'heat labile and therefore, specialist chemical or cold decontamination processes must be undertaken as these devices cannot be autoclaved by steam at high temperatures in the same way as surgical instruments and other invasive medical devices are reprocessed.

In addition to the cold sterilisation, the Trust has Ultraviolet radiation to decontaminate Nasendoscopes & Transoesophageal echocardiography probes.

Works at the St Helens Endoscope Decontamination Unit are now complete, which takes to washer capacity to 16 chambers supported by 3 Reverse Osmosis (RO) water treatment units. Each RO is individually podded to 5 or 6 washers which ensures full capacity is not lost in the event of an RO failure.

Whiston Endoscope Decontamination Unit washer disinfectors and endoscope drying cabinets are now >10 years old and although still compliant to all relevant standards and Health Technical Memorandum 01-06 the equipment will need to undergo replacement. Three rental RO units are in place to support the service.

To support the replacement of the endoscope decontamination equipment plans are ongoing to site a new endoscope decontamination unit on the ground floor of a new 4-storey building located on Whiston site which will see the Endoscopy Unit occupying the second floor enabling them to expand their treatment room capacity.

The Annual external IHEEM audit saw Whiston Decontamination Unit achieve an amber/green status. St Helens Decontamination Unit achieved a green status.

17.3 Instrument Tracking and Traceability

Healthedge is installed across both the Endoscopy and within the Sterile Services Department. This system is already being widely used across several neighbouring Trusts, providing the ability for each Trust to have instruments reprocessed at any facility as part of improved system resilience. This minimises any risk of patient cancellation or delays.

18. Health Work and Well Being

18.1 Vaccine Campaign

A co-administered vaccine model was offered with key staff targeted by roving flu clinics, available on all shift patterns including weekends, evening, and early mornings. However, nationally it was recognised that it was extremely difficult campaign due to vaccine fatigue.

Feedback from frontline staff indicated a reluctance to have a co administered vaccine. Some staff who have previously had flu vaccine refused it this campaign. Therefore, the CQUIN was not met, and this was the same for all Trusts in the region.

Actions taken to overcome challenges and issues included weekly data and targeted action plan were communicated to exec board for assurance. This will continue in 24/25 campaign. A timetable was completed weekly and based on data of uptake. High risk areas were targeted daily.

18.2 Needlestick/ Body Fluid Exposure:

The Exposure to Body Fluids and Sharps Injury policy was harmonised in March 2024.

Policy roll out and NSI awareness campaign has been completed across all MWL sites, supported by completion of annual audit

Challenges included.

NSI awareness for certain target groups implemented.

Following the NSI awareness campaign 2022 which highlighted doctors and students as difficult target groups HWWB now have sessions in legacy STHK L&D on the induction for doctors and preceptorship programme for newly qualified nurses and international nurses.

NSI data: Datix is still under reported compared to NSIs reported to HWWB. Feedback- staff don't have time to complete Datix.

Still using 2 Datix systems and 2 HHWB to record data across MWL

18.3 Communicable diseases and Outbreaks

Measles - HWWB have screened staff in high-risk areas (as agreed by UKHSA) to ensure immunity to measles and minimise the risk of spread of measles. This was a targeted approach in Q2/3. 1000s staff measles immunity statuses were checked.

Roving venepuncture and vaccine clinics (inclusive of evenings and weekends) were offered at key sites to support uptake and increase staff immunity. HWWB worked closely with Managers to identify at risk staff and offer guidance to support them remaining in workplace.

HWWB STHK have supported the swabbing of staff who were identified in any outbreaks and were able to support this swabbing by doing place-based swabbing across the different shift patterns and in person appointments in HWWB. HWWB have continued to work closely with key stakeholders to support all staff involved in outbreaks.

18.4 Pre employment assurance

All staff who have social and direct contact with patients are required to provide evidence of 2x MMR vaccine or positive measles and rubella antibodies via blood test to gain OH clearance (as per Department of Health green book recommendations)

Those who are found to be not immune will be asked to attend for course of 2 MMR vaccines 4 weeks apart. Staff, where the vaccine is contra-indicated, or staff who refuse the vaccine (as its not mandatory) the manager is advised on the fit slip to complete a risk assessment and use control measure to protect staff and patient.

Any staff who DNA x 2 for any vaccine this is now escalated to the People Performance Council and will be escalated to the care division leads. Staff who DNA for either bloods or

vaccines; managers are advised to complete a risk assessment as their immunity status will be unknown.

18.5 HWWB Plans/Actions for 2024/25

Winter Vaccine Campaign:

No Flu CQUIN

MWL want to offer a Co administered model winter vaccine Flu and Covid vaccines.

Roving model – where resources allow.

Target front line Health care workers

All sites – one MWL campaign

Needlestick awareness

Continue to look at data and target high incident areas and staff groups.

Continue to work with Datix on improving the quality of data.

Bring together one system of recording and reporting data.

Work with Key stakeholders to promote the reporting of Datix.

Skin surveillance

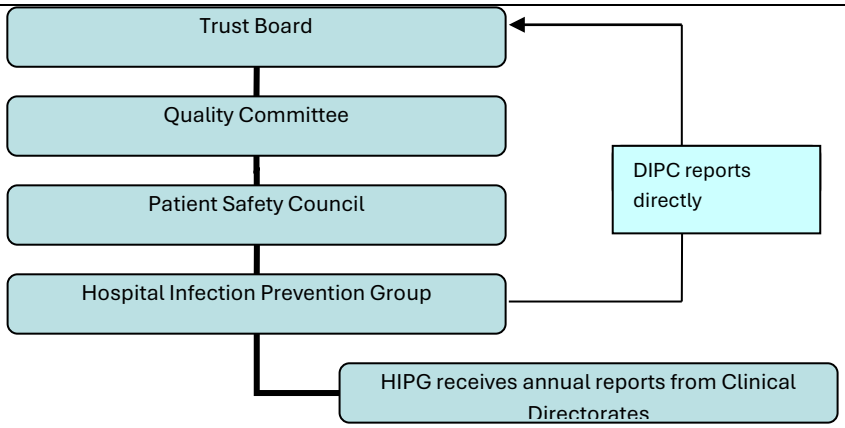
Following on from success of NSI awareness campaign, work with ICP and roll out the 'gloves off' and skin awareness campaign across all sites.

Plan to raise awareness and educate staff on importance of looking after skin and ICP.

Appendix 1 TOR HIPG

Terms of Reference	NAME: HOSPITAL INFECTION PREVENTION GROUP (HIPG) FINANCIAL YEAR: 2024/25
Authority	To ensure that Mersey and West Lancashire NHS Teaching Hospitals Trust has effective systems in place to prevent and control healthcare-associated infections and to provide assurance to the Trust Board. To maintain an overview of infection prevention priorities within the Trust, and link this into the clinical governance and risk management processes.
Terms of Reference	1.To oversee the delivery of the Trust's HCAI objectives and IPC-related indicators 2. To approve and oversee the implementation of the IPC Annual Plan 3. To receive reports and assurance from subgroups, including, decontamination, water safety, ventilation safety and antimicrobial stewardship. 4. To identify key standards for infection prevention as part of the Trust's clinical governance programme. 5. To ensure that programmes for the prevention and control of infection, including education, are in place and working effectively. 6. To ensure that appropriate infection prevention policies and procedures are in place, implemented and monitored. 7. To ensure that robust plans for the management of outbreaks of infection are in place and to monitor their effectiveness. 8. To monitor surveillance of infection results e.g. mandatory surveillance, post-operative infection rates. 9. To highlight priorities for action in infection prevention management. 10. To agree the annual infection prevention audit programme and monitor its implementation. 11. To approve the annual infection prevention report, prior to its submission to the Trust Board. 12. To ensure that national guidance and best practice in infection prevention is implemented within the Trust. 13. To ensure the delivery of national infection prevention objectives e.g. UKHSA alerts / NICE guidelines /CQC reports/ High Level Enquiries. 14. To appraise innovative products regarding infection prevention 15. To monitor antimicrobial/disinfectant usage & expenditure patterns.
Review	In the fourth quarter of the financial year, the HIPG will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Terms of Reference.

Membership	**Core members** • Director of Infection, Prevention & Control (Chair) • Consultant Nurse IPC • Lead Nurse Infection Prevention • Matron IPC • Consultant Microbiologists & Infection Prevention Doctor • Divisional Directors of Nursing • Heads of Nursing • PFI Contract and Performance Manager • Decontamination Manager • Antimicrobial Management Pharmacist • Health Work & Well-being representative • Estates and Facilities Manager • Medirest Manager (cleaning contractor) • Vinci Maintenance Services Manager • Head of Hard Facilities Management • Head of Soft Facilities Management • Consultant in Communicable Disease Control **In attendance** It is anticipated that the following senior officers will regularly attend: • Trust Infection Prevention Nurses • Community Infection Prevention Nurses • Director of Facilities and Contract • Clinical Procurement Specialist • Environmental officer • Health & Safety Advisor • Operational Services representative – Head of Patient Flow The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. In addition to formal members, the group shall be able to request the attendance of any other member of staff. Microbiology trainees are invited to attend the group as observers. Director of Nursing, Midwifery & Governance/ Director of Infection Prevention and Control chairs the group. In the absence of the Chairman, the Deputy Chair shall be the Consultant Nurse Infection Prevention or Consultant Microbiologist. In the absence of both the Chair and Deputy Chair the remaining members present shall elect one of themselves to chair the meeting.
Attendance	It is expected that Core Members (or appropriate deputies) attend a minimum of 70% of meetings per year.
Quorum	50% of the core membership (or appropriate deputies) must be present. To include at least one Infection Control specialist.
Accountability & Reporting.	The Hospital Infection Prevention Group was established by and is responsible to the Trust Board via the Patient Safety Council:



Meeting Frequency	6 times a year
Agenda Setting and Minute Production and Distribution.	**Agenda** Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the Group and any other person required to attend prior to the meeting. Supporting papers shall be sent to Group members and to other attendees as appropriate, at the same time. **Regular reports received by HIPG.**

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

	Support Services Divisions (to include IPC audits, outbreaks & incidents)		
	Reports from community	At each meeting	Community Infection Prevention Nurses
	Report from Decontamination Lead	At each meeting	Decontamination Lead or Deputy
	Report from Water Safety Lead	At each meeting	Water Safety Group Representative
	Report from Trust Estates and Facilities	At each meeting	Trust Estates and Facilities manager
	Report form IV Access Group	At each meeting	IV access group representative
	Report from Waste Management Group	At each meeting	Environmental officer
	Report from HWWB	At each meeting	Lead Nurse HWWB
	Report from public health	At each meeting	Consultant in Communicable Disease Control
	Minute Production and Distribution. The Secretary shall minute the proceedings and resolutions of all meetings of the Group, including recording the names of those present and in attendance. Minutes of Group meetings shall be circulated promptly to all members of the Group.		
Document Tracking/Control	Documents submitted to the group should be identifiable by using a standard report cover sheet and structure (Appendix1).		
Policy Management.	Policies approved by the committee must adhere to the overall guidance document “Document Control Policy” (Trust Policy on Policies). The Consultant Nurse/Lead Nurse Infection, Prevention & Control is responsible for ensuring that the Policy Checklist is completed in respect of each policy approved. All policies approved by HIPG will be taken to the Patient Safety Council for ratification prior to distribution.		

Mersey and West Lancashire Teaching Hospitals NHS Trust

The annual programme of the Infection Prevention and Control (IPC) Service for April 2024-March 2025 sets out the proposed activities which will ensure that the programme of work continues to focus on two main areas: raising awareness of IPC through education and training and reducing the incidence of Health Care Associated Infection (HCAI). It also supports the Trusts continuing registration with the Care Quality Commission (CQC).This programme is based around The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Care Quality Commission core standards (2014), and the National Standards of Healthcare Cleanliness (NHSE 2021). Learning from incidents, complaints, root cause analysis (LPR)) and observation of care audits have also contributed to this programme.

Infection Prevention and Control Annual Work Programme 2024-25

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

Infection Prevention Work Programme 2024/2025							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
	1. Infection Prevention Team Staffing						
	DIPC - Director of Nursing, Midwifery & Governance	Sue Redfern	Annual review of IPC establishment				
	Whiston/St Helens Sites:						
	Infection Control Doctor	Dr Kalani Mortimer					
	Lead Nurse IP	Claire Chalinor					
	Clinical Nurse Specialist Band 7	2.4 WTE					
	IP Staff Nurse Band 5	2.0 WTE					
	Audit and Surveillance Assistant	1.0 WTE					
	IP Secretary	1.0 WTE					
	Antimicrobial Stewardship Pharmacist	Andy Lewis, Elisha King, Jade Pickup					
	Southport & Ormskirk Sites						
	Infection Control Doctor	Vacant post	Locum Medical Microbiologist in post				
	Consultant Nurse IPC	Fionnuala Browne					
	Clinical Nurse Specialist Band 7	2.8 WTE					
	Support Worker Band 3	1.0 WTE					
	IPC Administrator	Julie Halsall WTE					
	Antimicrobial Stewardship Pharmacist	Alex Priestman) 0.5 WTE from Sept 2024					
	Hospital IPC Group (HIPG)						
	The IPC Team via HIPG will report to the patient safety panel , Quality Committee and Trust board	DIPC. Consultant Nurse IPC . Infection Control Dr					
	HIPG meet six times per year	DIPC. Consultant Nurse IPC , Infection control Dr	TOR reviewed annually . Bimonthly report from key services , complinace against DH objectives				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 3, 4 and 5 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**2. Surveillance**						
	Alert organisms	IPC Team, Microbiology	To maintain and alert Trust staff to risks associated with pathogenic organisms To provide IPC guidance to minimise the risks to patients, colleagues and visitors.				
	Mandatory Reporting			**Q1**	**Q2**	**Q3**	**Q4**
	MRSA, MSSA, E. coli, Klebsiella, Pseudomonas aeruginosa bloodstream infection	IPC Team, Microbiology, Executive Review Panel	To identify, communicate and instigate investigations with clinical teams for Trust-associated cases of all MRSA BSIs, MSSA and GNBSI HOHA cases. To ensure that lessons learnt are disseminated throughout the organisation and reported to HIPG.				
	Clostridium difficile infection (CDI)	IPC Team, Microbiology	To identify, communicate and instigate investigations with clinical teams for Trust-associated cases. To ensure that lessons learnt are disseminated throughout the organisation and reported to HIPG. To undertake a weekly ward round to review patients with CDI.				
	Carbapenem resistant Enterobacterales (CPE)	IPC Team	To manage patients with CPE colonisation as per policy Harmonise policies across MWL IT screening and risk assessment form in to be included in new Careflow (which will support monitoring of compliance)				
	Surgical Site Surveillance (SSI) Total hip and knee replacements	Orthopaedic Surgery	To support the orthopaedic team to review any learning from surveillance. To consider revisiting the One Together SSI improvement toolkit.				
	Respiratory Viruses e.g. influenza, Covid-19, RSV	IPC Team	To provide IPC guidance to minimise the risks to patients, colleagues and visitors.				

Infection Prevention Work Programme 2024/2025							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 5, 6 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**3. Hand Decontamination**						
	Continue to audit compliance with policy	IP Team	Report Trustwide Include in IPC Mandatory Training for all Trust staff Review potential approaches to undertake more objective audits, including the hand hygiene product provider, peer review and patients.				
	To undertake site survey for hand hygiene products with supplier of hand hygiene products, at MWL	IP Team	To optimise placement of products and standardisation of products. Site survey to be completed at STHK sites. Site surveys of all MWL sites to be reviewed and a plan established to refresh dispensers and signage.				
	To review RCN Gloves Off campaign post integration when the recommndation from the national IPC panel has been published late 2024/25	IP Team	To implement the Gloves Off campaign on the Critical Care Units. To further roll-out across other clinical areas following initial implementation, incorporating lessons learnt.				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**4. Policies and Patient Information Leaflets**						
	To agree plan for alignment of policies across MWL, prioritising harmonisation of high risk policies . (37)	DIPC	CDI, MRSA , VRE , PPE. Hand Hygiene , IPC major outbreak , 21 completed				
	To provide advice and support on policies where IP is an integral component	IPT	IP review policies as part of the consultation process				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 4, 5 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**5. ANTT/Intravascular Access and Therapy**						
	Training Needs Analysis (TNA) completed across MWL	IPT/Training & OD	Attend Mandatory Steering Group (MSG) to support TNA				
	Align ANTT policy across sites (in place at STHK)	IPT/Training & OD	To be harmonised following agreement of approach at MSG				
	Develop implementation plan for training	IPT/Training & OD	To establish frequency of training and and mode of delivery for key trainers and clinical staff.				
	Monitor Trust wide compliance	OD and subject matter expert (SME)	Provide updated compliance figures to the relevant care groups and for HIPG				
	Provide Key Trainer training at STHK sites	IPNs, Nurse Consultant ICU	Key trainer training sessions are provided at agreed intervals.				
	To act as an advisory role for vascular access and therapy related issues at STHK sites	Nurse Consultant : MET IV access. IPNs, Nurse Consultant ICU	To provide expert advice on matters relating to vascular access and therapy. Provide report to HIPG. Lead IP nurse to co-chair IV Access and therapy Group with Nurse Consultant ICU				
	Undertake annual Trust PIVC audit	IPT	Provide report to HIPG and PSC. Produce an action plan that will be monitored at the IV therapy group.				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**6. Training**						
	IPC training to junior doctors, volunteers, student nurses, preceptors.	IPC Team	Ongoing				
	Mandatory training	IPT	12 month mandatory training is provided via an online video for clinical staff. 3 yearly mandatory training update for non-clinical staff is via e-learning. Induction training is online.				
	E-learning package update at STHK	IPT/Training & OD	To go live in Q1				
	Lead Nurse IP to complete MSc in Clinical Leadership	IP Lead Nurse	To complete programme in 24/25.				
	Link Personnel	IPT	Quarterly face to face meetings				
	Antibiotic Prescribing	Antimicrobial Management Pharmacists, Medical Microbiologists	Junior doctor training (medical and surgical twice yearly), medical student teaching, medical staff induction.	STHK S&O	STHK S&O		
	Keep IP staff updated with evidence based practice	IPT	Attend North West/ national Infection Prevention Society/ infection control conferences. Undertake webinars by accredited IP organisation e.g. Hospital Infection Society				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6 7, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**7.Audit**						
	To provide assurance to the Board and relevant committes of adherence to high quality IP practices	IPT	Reported to quality leads, matrons, ward managers, supports services, HIPG and PSC				
	Annual Programme revised annually	IPT	Areas with a suboptimal score are revisited until issues compliant				
	Use Tendable platform for IPC audits	IPT	To work with MWL digital leads to optimise this platfrorm for IPC audits				
	Further audits are undertaken by the IPT as the service requires	IPT	e.g. Commodes and dirty utility, flushing audit (augmented areas), Sharpsmart audit, ward kitchen audit, hand sanitiser placement, blood culture audit, deep clean audit.				
	Urinary Catheter care & maintenance point prevalence audit	IPT	To undertake annualy across al inpatient areas				
	Vascular access devices point prevalence audit		To undertake annual poiunt prevelenec in Q4 across al inpatient . Monthly spot checks				
	Vascular access devices	IPT	VIP audits are undertaken if issues are identified through RCA. Monthly reporting via IP audit indicators				
	Compliance with IP precautions including isolation, careplans, PPE etc	IPNs	Quarterly				
	Mattresses	TK	Audited bi-monthly on the inpatient areas by clinical teams. Recorded on tendable Reporting included in Divisonal IPC meetings with assurance to HIPG.				
	Blood culture contamination rates below 5%	KM	ED rates reported weekly to clinical leads. Trust rates reported monthly in IP report at STHK sites.				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 3, 4, and 5 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**8. Antibiotic Prescribing**						
	Participate in IVOS audit (IV to oral switch)	AMT	Report quarterly to HIPG				
	Undertake weekly AMT wardrounds on medical and surgical wards at STHK sites	AMT	Immediate feedback provided on wards, reported in IP monthly report				
	Undertake microbiology wardrounds on Critical Care, Orthopaedic Surgery, Spinal Unit and other ward rounds as staffing allows	Consultant Microbiologist, Southport Site	Immediate feedback provided on wards				
	Point prevalence audit of policy adherence, missed doses, antibiotic review and course lengths at STHK sites	Antimicrobial Management Pharmacists	Reported to Trust clincial leads and in IP monthly report				
	Antimicrobial expenditure information at MWL sites	Antimicrobial Management Pharmacists	Reported to HIPG and DTG				
	. Migiation of Micr glide to EOLAS system go live set 2024	AMT	Rolling process with regular reviews of underlying adult/ paediatric and neonatal policies				

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

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

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 9 and 10 **Trust Objectives:**							
	Develop IPC Resources for clinical areas	IPC Team	buisness case in progress				
	Reinvigorate IPC Link network with reps in all clinical depts	Matron IPC	bimonthly meeting and education events				

Infection Prevention Work Programme 2023/2024							
IP Code and Trust Objectives	**Plan and Priority Activities 2023/2024**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6,9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**12. Interface with relevant groups**						
	Care Group/Divisional meetings	ICNs	To provide expert advice and support as required				
	Decontamination	IPT	To attend quarterly scheduled decontamination meetings. To provide expert advice and support as required.				
	Water Safety	KM	Attend Water Safety Meeting				
	Ventilation Safety	KM	Attend Ventilation Safety Meeting				
	Waste Management	IPT	To provide expert advice and support as required				
	Medical Devices Group	IPT	To provide expert advice and support as required				
	Estates & Facilities	IPT	To provide expert advice and support as required, for capital schemes, linen, catering and other elements.				
	Health & Safety	IPNs	To provide expert advice and support as required				
	Emergency Planning	IPT	To provide expert advice and support as required				
	Health, Work and Wellbeing	IPT	To provide expert advice and support as required				
	ICB meetings	IPT	To attend and provde assurance to commissioners related to IPC				
	NW IPC Regional Meeting	IPT	To engage with and share best practice with peers				
	Ad hoc meetings	IPT	To provide expert advice and support as required				

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	30 October 2024
Agenda Item	**TB24/079**			
Report Title	**Nurse Staffing Establishment Review**			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

To inform the Trust Board of the outcomes of the latest nursing establishment reviews.

Executive Summary

This paper aims to provide assurance that Merseyside and West Lancashire NHS Teaching Hospitals (MWL) has the necessary arrangements in place to review nursing and midwifery staffing levels in accordance with regulatory requirements. It presents the findings from the bi-annual establishment reviews conducted in July 2024 for acute inpatient wards, based on the current ward configuration and clinical pathways.

The paper outlines the framework used to assess current staffing levels, leveraging nationally recognised methodologies. It is important to note that while additional bed capacity remains open, this review focuses solely on the established bed capacity. Staffing for these additional, non-established beds is currently being managed through temporary staffing measures, including the use of bank and agency personnel.

Looking ahead, there is a need to reassess the overall ward configuration and clinical pathways to ensure a bed and staffing model that is clinically, operationally, and financially sustainable for the future.

It should be noted that this review does not include maternity services, as they conduct their establishment reviews independently. These have previously been reported to Trust Board.

Key messages of the report

- The bi-annual review of nursing and midwifery staffing establishments was conducted in July 2024 across all MWL sites.
- The review aims to standardise nurse staffing levels and skill mix across MWL to ensure consistency and maintain a safe standard of care.
- A uniform approach to nurse staffing establishments has been implemented across all sites, aligning with nationally mandated guidelines, including NICE guidance for inpatient adult wards, NHSi's "Developing Workforce Safeguards" (2018), and the RCN Nursing Workforce Standards (2021).
- The review acknowledges the challenges posed by the high number of additional beds that remain open.
- There is a continued organisational focus on filling all registered and unregistered nursing vacancies, with an emphasis on the development and retention of the nursing and midwifery workforce.
- A key objective is to reduce reliance on bank and agency staff.

Financial Implications

None directly as a consequence of this report.

Quality and/or Equality Impact	
None directly as a consequence of this report.	
Recommendations	
The Board is asked to note the Nurse Staffing Establishment Review.	
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

1. Introduction

The purpose of this paper is to present the latest findings from the bi-annual nursing staffing establishment review for inpatient wards, conducted in July 2024 (with data collection beginning in June 2024) across all 54 inpatient wards at MWL.

NHS providers are required to ensure that they have the appropriate staff with the necessary skills, in the right place at the right time, to maintain safe nursing and midwifery staffing levels. This aligns with the National Quality Board (NQB, 2016) requirements, which specify that providers:

- Must deploy a sufficient number of suitably qualified, competent, skilled, and experienced staff to safely and effectively meet patient care needs.
- Should adopt a systematic approach to determining the number and skill mix of staff required to maintain safety at all times.
- Must use an approach that complies with current legislation.

The report provides the Committee with assurance that the Trust has a robust, validated process for monitoring and ensuring safe staffing levels. The Trust's compliance will be evaluated in the annual governance statement by verifying that staffing governance processes are both safe and sustainable.

This compliance will also be reviewed during any CQC inspections to demonstrate adherence to fundamental standards. The Trust uses a 'triangulated approach' that incorporates evidence-based tools, professional judgment, and outcomes to ensure that the right staff with the right skills are in place at the right time.

Additionally, it is a requirement for every Board to receive an annual staffing establishment report, with further updates provided on a bi-annual basis, as per the National Quality Board (2016).

This paper will also provide recommendations for any necessary adjustments to the current staffing establishments for consideration by the Executive Committee.

2. Background

Following the merger of the legacy STHK and S&O Trusts to form MWL on July 1, 2023, both legacy trusts conducted a joint 6-monthly review of nurse staffing establishments in December 2023. The review, approved by the Executive team, resulted in the addition of one Healthcare Assistant (HCA) for night shifts on seven wards (18.78 WTE total) and one additional Registered Nurse (RN) for late shifts on two wards, all at the Whiston site (14.41 WTE total), with a total financial cost of £901,213. It was proposed that this cost could be mitigated by reducing discrepancies between sites regarding Ward Manager (WM) supervisory time headroom and paid breaks.

The objective of this establishment review was to:

- Harmonise nurse staffing levels and skill mix across MWL to ensure consistency and maintain a safe standard of care. By implementing a standardised approach to nurse staffing establishments across all sites, in accordance with nationally mandated guidelines, such as NICE guidance for inpatient adult wards, NHSi's "Developing Workforce Safeguards" (2018), and the RCN Nursing Workforce Standards (2021).

- Provide recommendations for any necessary changes to the funded staffing establishments on the wards.
- Ultimately, provide assurance that MWL has a well-planned nursing workforce with adequate staffing resources to meet patient care needs safely and effectively.

3. Methodology.

In June 2024, data collection using the Safer Nursing Care Tool (SNCT) was conducted across adult inpatient wards, emergency care, and children's and young people's services. Prior to this review, the SNCT introduced a revised tool that now includes supplementary care, which was previously excluded. To support this, a comprehensive training program was implemented ahead of the data collection. The Trust has been consistently capturing supplementary care data, which is reported through the monthly safer staffing report. Following a presentation to the Executive team and the Quality Committee on the supplementary care point prevalence review, a service improvement program was initiated, with contributions from the service improvement team.

4. Variation between 2 legacy sites.

This paper outlines the MWL approach to the Trust-wide nurse establishment review. The process has previously identified several key differences in the current staffing structure, including:

- Variations in Care Hours per Patient Day (CHpPD) due to different working arrangements.
- Differences in baseline staffing levels and skill mix across similar specialties.
- Inconsistencies in skill mix and headroom, requiring alignment across sites.
- Allocation of supervisory time for Ward Managers.
- Management and oversight of the e-rostering system.
- Differences in the allocation of breaks during 12-hour shifts.
- Variations in the provision of catering and housekeeper roles.
- Differences in ward layouts across sites.

4.1 Care Hours Per Patient per Day (CHpPD)

CHpPD is calculated by adding the hours of registered nurses and the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight). CHpPD is reported as a total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix.

$$\textbf{Care Hours per Patient Day} = \frac{\text{Total hours of nurses and midwives plus total hours of care support workers}}{\text{Total number of inpatients}}$$

The national benchmark is 7.0

The review has highlighted the variations in the CHPPD calculations across the legacy sites.

At the time of the establishment review the CHpPD for legacy STHK was 7.9 and for legacy S&O was 8.8. The overall CHpPD for MWL was 8.2. It was recognised there are differences in the 2 sites CHpPD, this is to be partially due to difference in staffing skill mix, for example, HCAs undertaking hostess and housekeeper roles .

It has previously been highlighted that there is a difference in the unify reporting of safer staffing fill rate at legacy S&O i.e they have been adjusting the funded, planned staffing levels to included additional shifts required for acuity on a daily basis, as required, which ultimately impacts on the monthly fill rates as these additional shifts should have been added to the actual staff on duty (not the planned). This has been corrected for August 2024 Unify reporting period and is now consistent across all sites.

4.2 Variation in baseline staffing levels across the same specialties

The December 2023 review identified variations in staffing skill mix and bed numbers across specialties. However, it is essential to consider differences in ward environments, patient acuity, and staffing requirements to meet patient needs, all of which impact the appropriate skill mix for each ward. The previous review recommended maintaining the current levels of HCAs due to their involvement in additional duties such as hostess and housekeeper roles.

5 Supplementary care

Data was collected for this review using the newly launched version of the tool, which also calculates a supplementary care provision. Initial findings from this identify the requirement for increased baseline establishments to manage patients requiring level 3 supplementary care (bay tagging). A second data collection, with validation, is scheduled for December, to determine accurate staffing requirements for this level of patient. A point prevalence audit will also be conducted to triangulate data. The tool also provides data on staffing WTE required to manage level 4 supplementary care patients (1:1), to understand the impact on baseline establishments. Other models are also being considered from within Cheshire and Merseyside, and beyond.

6 Variances in temporary staffing provider in relation to reporting of bank/agency use and associated costs.

There are currently two separate providers for temporary staffing requests: NHSP and Staffing Solutions. A review of the previously varying rates of pay and overall costs to the Trust has been conducted, resulting in alignment between the two. Human Resources and Finance are now conducting an options appraisal regarding the selection of a single temporary workforce provider.

7 Variation in provision of catering / housekeeper roles

Across legacy STHK in-patient wards there is variation in the hours allocated to the housekeeper role. Historically the posts have been funded from HCA posts. It is recognised this important role supports the release of nursing time to focus on delivery of patient care. In addition, the hostess role, allocated to each ward is supported by Medirest.

The housekeeper and the hostess roles at S&O and the roles and responsibilities of this role if undertaken by the ward HCA. It is recommended that currently we do not reduce the HCA staffing at S&O and accept there is a variation as this role.

8 Additional beds

The establishment review currently does not take into consideration the use of escalation beds. However, it is recognised that additional staffing has been required to safely manage the opening of these additional beds. This has resulted in additional patients being nursed in the main bays within the wards (additional patient in bays and treatment rooms). This staffing has previously been provided by bank and agency if resources cannot be redeployed from other areas. RN funding has recently been approved to increase substantial workforce establishments on some affected wards to support this increase in patients.

9 Acuity review update

Acuity reviews using SNCT were undertaken in July 24. Acuity data was collected across all sites and was reviewed during the staffing establishment process alongside staffing ratios, quality metrics and professional judgement was applied to triangulate the information and inform the ward staffing establishment.

10 Band 2/3 review

As part of the Bands 2 – 3 Health Care Assistant (HCA), Health Care Support Worker (HCSW), Dual Role Worker (DRW) re-banding resolution has commenced and is progressing well so far. Regular meetings with Trade Unions and HCA representatives are planned to monitor.

11 Establishment review outcome summary by Division

Below summarises the proposed nursing establishments following the senior nursing team meetings held in July 2024.The resulting gap in the ward establishments are primarily due to safe staffing ratio compliance.

11.1 Medicine

As explained above, for this review Shelford recommendations, staffing ratios, quality metrics and professional judgement was applied. The senior nursing team makes the following recommendations of an uplift from band 5 to band 6 1 x RN on wards 5A and 5B. A case is being developed to be fully considered.

Rationale for this is that both wards currently accommodate 38 patients, with funding for 2 band 6 registered nurses (RNs) only. All other wards at the Whiston site are funded to 3 x band 6 RN’s which allows for a greater senior presence and leadership on these wards. Overall, the presence of senior nurses on wards enhances patient care, supports junior staff, and ensures the smooth operation of healthcare services, making them an essential part of the nursing team.

11.2 Surgery

All ward establishments have undergone thorough reviews, incorporating Shelford recommendations, staffing ratios, quality metrics, and professional judgment. The resulting overall established staffing levels are currently deemed appropriate for the established bed numbers. However, the review has highlighted that an operating theatre review across all sites is required outside of the establishment review process.

11.3 ED

EDs across all sites continue to experience a substantial increase in attendances and acuity resulting in overcrowding in waiting areas and frequently utilise corridors to accommodate patients awaiting beds, prioritising patient safety. As a response to this evolving landscape, adjustments have been made to the departments' layouts. Consequently, the senior nursing team recommends the development of a business cases, distinct from this establishment review, to substantiate the need for additional staffing on the Southport site and to substantively establish staffing for corridor care on the Whiston site to effectively support these changes across both sites. Consideration should be taken into the difference in corridor staffing models between sites.

11.4 Intermediate Care

Following a comprehensive review of all ward establishments, recommendations have been formulated considering current nurse-to-patient ratios, as well as Shelford, CHpPD and outcomes. The senior nursing team proposes the addition of an extra band 4 registered RN on Newton ward to achieve a nurse-to-patient ratio of 1:11 and bolster CHpPD. Presently, the ward is staffed with 2 RNs during the night shift, resulting in a challenging nurse-to-patient ratio. The Executive Team will be supporting this recommendation by addressing with commissioning colleagues.

12. Strategic Staffing Reviews – Summary

There is a continued need to be responsive to staffing requirements with consideration for bed reconfigurations and expansions to ensure expected capacity requirements are met. Changes to the ward bed base and patient pathways have affected the staffing requirements, to ensure we meet the nationally recommended safe staffing ratios and patient safety. Work is continually required to review the ward configurations and clinical pathways to ensure that there is an operating and staffing model for the period ahead which is clinically, operationally, and financially sustainable.

13. Recommendations

The Trust Board is asked to note: -

- That the bi-annual establishment review process for nursing and midwifery staffing has been undertaken in line with agreed methodology, with new evidence-based tools implemented in adult wards.

- Support the recommendations that registered and unregistered nurse staffing levels need to be a continued area of review in line with evidenced based reviews, including outcomes from the new Shelford tool incorporating supplementary care provision.
- Further work is required to review and align were possible ward base establishments for same speciality wards recognising the differences.
- Following agreement for the proposal the ward budgets and e-roster will be adjusted.