Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting - Part 1

Wednesday 4 October 2023
10.00am-12.30pm
Trust Conference Room WHH/Via MS Teams

Supplementary Pack

BM/23/10/125 – Learning from Experience Q1 (Quality Assurance Committee 08.08.23)
BM/23/10/126 – Nurse Staffing Bi-Annual Report (Quality Assurance Committee 08.08.23)
BM/23/10/127 – Learning from Deaths Q1 (Quality Assurance Committee 12.09.23)
BM/23/10/128 – Director of Infection Prevention & Control Q1 (Quality Assurance Committee 08.08.23)
BM/23/10/129 - Digital Strategy Group Update (Finance and Sustainability Committee 27.09.23)
BM/23/10/130 - RTT Validation Assurance Report (Finance and Sustainability Committee 27.09.23)

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/10/124 – BM/23/10/128**			
SUBJECT:	**Supplementary Papers**			
DATE OF MEETING:	4 October 2023			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
	SO1: We will.. Always put our patients first delivering safer and effective care and an excellent patient experience.	√		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All Risks			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
	Further Information: ***Each paper is individually marked from September 2023***			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
	Further Information: ***Each paper is individually marked from September 2023***			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
	Further Information: ***Each paper is individually marked from September 2023***			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In following best NHS corporate governance practice, and to support WHHs commitment to openness and transparency, the papers listed below are provided as supplementary papers for the Trust Board meeting 2nd August 2023. No actions are required from the Trust Board they are provided for information only. The papers provided are: • **BM/23/10/125 – Learning from Experience Q1** presented at Quality Assurance Committee 08.08.23 • **BM/23/10/126 – Nurse Staffing Bi-Annual Report** presented at Quality Assurance Committee 08.08.23 • **BM/23/10/127 – Learning from Deaths Q1** presented at Quality Assurance Committee 12.09.23			

	• **BM/23/10/128 – Director of Infection Prevention & Control Q1** presented at Quality Assurance Committee 08.08.23 • **BM/23/10/129 Digital Strategy Group Update** presented at Finance and Sustainability Committee 27.09.23 • **BM/23/10/130 RTT Validation Assurance Report** presented to Finance and Sustainability Committee 27.09.23			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the supplementary papers provided for information.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Multiple Committees, as listed above		
	Agenda Ref.	As listed above		
	Date of meeting	As noted above		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/23/08/276**			
SUBJECT:	**Learning from Experience, Quarter 1 2023/24**			
DATE OF MEETING:	8 August 2023			
AUTHOR(S):	Layla Alani, Director Integrated Governance, Deputy Chief Nurse Nicola Edmondson, Associate Director of Governance Ernesto QUIDER, Associate Director for Quality Maresa Kelsall, Patient Safety Manager Matthew Nuttall, Governance Administration Co-Ordinator The paper was written with input from service leads.			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EXECUTIVE SUMMARY	The Learning from Experience Report, Quarter 1, 2023/24 provides an overview of the Learning from Experience across the organisation. The information within the report is extracted from the Datix Incident Management System and other Clinical Governance functions to triangulate the data and learning from Incidents, Complaints, Claims, Health and Safety, Clinical Audit, Quality Improvement and Research and Development related to Quarter 1, 2023/24			
PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
RECOMMENDATIONS:	The Quality Assurance Committee is asked to note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Learning from Experience, Quarter 1 2023/24	AGENDA REF:	QAC/23/08/176

1. BACKGROUND/CONTEXT

The Learning from Experience Report, Quarter 1, 2023/24 relates to data reviewed during the period 1st April 2023 to June 2023 (Q1). It contains both quantitative and qualitative data analysis using information obtained from the Datix Risk Management System and other governance functions to triangulate the data and learning from incidents, complaints, claims, health and safety, clinical audit, compliance, quality improvement and research and development.

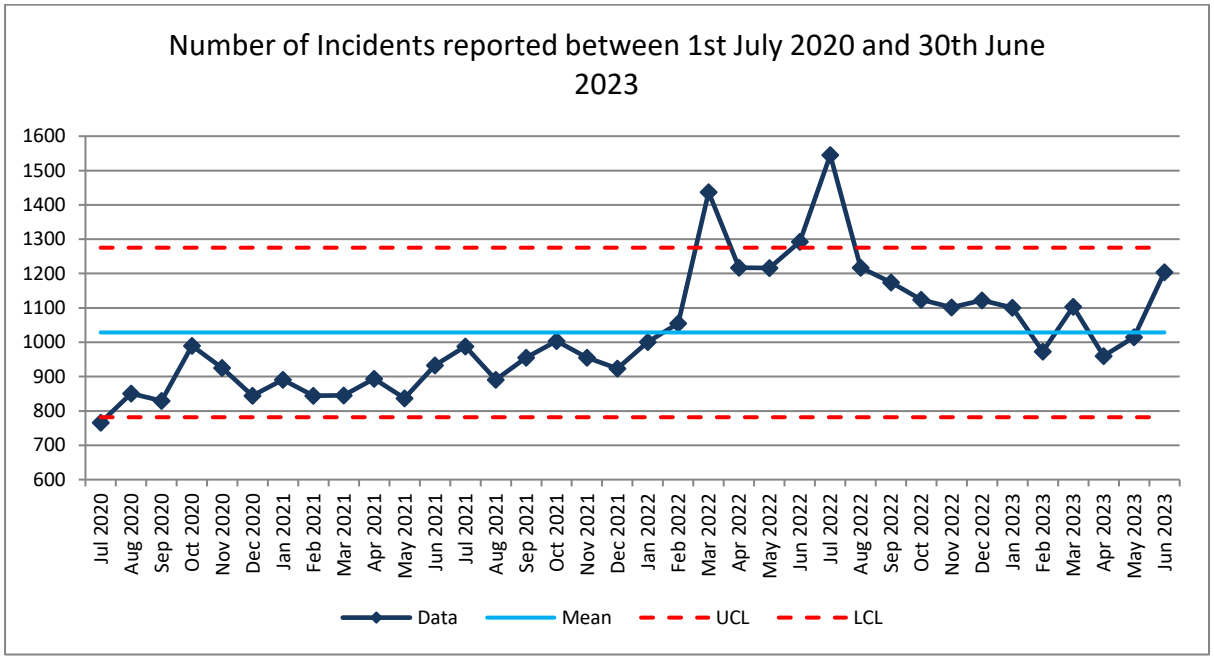
The report includes a summary of themes, trends and key findings that have influenced learning and action to support and sustain improvement.

2. Learning from Incidents

2.1 Incident Reporting Position

In 2023/04 Q1, a total of 3179 incidents were reported compared to 3177 incidents reported in 2022/23 Q4. This represents an increase of 2 incidents. The area with the largest decrease in the number of incidents reported is Surgical Specialties with a variance of 60 (17%), when compared to the last reporting period. The Care Group are aware of the decrease and the incident reporting position will be monitored, recognising that fragile services also sit within this area. The largest decreases in reporting in Surgical Specialities mainly relate to Assessment, Diagnosis and Investigation and Infection Prevention and Control (IPC). The decrease in IPC incidents is expected as the Trust is not admitting as many in patients with a known Covid positive status and there has been a reduction in patients that acquire covid during their hospital stay.

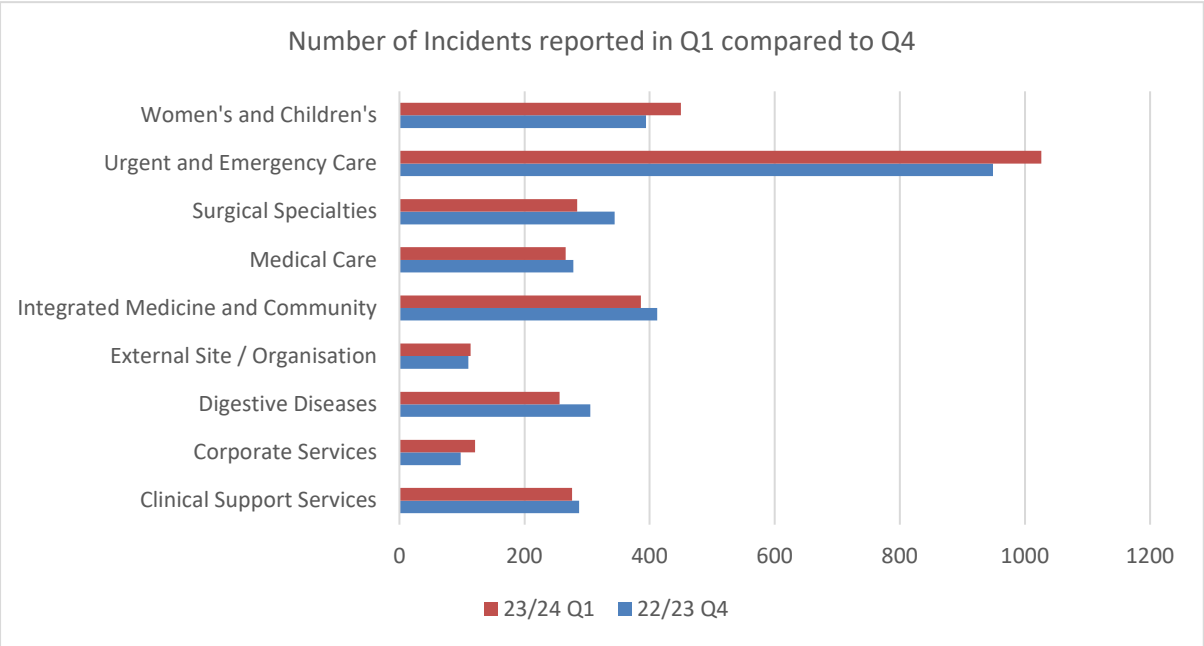
Graph 1



2.2 Incident Reporting Position per Clinical Business Unit (CBU).

In Quarter 1, a total of 2944 incidents were reported across the CBUs and Clinical Support Services as shown in graph 2 below. The remaining 114 were reported as external incidents and 121 were reported within corporate services. Corporate Services incidents include the following areas: Digital Services, Education and Organisational Development and Estates and Facilities.

Graph 2



Following review of Q1 data, areas that have noted a noted decrease in reporting compared to Q4 are Surgical Specialities 60 (17%) and Digestive Diseases (49) (16%). Increases in reporting are noted in Women's and Childrens (56) (14%) and Urgent and Emergency Care (77) (8%).

The largest decrease in Digestive Diseases relates to documentation, Infection Prevention and Control and Treatment and Procedure.

Themes within Women's and Childrens include staffing levels, medicines management, appointments / clinical review and Infrastructure, Environment and Resource. Environmental and medicines incidents relate to the temperature of the clinical preparation rooms where medications are stored during the recent period of hot weather. The Estates team are aware, and a piece of work is underway to install air conditioning units into the relevant rooms.

Within Maternity/Neonatal category there were 47 incidents related to PPH reported in Q1, compared to 33 in Q4. PPH Rates for June were above the benchmark, however there is an improvement from May 23. A deep dive was presented to the Quality Assurance Committee in May 23 and learning has been captured in an action plan which is underway. This includes the introduction of a new medication regime for those undergoing elective caesarean section and further simulation training to support management of cases. PPH >1500mls will continue to be reviewed on an individual basis via governance processes but will also be subject to additional review through the Intrapartum Incident Review Group which meet regularly to review patterns and themes from incidents of PPH >1500ml. Rates of PPH >1500mls are also reported via the Maternity dashboard to CBU Governance meetings.

The largest increases in reporting in Urgent and Emergency Care mainly relate to Safeguarding, Assessment, Diagnosis and Investigation and Clinical Care. Additional safeguarding support is being offered to the department to support new starters in understanding the referral process and to support any staff knowledge or questioning requirements. Training is being incorporated into the induction for new staff and training trajectories are being monitored by the Care Group.

2.3 Themes and learning from incidents by CBU:

2 Never Events were reported in Q1 2023/24.

- Patient receiving an incorrect blood transfusion on the Programmed Investigations Unit (PIU) at Halton
- Missed swab left in situ following breast surgery.

Learning and actions taken from the first Never Event were:

- Supporting and reviewing processes of work with staff -understanding workload and human factors.
- Staff received training and competencies were re assessed.
- An awareness initiative was completed to highlight the correct process of blood transfusion administration and importance of ensuring distractions are minimised.
- An additional checklist was introduced, this requires the staff to sign for each individual step of the process rather than one signature that covers the whole process.

The second Never Event relating to a missing swab remains under review with completion scheduled for 4.8.23. A full understanding of the review with identified learning will be provided in the Q2 report.

Following the Never Event staff on all 3 sites were safety briefed regarding the incident, each day for the remainder of the week. Further learning will be identified as part of the investigation process.

2.3.1 Medical Care. Tracheostomy Care

There have been four incidents relating to tracheostomy care reported in Quarter 1. An emerging theme has been identified around displacement of tracheostomies when patients have changed position. A cluster review of these incidents is underway by the Associate Director of Governance and Patient Safety Manager in conjunction with the clinical team, this will be presented at the Weekly Executive Led Safety Oversight Meeting in August in the first instance.

2.3.2 Urgent Emergency Care (UEC). Hospital Acquired pressure ulcers.
During Quarter 1, 8 pressure ulcers occurred within UEC:

- 4 category 2 on A1
- 2 category 2 on A2
- 1 category 2 in ED
- 1 category 3 on A1

The CBU have been liaising closely with the Tissue Viability Nursing Team (TVN) to support SKKIN bundles, incorporating a time of completion for the body map on all patients. The TVN team are holding link nurse meetings and Ward Managers across UEC are to ensure attendance which is being

monitored by the Associate Chief of Nursing. A pressure ulcer champion study day has taken place, with more planned for in Q2 2023 linking with the Quality Improvement Team to share ideas across the trust. Daily ward rounds are being completed across Urgent and Emergency care by the Ward Matron and Lead Nurse to support escalation where required.

In addition, following the review of RCA investigations, the Emergency Department have been working closely alongside the Tissue Viability team to identify ways in which pressure ulcers can be prevented. They are in the process of trialling the application of film dressings on high-risk patients. This will reduce friction and shear to the heels and therefore reduce the risk of pressure damage. The Emergency Department have also increased their stock of air flow mattresses to enable prompt and appropriate pressure relief because of continued increased demand and acuity.

Actions to improve include:

- The application of heel film dressings for all patients in the Emergency Department (ED), in addition to regular pressure ulcer prevention measures.
- The QI Team support the Matrons to monitor the sustainability of the change package. Areas of higher incidence identified, ED, A6, B18, A1, A2. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses.
- Nursing staff regularly shadow the Tissue Viability Nurse (TVN) Team to gain experience in pressure ulcer prevention and management.
- A workshop for pressure ulcer prevention was held in May and June, information has been collated and areas for improvement/training identified.
- New PSIRF methodology to be applied to harms as a result of pressure ulcers going forward.
- Display posters circulated for prevention of damage to heels.
- New kit for use of prevention of heel pressure ulcers to be trialled across A7/A8 on week commencing 24th July 2023.

2.3.3 Surgical Specialities. Ophthalmology.

Two incidents occurred in Quarter 1 related to delays in appointments within Ophthalmology. Two patients had delays in their care which had affected their vision, these patients have now received an appropriate review. Learning identified was as follows:

- Patients were being seen inconsistently due to capacity challenges in the clinic capacity. It is important that patients have their treatment/injections at the timescales indicated by clinician and within the NICE guidelines.

Actions related to:

- Ensuring that all patients are treated within set timeframes. With support of the 18-week Insourcing Team and extra waiting lists at Warrington Hospital, the Trust has met this target in April, May, June and July. Planning has commenced for August.
- This position is being monitored as part of work around fragile services at Patient Safety and Clinical Effectiveness Sub Committee and Quality Assurance Committee.
- There are plans to expand the Acute Macular Degeneration (AMD) Service.

2.3.4 Integrated Medicine and Community (IMC) Falls.

In Quarter 1 of 2023/2024 there were 63 falls compared to 59 in Quarter 4 2022/2023 (4). Two of these were confirmed as moderate harm on Ward B12. Ward B12 are reviewing enhanced care daily, supported by the Matron and Lead Nurse.

Themes for learning relating to falls relate to:

- Consistent use of the fall's equipment.
- Timely risk assessment on admission.
- Ensure appropriate cohorting.
- Ensuring enhanced care is provided when appropriate.

Actions are in place to ensure improvement; this has included a review of all fall's equipment and stocks on each ward to make sure the kit is available in each area whilst also supporting the staff to do timely risk assessments.

The wards have completed a third round of data collection for the safer nursing care toolkit, the results of this are currently being reviewed, this will identify mis- match between staffing establishments and dependency and acuity. This will be reviewed as part of the nurse staffing reviews with the Deputy Chief Nurse.

2.3.5 Women's and Childrens. Safeguarding.

In Quarter 1 of 2023/2024 there were 29 incidents reported relating to safeguarding. Although this was a reduction from Quarter 4 in 2022/2023, one incident was declared a serious incident (SI).

The SI declared involved a patient who received antenatal and postnatal maternity care at Warrington and Halton Hospitals NHS Trust (WHH) and denied any social care involvement. Learning following review of the incident identified missed opportunity to review the previous alerts, which if reviewed would have prompted a conversation with Safeguarding. Immediate actions taken to support future learning include:

- The development of an educational single point lesson on professional curiosity
- The development of a flow chart for actions to take when women do not attend for antenatal appointments.
- All staff have been reminded of the alerts process on Lorenzo through the governance newsletter.
- The learning and the report have been shared with appropriate teams.

Further long-term actions relate to:

- The design of a cross organisational pathway relating to the sharing of information between the GP and Maternity services, when women self-refer for care.
- Supporting the community Midwife to share personal learning relating her involvement in the care.

- Developing and sharing safeguarding Childrens lessons learned through the maternity training.

3.0 Learning overview from individual incidents across the CBUs.

The following section provides a sample of learning from individual incidents across each CBU:

Women's and Childrens

We learnt that….
A woman fainted in the bathroom whilst showering post birth. The Midwife had left the room to dispose of soiled laundry and the woman had mobilised to the bathroom unsupported. There, she had felt dizzy and fainted. She was reviewed by the medical team with no harm caused. The woman was deemed a falls risk, due to having been 10 hours in labour, having a forceps delivery and having blood loss of 945mls. Risk assessment had been obtained prior to the Midwife leaving the room. The fall incident was presented at Trust Wide Safety Brief and the Weekly Harm Meeting by the falls champion for Maternity.
We acted upon …
➢ Learning opportunities were identified and shared with the wider team within the team safety briefs. ➢ There are safety alerts for falls posters in the birth rooms, highlighting the risk of falls to women and the requirement to mobilise with support following birth. ➢ A maternity specific falls guideline and risk assessment has been developed through collaboration with maternity and patient safety colleagues.

Medical Care.

We learnt that ….
A patient attended the Emergency Department with an acute infarct in the right occipital lobe and was transferred to The Walton Centre for an embolectomy and then returned to Warrington ICU. On arrival there were only two junior staff nurses and a new Operating Department Practitioner (ODP) preparing the admission.

The staff nurse was withdrawing blood from the line containing Noradrenaline to check for patency and upon noticing blood pushed it back instead of discarding it, causing an accidental bolus of the drug.

Noradrenaline is designed to increased blood pressure; the volume given is unlikely to have had any significant effect but could have done.

We acted upon …

- The patient had a senior medical review and was stabilised before a repeat Head CT was completed.
- All ICU staff involved were booked to attend a refresher course regarding the infusion of inotropes and Intravenous management.
- The admissions policy was adjusted to advise there must be always a senior nurse present during the admission of an intubated patient.

Integrated Medicine and Community

We learnt that….

A patient has been repatriated from Whiston Hospital following acute stroke treatment / care. The patient arrived on Ward B14, after the doctor's day shifts had finished and was not clerked until 6am. The patient also required medicines prescribing, an i-bleep was placed out of hours due to the business of the evening. Had the patient deteriorated ahead of medical review this would have been a significant safety concern, hence WHH have an agreement with Whiston Hospital of a transfer time of 4pm.

We acted upon….

- Lead Consultant reviewed the incident – the patient came to no harm. Communication and compliance to the agreed pathway was identified as points for learning.
- Spoke to the therapy staff who speak to Whiston on a daily basis, to reinforce the agreement that the cut off time for Whiston patients transferring to B14 is 4pm. This helps to ensure that the medical team have the opportunity to clerk the patients in, and to prescribe appropriate medications in a timely manner.
- Should a patient arrive inadvertently after 5pm to be escalated to Patient Flow / SMOC to ensure patient is reviewed and any medications prescribed.
- Repatriation to be agreed at the 8:45am bed meeting and Whiston Hospital contacted to confirm repatriation.
- If the patient has not arrived by the 12noon bed meeting Whiston Hospital to be recontacted and 4pm deadline to be re-enforced.
    - CBU monitoring process is in place.

Urgent and Emergency Care.

We learnt that …

A patient absconded from Ward A2, who was under a section 5:2 at the time with external supporter workers. The patient had a suicide attempt in the community following absconding. There was poor communication from the police with updates to the ward staff about the incident.

The Ward was informed by carers present on the ward from the Brooker centre that the patient was going to Aintree hospital.

We acted upon …

A Rapid Incident Review was undertaken:

- It was felt by the panel that the Trust, had not caused direct harm to the patient however there was an opportunity to improve and learn from this: actions were assigned as following:
- Raised awareness with staff of the clear guidance and requirement when a patient absconds.
- Staff were supported following the incident.
- Reviewed all patient's paperwork provided from Brooker Centre to ensure appropriate paperwork and risk assessments were transferred with patient – if not this is to be made clear and should be reviewed upon initial arrival to ED.
- In Q2 a review the Trust policy for "missing patients" will be undertaken to improve communication from external teams to WHH.

Digestive Diseases- Theatre

We learnt that….

A Patient attended PIU for a blood sample, the patient's blood was collected using paperwork for a different patient – staff did not realise until the patient whose paper work had already been used arrived for bloods to be taken.

Learning related to:

- The importance of correct paperwork for blood samples shared with all staff on PIU.
- The need to review processes currently in place and how these impacted outcome.
- The need to review work as done rather than work as imagined.

We acted upon….

- Incident reviewed using a systems approach with recommendations:
- The paperwork is now given to the patient to hand to the nurse when booking in at reception, the nurse does not now need to search through multiple forms.
- Created a dedicated room for bloods to be taken rather than this being done in a ward bay with multiple distractions/other pts and staff. This allows for a quiet dedicated space that stops interruptions and minimises distraction and enables the staff to concentrate on the task at hand.
- Review of appointment system for PIU to ensure that workload is manged at safe levels and staff can plan and prioritise care safely and effectively.
- All recommendations have been implemented and are being evaluated by the ward manager senior nursing team and governance to monitor effectiveness and staff/patient experience.

Surgical Specialities

We learnt that….
An Orthopaedic Patient came back from Theatre with an Intravenous variable (IV) rate insulin infusion; however, fluids had been completed and not replenished prior to transfer. Incorrect advice was given to stop the IV variable rate insulin infusion overnight. The patient had type 1 diabetes. The patient developed Hyperglycaemia and ketosis.
We acted upon….
➢ Hyperglycaemia algorithm was shared with ward clinical team. ➢ Reflection and clinical supervision discussion took place. ➢ A safety brief was completed for recovery and the care, maintenance, and use of variable rate insulin infusions. ➢ A single point lesson was completed. ➢ Forum of insulin/diabetes learning sessions took place. ➢ liaison with Governance lead to take place regarding training for new Dr's and Diabetes

4.0 Learning from Incidents and Assurance.

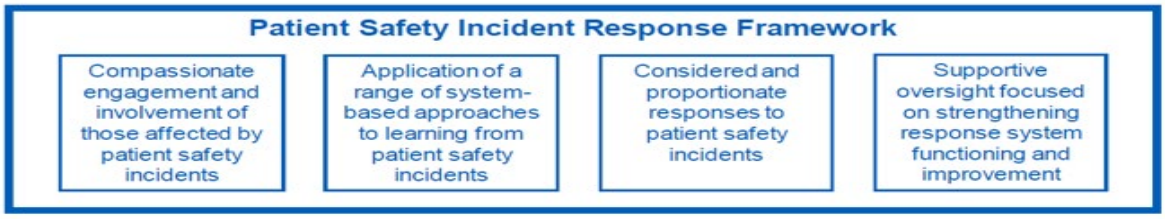
The Patient Safety Manager continues to attend the PLACE (previous CCG) meetings to present Serious Incidents alongside the Investigating Officer. This ensures that learning is shared externally as well as internally. Incidents and complaints are also discussed at the Clinical Quality Focus Group (PLACE) by the Director of Governance. Learning is shared within governance and speciality meetings with wider learning shared through other modalities such as safety alerts and other relevant meetings such as the Nursing and Midwifery Forum, Mortality Review Group, and the Medical Cabinet.

5.0 Patient Safety Incident Response Framework (PSIRF) - learning and improving patient safety.

The PSIRF was introduced in September 2022 and is mandated for any organisation who provide funded NHS care. WHH has a live date for implementation of the 1st of September, the Integrated Care Board are fully appraised of these plans and the Coroner is aware.

Local priorities for review have been discussed focusing around, care of patients with mental health complexities, care and escalation of deteriorating patients and patients where cancer may have been missed. There are also nationally mandated priorities.

- PSIRF replaces the Serious Incident Framework but in itself is not an investigation framework.
- PSIRF aims to support organisations to change culture in order to improve patient safety.
- PSIRF does not mandate investigations as the only method of learning from patient safety incidents or prescribe what to investigate.
- PSIRF aims to move away from targets attached to incident investigations and instead focus on learning and improvement.
- PSIRF supports the development and maintenance of an effective patient safety incident response system with four main aims:



The various tools, and types of investigations and reviews that can be used for learning and improving patient safety include:

- Patient Safety Incident Investigation (PSII) – in-depth review of a single or cluster of incidents to understand what happened and how.
- Multidisciplinary Team Review – aims to through open discussion to agree the key contributory factors and system gaps that impact on safe patient care.
- Swarm Huddle – initiated as soon as possible after an event and involves and MDT discussion. Staff 'swarm' to the site to gather information about what happened and why and decide what needs to be done to reduce reoccurrence.
- After Action Review (ARR) – structured facilitated discussion of an event, based around four questions.

In addition, a move away from the use of Root Cause Analysis (RCA) to a more systems-based learning approach including system engineering and human factors will bring about enhanced learning from incidents and support harm reduction.

WHH has already started introducing the new learning response methodologies (to support incident investigations) and local priorities are currently being finalised. The PSIRF policy and plan are currently being ratified. Training is being provided to staff to support the PSIRF requirements.

The fostering of a culture which support staff to feel psychologically safe is imperative to the success of PSIRF and a programme is in development to support this important work.

Alongside the implementation of PSIRF is the requirement to move towards using a new national learning and reporting system Learn From Patient Safety Events (LFPSE) this will replace both the current National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS). The new system is built on modern architecture and will include machine learning, which will support health care wide improvements and enable improvement efforts to be targeted to support organisations. An extensive programme of work in underway to support the safe transfer to the new national system. To support this work the National Patient Safety team have also released a framework to support organisations to explore compliant providers of Local Risk Management Systems, and an evaluation of these are underway to consider if the current system used in WHH (DATIX) could be provided by an alternative supplier.

WHH are participating in the engagement events with the national Patient Safety Team, as well as the Northwest PSIRF hub, which has been bringing all organisations together to focus on the PSIRF key deliverables as well as share learning from the 17 acute hospital pilot sites. WHH is also working closely with ICB and Place leads as part of the work to embed PSIRF and LFPSE.

Weekly executive oversight meetings are in place with bi-weekly task and finish group also in place to support the implementation of PSIRF with a representative membership from across the organisation.

Both PSIRF and LFPSE will go are scheduled and on track to go live on 1st September following sign off through the appropriate governance processes.

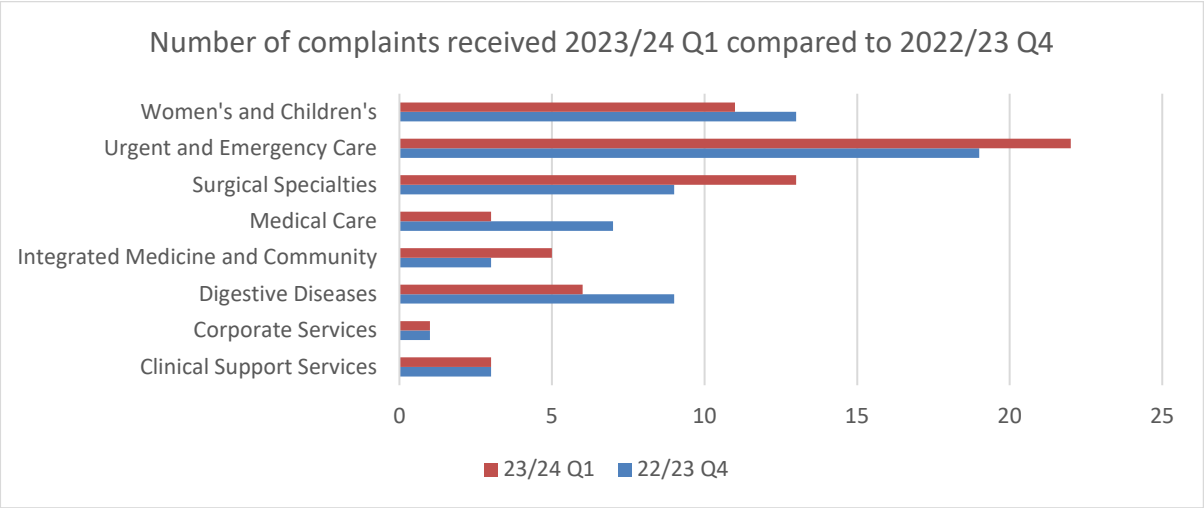
6. Learning from Complaints and PALS

6.1 Complaints.

6.1.2 Complaints received.

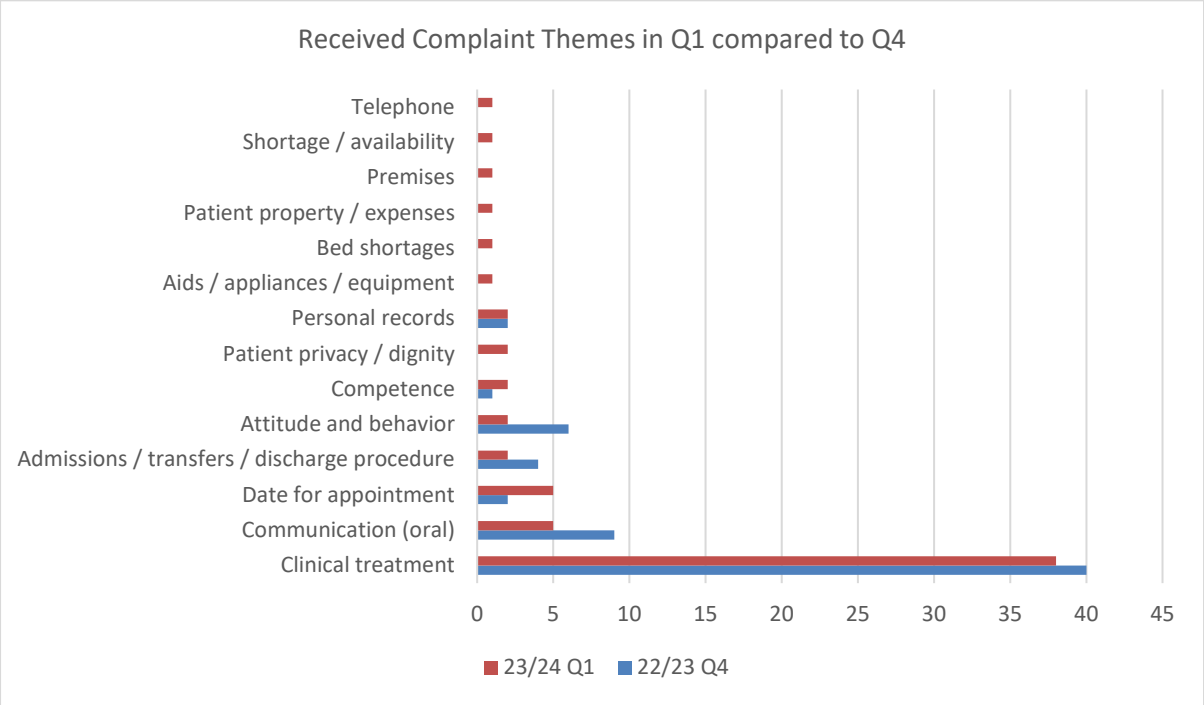
In 2023/24 Q1, there were 64 complaints received in which is the same compared to 2022/23 Q4. Surgical Specialties and Urgent and Emergency Care reported an increase in the number of complaints received **(Graph 3**).

Graph 3



The themes of complaints received in Q1 compared to Q4 are outlined within **Graph 4.** Clinical treatment remains the most common theme of complaints received. This category of complaints includes perceived delays in treatment, waiting times and/ or misdiagnosis. This is triangulated with the themes noted within incidents. The number of complaints relating to this theme has decreased from 40 in Q4 to 38 in Q1. The complaints received with a subject of 'clinical treatment' are spread across CBU's and a variety of specialties.

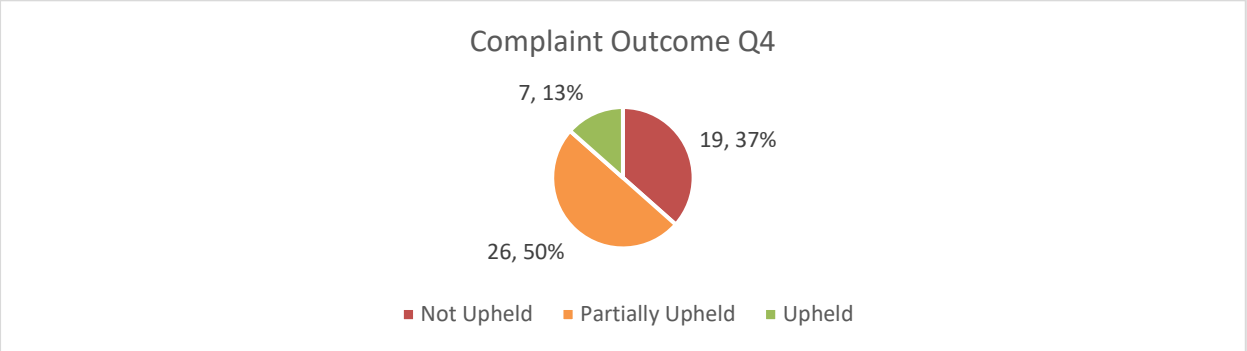
Graph 4

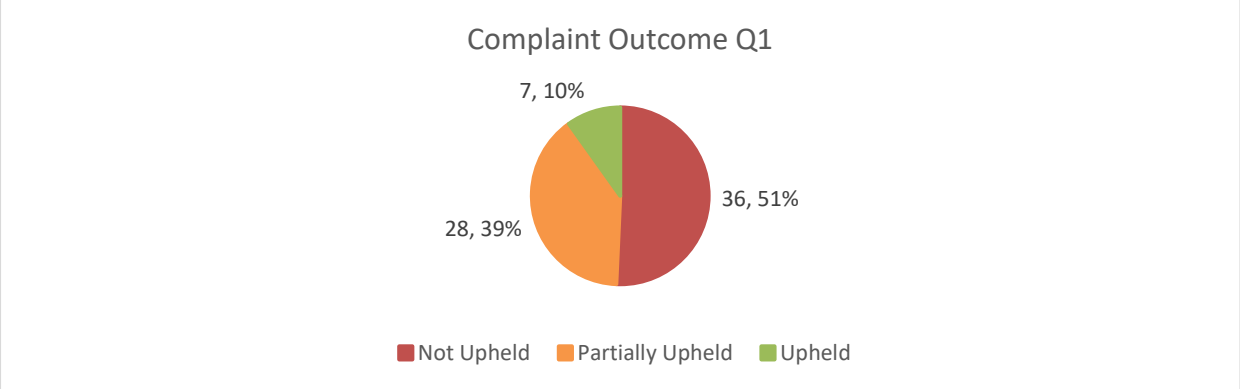


6.1.3 Complaints closed.

All complaints were closed in Q1 within timeframe. The below pie charts demonstrate the outcomes for complaints closed in Q1 compared to Q4. In Q1, a greater percentage of complaints were not upheld (51% in Q1 vs 37% in Q4). There has been a smaller percentage of complaints that were partially upheld (39% in Q1 vs 50% in Q4). The percentage of upheld complaints in Q1 has reduced slightly from Q4 (10% in Q1 vs 13% in Q4). There are no breached complaints or any complaints over 6 months old.

*Partially upheld complaints are those where aspects of the complaint are upheld, but the main issues are not.





6.1.4 Actions resulting from Complaint investigations.

The following table provides examples of complaints raised in Q1, and the actions taken to address the concerns raised as well as improvement processes. For further assurance, a complaints position with learning is provided quarterly to the Quality Assurance Committee. The Chairman also holds a monthly complaint meeting where a CBU or speciality will present a complaint, the lessons learnt, and the actions implemented.

You Said….	We Did….
Urgent and Emergency Care: The complainant had concerns that a Do not attempt cardiopulmonary resuscitation (DNACPR) had been put in place for her mother without agreement. Nursing concerns were also raised as the ward staff	A reminder was shared at the safety huddle regarding the updating of alerts and staff were reminded of the importance of contacting relatives prior to patient discharge. The complaint has been shared with staff for learning. Environmental audits are ongoing.

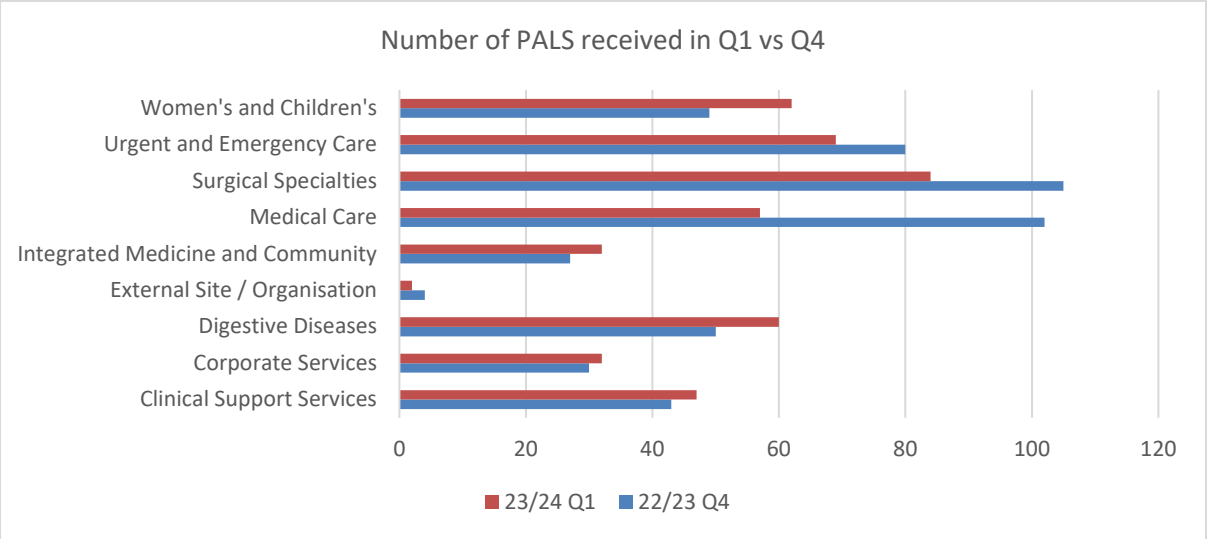
were not aware of her mother's needs and provided limited assistance with the commode.	Checks are also being completed on the ward regarding care and comfort round completion.
Women's and Childrens: The complainant had concerns over the time spent waiting to be induced and then the time spend on ward C21 following birth. Concerns were also raised regarding the number of moves, being told to wait in the wrong area and the need to repeat her medical history.	A meeting was arranged with C23 ward manager and Postnatal Matron to allow patient to share her story/experience when admitted to the ward for an extended period of time with an unwell baby. This will inform any future estates work on the ward.
Digestive Diseases: The complainant was not happy that they were not provided with adequate pain relief despite requesting it from the nursing team. The complainant advised that a friend had to initiate a plan to manage the pain instead of the nursing team. Concerns were also raised relating to the delays in receiving medication.	A reminder was added to safety brief regarding Patient Controlled Analgesia (PCA) observations. Nursing staff were reminded regarding the importance of timely administration of pain relief. A single point lesson was undertaken with individuals concerned regarding PCA observations.
Medical Care: Complainant had concerns over their rheumatology care. Complainant was given misinformation regarding the timescales of treatments and was not happy that medication was not ready for her on one of the days she attended for treatment.	The concern has been anonymised and shared with staff via the daily safety huddle on the W/C 3rd April 2023. Staff have been reminded to be mindful of the language used when discussing time periods of treatment with patients. A visible sign has been put up in the ward to highlight the availability of refreshments
Surgical Specialities: Complainant was unhappy with the wait for their son's surgery for an injury that occurred in June 2022. Apologies were offered for the delay in surgery and for the lack of communication from the secretaries.	A process has now been implemented to ensure cover of systems and processes in the event of staff absence to ensure that patients and their families are responded to promptly.
Clinical Support Services: Complainant had concerns regarding the documentation on medical records and GP clinic letter. Concerns related to a dispute over what is documented following the patients review at the Long Covid clinic.	A revised letter was sent to patients GP surgery and notes were updated and amended accordingly. Apologies were given and evidence uploaded. A double check process has also been introduced within the department as a preventative measure.

7.0 Patient Advice and Liaison Service (PALS).

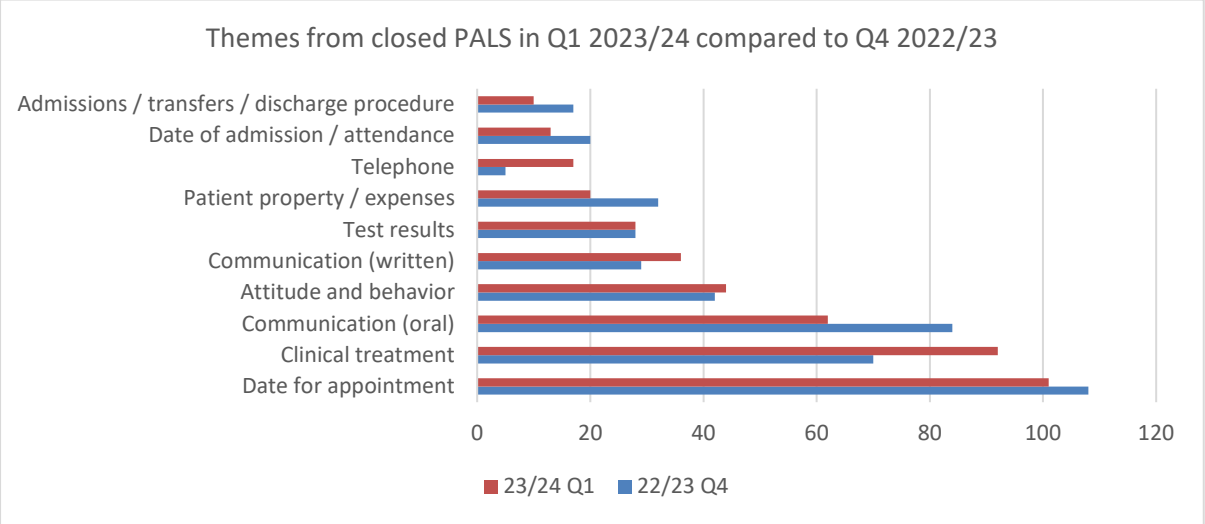
7.1 PALS received.

There were 445 new PALS referrals received in Q1, a decrease of 45 received in Q4. **Graph 5** demonstrates the breakdown of PALS received for each service.

Graph 5



Graph 6



8. Learning from Quality Improvement (QI)

8.1 Learning from QI training evaluation

The QI team collect and review feedback following each training session delivered to ensure that we continuously learn and improve the training provided, and ensure we meet the needs and expectations of participants. Overall, QI training evaluates very well; QI Foundation training sessions were rated an average of 9.4 out of 10 during quarter 1, and QI Practitioner sessions rated an average of 9.1 out of 10.

8.1.2 Learning from registered QIPs completed during Q1 2023-24

A number of QIPs have been undertaken across the Trust which includes work around:

- Psychological safety, also recognised as a fundamental element of PSIRF. The project focused upon leadership and engagement behaviours in ensuring wellbeing and morale and the importance in how that translated through to team performance in the Acute Therapy Team.
- Improve accuracy of weight documentation on ward B18. The documentation was reviewed to offer a more user friendly approach to completion ultimately improving patient care. This project will be reviewed further by the Nutrition and Hydration Steering Group for improvement/ sustainability with consideration for wider use.

8.1.3 Learning from the application of QI and knowledge and evidence

1. **Suppression treatment for staphylococcus aureus (MSSA) for elective arthroplasty procedures**

Evidence requirement

An evidence review was requested by Consultant Microbiologist and Trust Infection Control Doctor to determine the clinical and cost-effectiveness of pre-operative screening for staphylococcus aureus (MSSA) for elective arthroplasty procedures, following on from rise in infections in our elective arthroplasty cases. This request was made following a concern on rise in MSSA infections in our elective arthroplasty cases.

Learning Outcomes

The evidence base supported cost effectiveness so a recommendation was made by the Consultant Microbiologist to the orthopaedic team and the Chief Nurse, to introduce preoperative screening for MSSA for 4 main orthopaedic procedures (i.e., total hip replacement, total knee replacement, shoulder replacement and high tibial osteotomy) and if positive, advise patients to use suppression treatment for eradication of MSSA. This led to the development of the SOP for 'MSSA Screening for Elective Arthroplasty Procedures'.

Impact

Through screening, data was collected on epidemiology of MSSA carriage in this patient group. The carriage rate was found to be as of national carriage rate in general population i.e., around 30%. Based on this data, the Trust are now going to provide suppression treatment for all patients undergoing any of the above 4 categories of surgical procedure without screening for MSSA.

8.1.4 Significant impact on patient outcomes of a music and singing group to support stroke rehabilitation.

Learning Outcomes

An evidence review requested by Clinical Lead OT identified a growing body of evidence demonstrating the effectiveness of music and singing therapies on mood and cognitive function in stroke patients, as well as an increased patient motivation to engage in music therapy as compared to other rehabilitation activities. This evidence was applied to underpin the creation of music and singing group for patients recovering from stroke on B14.

Impact

The group has demonstrated significant improvement in patient outcomes including:

- Dramatic improvement in patients' mood
  - up to 100% as measured by the Visual Analogue Mood Scale
  - several individuals experiencing an increase from 5 to the maximum score of 10.
- Improved patient outcomes
  - "One lady who had been unable to speak for 8 weeks surprised herself and the staff by singing 'We are the Champions' by Queen, leaving everyone in tears."
- Improved patient and staff engagement
  - Practice echoed the evidence base as patients demonstrated high engagement requesting to attend and a keenness not to miss it
  - Social and emotional impact 'friendship circles formed between patients who could be heard laughing together as well as offering emotional support.
  - The informal sharing of memories allowed staff to get to know the person beyond the patient.

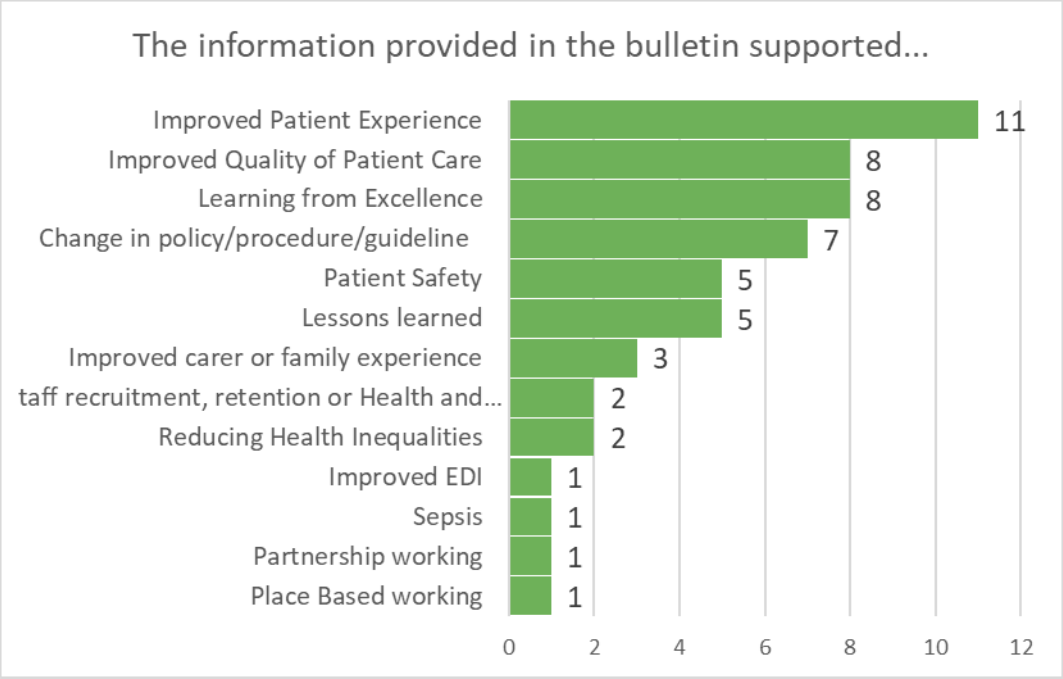
8.1.5 WHH staff use of learning identified through horizon scanning.

The learning and current awareness of core services and several specialties are supported through bespoke horizon scanning bulletins. Produced on a quarterly basis these source evidence, best practice, guidance, innovation and practice changing updates from professional, governing and advisory bodies, and information published by outstanding Trusts or departments. Topics of focus are identified by interviewing service or speciality leads so that updates explicitly target areas of priority. A recent survey investigated how WHH are using these resources to keep their knowledge current and to inform their practice. Of the staff who responded:

- 95% state the bulletins have drawn their attention to guidance, research, or innovation that they were previously unaware of.
- 86% have actively used the bulletin to increase their knowledge in their speciality.
- 67% have discussed or shared topics raised in the bulletins with colleagues or in Team Meetings.

Staff highlighted a number of key areas which the information provided within the bulletins supported, with dominant areas being:

- Improved Patient Experience (11)
- Improved Quality of Patient Care (8)
- Learning from Excellence (8)
- Change in policy, procedure of guideline (7).



8.1.6 WHH Learning Consultation summary of findings.

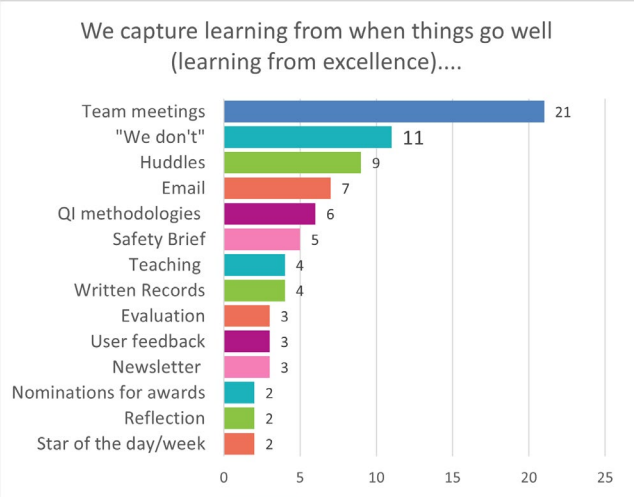
Warrington and Halton Teaching Hospital NHS Foundation Trust (WHH) is embarking on a journey to develop our very first learning framework. The first step towards this is to identify how knowledge is mobilised across the Trust, how learning is captured, shared and then embedded into practice at CBU and team level. A survey designed to capture this was distributed Trust wide.

- A total of 71 responses were received.
- Generating over 490 unique comments
- Representing 100% of all CBUs.
- 34% (24/71) of responses were Corporate.
- 66% (47/71) Clinical.

Key findings

- Preferred communication style:
  WHH staff overwhelmingly prefer learning to be communicated:
  - Face to face (40%, 145/364 responses) of which:
    - Group Meetings (10%)
    - Team Huddles (9%) and
    - 1:1s (8%) are most popular.
- Second communication preference
  WHH staff's second preference is for learning to be communicated by the:
  - Written word (23%, 82/364) of which:
    - email (10%)
    - Newsletters (7%)
    - Single Point lessons (7%)
  - Email was selected by roughly the same proportion of Corporate (50%) and (56%) Clinical respondents, and so did not reflect a bias around environment.
- The Predominant learning style of WHH staff is:
  - Kinaesthetic at 34%

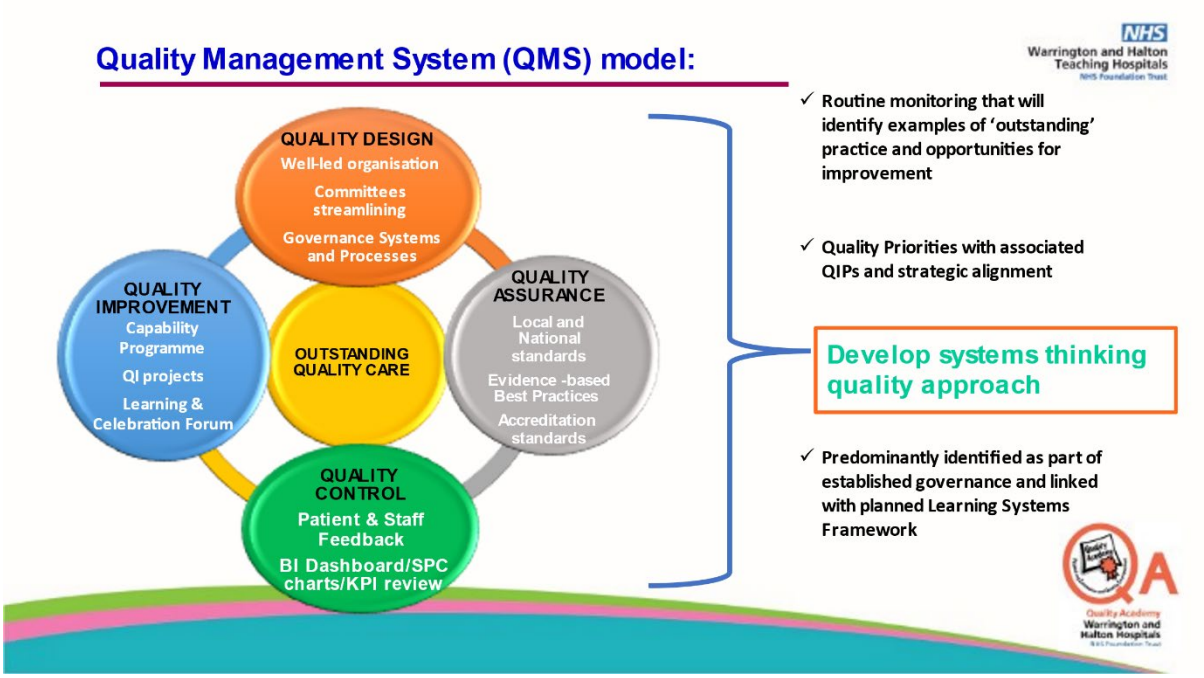
  - Reading / writing at 20%
- Feedback from Datix is felt to be inconsistent with:
  - 28% of staff stating they don't get feedback.
  - 41% that they receive it only sometimes.
- There is consensus that we do capture, share and act on learning from when things don't go to plan and that meetings and team huddles are the preferred mechanism for doing so with email 3rd.
- There is a consensus that we don't capture learning from excellence as much as we could. When asked how we capture or share learning from excellence, the second highest response in both cases was 'We don't.'
- When we do capture or share learning from excellence, the preference is for this to be communicated face to face though Team Meetings and Huddles.



8.1.7 Forward Plan: Establishing Quality Management System (QMS) for whole system quality, learning and sustained improvement.

Whole system quality requires leadership principles and practices that foster a culture of learning to meet the evolving needs of patients, populations, and communities reliably and sustainably. By establishing Quality Management System (QMS) model, it would provide more systematic and integrated organization-wide approach to quality and aligns to how leadership principles and management practices can enable health systems to pursue patient-centred quality — with ambition, alignment, and agility — through a commitment to learning and continuous quality improvement.

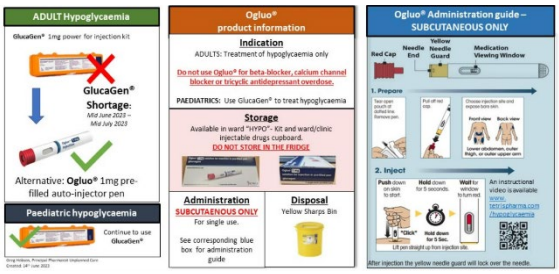
In line with the NHS England's report on building NHS Impact (Improving Patient Care Together), single improvement approach for all NHS providers, embedding QMS is one of the five components form the 'DNA' of all evidence-based improvement methods. The QMS principles that includes *quality design or planning, assurance, control and improvement* all underpin a systematic approach to continuous improvement and integrated organisational quality system. The Quality Academy spearheaded by Associate Director of Quality and Director of Governance and Quality will develop an overarching plan to address the NHS Impact recommendations and will aim to establish a workshop series for our Quality Strategy refresh to embed a QMS model with all relevant stakeholders including lived experience panel members and partners.



9. Learning from Safety Alerts

WHH uses the daily safety brief to share learning on a wider scale, these are shared Trust wide via communications, and noted as pop-ups on computer screens and shared at daily brief with 16 alerts being issued through Q1. When alerts are issued, some will be shared over a number of days, giving staff an opportunity to see the alert. Alerts cover many topics including changes in equipment or procedures and can provide learning from incidents that occurred. Examples of learning are below:

Shortage of GlucaGen® 1mg powder for injection (Glucagon). The reason for this alert was to inform of a GlucaGen® shortage and recommendations for alternatives.



Medications given to new mothers. The reason for this alert was because a baby had fallen from a mother's arms on Ward C23 due to a mother falling asleep, who was under the influence of prescribed medications.

Safe removal of CVC lines. A recent investigation found that central line removal was completed whilst the patient was sat upright in the chair at the side of her bed.

10.Learning from Claims

10.1 Clinical Claims

i. Clinical Claims Received.

There were 32 clinical claims received in Q1, 26 were received in the previous quarter.

ii. Clinical Claims Closed.

23 Ongoing Claims were closed in Q1, 6 of which were with damages (totalling £404,438.00) (excluding the costs of instructing Trust solicitors). 2 were successfully repudiated and 15 were withdrawn, including closed due to lack of further correspondence from the claimant.

Specialty	Damages Paid	No of Claims
Emergency Medicine	£23,000.00	2
Radiology	£275,000.00	1
Theatres	£13,750.00	1
Trauma & Orthopaedics	£72,000.00	1
Urology	£20,688.00	1
Grand Total	**£404,438.00**	**6**

10.2 Non-Clinical Claims (Employee Liability/Public Liability)

10.2.1 Non-Clinical Claims Received.

There was 6 employer liability claims and 1 public liability claims received in Q1 in comparison to only 1 claim received in Q4, which related to Public Liability.

Quarter 1

Employer Liability	6
Abuse etc of Staff by patients	1
Environmental factor – wet floor, fractured wrist	1
Exposure to infection, hazardous substance, electricity	1
Financial Loss – Human Resources	1
Slips, trips, falls and collisions	2
Public Liability	**1**
Slips, trips, falls and collisions	1
Grand Total	**7**

10.2.2 Non-Clinical Claims Closed.

There were 3 Employer Liability Claims closed in Quarter 1, all with damages paid. There was 1 Public Liability Claim with no damages paid. The total damages paid is £36,500.00 excluding costs.

Public liability Claim

The public liability claim closed with no damages related to an alleged damage to a car caused by an unsecured bin, but there was no evidence that the damage occurred on site and the Trust repudiated this claim.

10.2.3 Claims Learning and Actions.

Following claims investigations for claims closed in Quarter 1, the following themes were identified, and actions implemented. The clinical claims review group continues to monitor themes and trends. All claims had previously been investigated through the incident process.

Claims Learning	
Closed: 15/06/2023 **Failure to diagnose and treat ectopic pregnancy**	1. Triage process for Gynaecology Assessment Unit and Early Pregnancy Assessment Unit to be formalised. This will include the ability for gynaecology staff to be able to make EPAU bookings out of hours. 2. Audit time from referral to appointment in EPAU to review length of time from booking to attendance. 3. All doctors involved to reflect on the case prior to their next appraisal/Annual Review of Clinical Practice (ARCP) 4. The Gynaecology Advanced Nurse Practitioner (ANP) will liaise with the ED lead nurses to provide learning opportunities for the team who at the point of contact providing care to women with Gynaecological and pregnancy related problems. 5. increased awareness among ED triage staff to incorporate observations taken in the ambulance and on initial triage to the patient journey in ED. 6. Learning to be feedback to ED and gynaecology as part of lessons learnt 7. Introduction of electronic task management system to the trust to enable efficient on call task rated management when a referral is made to a specialty from the emergency department
Closed: 22/06/2023 **Failure to consider alternative treatment resulting in loss of kidney function**	1. Regional stone MDT meeting. One or more consultants within the Trust should have the opportunity to attend this MDT, and to present difficult cases. This should be reflected in their job plan. This would allow discussion regarding alternative management options, including surgical and nephrologist opinion. 2.All PCNL procedure carried out within the Trust should be entered on the national PCNL database rune by the BAUS. The outcomes should be regularly audited. Provision of a part time data clerk may be required in order to facilitate this. 3.The current waiting times for PCNL procedures should be reviewed and a contingency be put in place to deal with the current unacceptably long waiting list.

Claims Learning	
Closed: 11/05/2023 **Failure to diagnose rupture ligament**	Limb assessment to include joints above and below primary injury
Closed 28/06/2023: **Failure to diagnose infected foot resulting amputation**	Claim discussed at Clinical Claims Review Group Currently this patient would almost certainly have been referred directly to the vascular team at Chester rather than going to Trauma and Orthopaedics (T&O). This case demonstrates why there was the need for the current arrangements. The DFC has been implemented , and there is now a discussion of all acute cases with Chester (Vascular Surgeons), and referral for everyone else to the clinic (ICE referral).

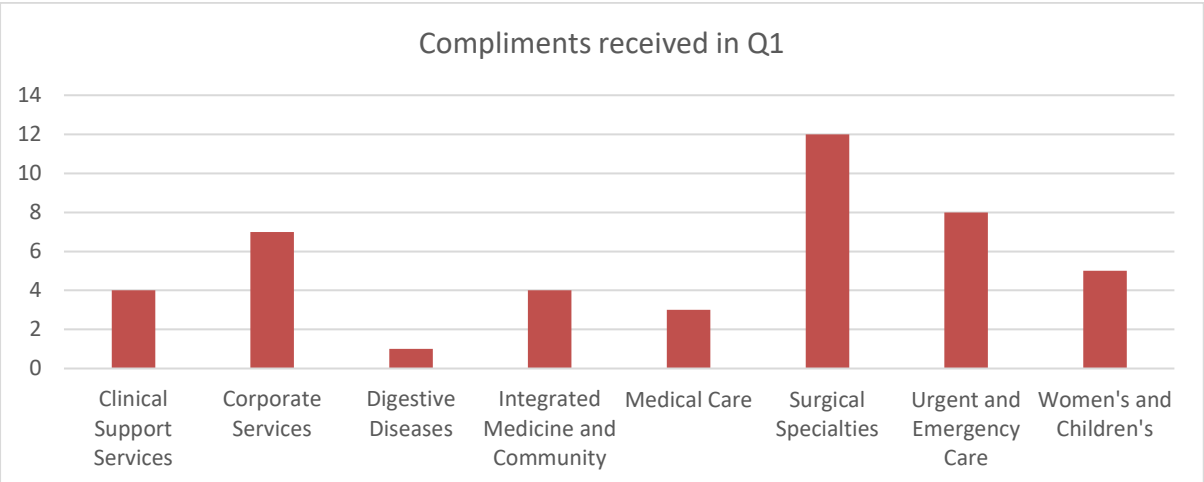
11.Learning from Inquests

42 inquests were heard in Quarter 1, 16 with narrative verdicts, 5 with natural causes, 5 with suicides concluded, 7 with industrial disease concluded, 4 with accidental death concluded, 1 with drug related concluded, 1 with alcohol related concluded, 1 open verdict and 2 discontinued. The Cheshire Coroner was satisfied with the learning implemented. There were no Regulation 28 (prevention of future deaths) concerns.
Three of the inquests had legal representation. 1 was rescheduled, 1 was natural causes and another was narrative verdict.

12.Learning from Compliments

A positive safety culture is one where compliments are fed back to staff in the same way that investigations are. Compliments are an extremely useful tool for the Trust to be able to identify what areas are working well. In Q1 the Trust received 44 compliments which has increased compared with 28 compliments received in Q4

Graph 7



It has been identified that compliments are often received within letters of complaint, whereby the patient or relative will take the time to acknowledge the positive impact of staff members involved in their care. When investigating a formal complaint, another learning consideration is to share the positive messages contained within these. For example, although an experience can provoke a formal complaint, this does not been that all elements of care were negative.

13.Learning from Patient Experience

Patient stories are developed monthly by the Head of Patient Experience and Inclusion as well as Senior Nurses within Clinical Business Units. Patient stories are shared across multiple committees such as Patient Experience Sub Committee, Patient EDI Sub Committee, Quality Assurance Committee and Trust Board meetings to ensure celebration of good practice and to highlight areas of improvement required.

The Patient Experience and Inclusion team have a series of methods of gaining qualitative data from patients to celebrate good practice and to initiate improvements required that are identified via patient feedback. Methods used include:

- Friends and Family Test
- Monthly Patient Experience and Inclusion team observation wards.
- Monthly Governors observation rounds
- Feedback from complaints / PALS.
- Feedback from Community Partners and Advocacy Groups

As a result of feedback received from these various methods examples of improvements are as follows;

- Focused attention on improving access to a face-to-face BSL interpreter for the d/Deaf community we serve which has included:
    - Initiation of monthly d/Deaf awareness training sessions to commence in August 2023
    - Flag on Lorenzo to be added from July 2023
    - Focused meetings and ward visits to ensure compliance with the interpretation policy.
- It was raised patients were unhappy with the temperature of their meals on the ward which has resulted in actions such as
    - Observation visits on wards undertaken at mealtimes by the patient experience and inclusion team and Head of Facilities to identify areas to improve.
    - Details of meal delivery times shared with all wards to ensure patients were adequately prepared for meal arrival.
    - Communications shared re best practice on how to receive and distribute meals on wards including keeping the meal trolley door closed in between serving.

14.Learning from Clinical Audit

14.1 Learning from National Audits

National Paediatric Diabetes Audit (NPDA).

Summary:

The BTS pleural services organisational audit aims to provide benchmarking data which can be used to drive improvements and outcomes. It also establishes if there are any concerns about patient safety. The provision of thoracic US/pleural procedures is currently listed as a risk at WHH.

Learning:

- The Clinical outcomes continued to be good with HbA1c levels in our cohort of patients above the regional average and sustained at 61 mmols/mol despite COVID pandemic and patients seen virtually.
- The percentage of patients receiving sick day rules and flu vaccinations were significantly high and better than the national average.
- The patients with poor control were consistently lower comparable to national rates and there is improvement with a greater number of patients with good control despite COVID pandemic pressures.
- The newly diagnosed patients had lower coeliac screen and thyroid tests performed at diagnosis as patients were seen virtual post diagnosis.
- The data on abnormal eye screening were inappropriate as we do not receive eye reports from the community regional screening team consistently.
- The eye screening during COVID pandemic were done once in 2 years instead of annually and thus not appropriately reflecting the data. We have lower than national average patients with kidney disease.

Improvement Action Plan:

- Appointment of trust pleural lead through recent consultant appointment
- Business case for dedicated pleural nurse / ACP (this is also a GIRFT action)
- Dedicated pleural service with OP clinics, data capture for BPT, pleural in-reach and dedicated referrals pathway.
- Develop indwelling pleural catheter service and medical thoracoscopy.

Ongoing pleural LocSSIPs audits **Assurance Rating:**

AMBER	**Moderate Assurance**	Audit meets majority of standards. The audit demonstrated a potential Patient safety risk and / or operational risks if not acted upon.	Actions are required against standards that were not met within an action plan. The action plan should include SMART action with designated leads and timelines. Re-audit once actions implemented and embedded practice. For national clinical audits, results will be tabled in PSCESC report for presentation of action plan by the National Clinical Audit Lead.

14.2 Learning from Local Audits

Summary:

NHS policy across the nation is to perform VTE assessments for all patients above the age of 16 to prevent negative outcomes of thrombosis/embolus formation whilst inpatient by assessing the risk of VTE and prescribing chemical (anticoagulants) or mechanical prophylaxis for VTE for the duration of their stay in the hospital, and after if indicated, or if no VTE risk is identified to document that there is no risk and that no VTE prophylaxis is needed.

Results:

Key:	
Green	90% and above
Amber	80% to 89%
Red	79% and below

no.	Standard	Yes	No	Total	Compliance Rag
1	VTE Risk Assessment Form	36	20	56	64%
		64%	36%		

Learning:
There is a reluctance to complete VTE Risk assessment if the patient is expected to stay in the hospital for less than a day. It is recommended that all healthcare professionals clerking a patient complete the risk assessment form regardless of how long they are expected to stay in the hospital.

Improvement Action Plan:

- Cover the importance of completing VTE form at Paediatrics induction for newcomers.
- Develop a clerking template on Lorenzo that can only save the document after VTE assessment is done.

Consultants to review VTE assessments on first Ward round.

Assurance Rating:

AMBER	Moderate Assurance	Audit meets majority of standards. The audit demonstrated a potential Patient safety risk and / or operational risks if not acted upon.	Actions are required against standards that were not met within an action plan. The action plan should include SMART action with designated leads and timelines. Re-audit once actions implemented and embedded practice. For national clinical audits, results will be tabled in PSCESC report for presentation of action plan by the National Clinical Audit Lead.

15.Compliance

15.1 Learning from a recent Mock CQC Inspection

In June 2023 a Mock CQC inspection was undertaken in the Emergency Department. An action plan has been developed to address issues and progress will be monitored via the Moving to Outstanding meeting. The mock inspection team included internal and external colleagues. Action plans are in place with focus upon remaining regulatory breaches following the 2019 inspection; crowding, staffing, deterioration and escalation, good governance. Triage is also an area of focus for improvement.

16.Learning from Research and Development Activity

16.1 Learning from Research and Development

mRNA-1283-P301 COVID-19 Booster Age 12 + ("NextCOVE")

NextCOVE, a covid-19 vaccine study Sponsored by Moderna, was a chance for the HCRU team to implement learning from the mRNA-1273.529-P206 study, also Sponsored by Moderna, which recruited in the previous year. A planning meeting with representation from all departments involved was held to coordinate set up activities and expectations as well as reviewing information supplied to date. This was useful to ensure understanding of the study was uniform across the team, identifying barriers and possible resolutions at an early stage, and setting timelines.

The subsequent set up and delivery of the study has proven challenging for reasons outside of the HCRU team's control. Despite this, all departments and individuals contributing to the set up and delivery of this study have demonstrated incredible support and agility. Timelines slipped and delivery plans required multiple – and sometimes major – adjustments, however all involved were understanding and responsive.

Outside of the HCRU team, many departments, individuals and organisations are involved in the support of this study and all were exemplary in their support: Contracts, Finance, Pharmacy, consultants providing medical oversight from WHH, Liverpool University Hospitals NHS Foundation Trust (LUHFT) consultant, and the Clinical Research Network North West Coast Agile Workforce.

MHRA Inspection Readiness

HCRU partners, Liverpool University Hospitals NHS Foundation Trust (LUHFT), were inspected by the Medicines and Healthcare products Regulatory Authority (MHRA). The LUHFT team were kind enough to share their learning points from the inspection of their Phase I Clinical Research Facility.

Although it is highly unlikely that an MHRA inspection would be announced for the HCRU, the shared learning was useful for assessing HCRU processes for robustness. The HCRU is more likely to undergo study specific Sponsor-initiated inspections.

To support the learning, the Head of RD&I has attended an Inspection Ready course run by the R&D Forum which was delivered by the Governance Manager of LUHFT. The learning from these is being incorporated into an audit framework for the HCRU and wider R&D department.

GBS3 Study

The GBS3 study which screens women in labour for Group B Streptococcus has been well-received by expectant parents. The WHH labour ward has been randomised to the rapid bedside test which results in under an hour, providing opportunity for early medical intervention based on the result. The study has not been without its challenges but the team at WHH from Maternity and R&D have been proactive with the detection and reporting of potential issues. The team have escalated appropriately, with observations about the rapid testing software reported to the study team which in turn triggered Research Ethics Committee (REC) review. The REC recommended remediation action in the form of audit which has been followed.

There will likely be further learning that can be taken away from REC following the outcome of the audit. Key lessons thus far are to ensure that all data platforms/software are compliant with patient identification procedures, can be audited and users assigned with appropriate read/write access.

Sharing Best Practice

The senior R&D team continue to engage with other Trusts across the region to share best practice. This is done through attendance at quarterly regional R&D Managers' meetings, facilitated by the Clinical Research Networks North -West Coast and Greater Manchester. The WHH team continue to strengthen these networks, meeting with the team at Wrightington, Wigan and Leigh Teaching Hospitals. Meeting with Trusts that have a similar profile to WHH is useful for accelerated learning, reducing duplication and sharing solutions to common problems.

17.Quarterly Learning Opportunities Section

17.1 Your Future Your Way Celebratory Event April 2023

Your Future Your Way (YFYW) celebratory Event on too place on Tuesday 18th April.

YFYW was designed to develop aspiring nursing, midwifery and AHP leaders from multi-ethnic backgrounds (the global majority) reach equity, further recognising their talent and skills as well as helping to remove any barriers to professional career development. This first pilot programme ran in two parts: Part A aimed to ensure that our existing senior nursing, midwifery and AHP team develop a deeper understanding of the barriers that colleagues from a multi-ethnic background can face during their career. Part B was aimed at nurses, midwives and AHPs from multi-ethnic backgrounds in professional bands 5-6, providing delegates with the leadership skills, peer support and senior professional sponsorship to enable career development. Senior staff from Part A were then appointed as a 'sponsor' to a staff member on part B of the course.

22 staff members on YFYW (cohort 1 of the new programme) celebrated completion of the programme following submission of individual assignments which were showcased as poster presentations.

Seven staff members have now already been successful in promotion. Next steps are currently being and cohort two starts in June.

17.2 Autism Acceptance Month (April)

It is estimated that 1 in every 100 people in the UK are autistic. That's around an estimated 700,000 people with an autism diagnosis, and charities such as the National Autistic Society believe that the actual number of autistic individuals is bigger than that. Despite this, the Office for National Statistics shows that autistic people are the least likely to be in work of any disabled group, with only 21.7% of autistic people being in employment.

The National Autistic Society have created a resource of different tools which spark the conversation, "What is autism?"

In the coming weeks the Workforce Equality, Diversity and Inclusion Team are also preparing to launch a new Workplace Passport and Reasonable Adjustments guidance to support our workforce living with a disability, neurodiversity, or long-term health condition.

17.3 Clinical Audit Week 19th-23rd June

The Clinical Audit Awareness Week is an annual national campaign to promote and celebrate the benefits and impact of clinical audit and quality improvement work in healthcare. The CAAW was held from 19th-23rd June 2023, and included:

- **Clinical Audit training session:** 'Making your audit – Top of the Pops'. This explained how to complete your clinical audit project for maximum benefit, following the WHH policy.
- **Drop-in sessions:** Held at various times in the Wingman Lounge. These are for staff to pop down, on an informal basis, to discuss any audit requirements their service may have or to seek help with a specific query about a clinical audit.
- There were posters to view and handouts available during these drop-in sessions.
- The Clinical Audit team visited various wards/departments to discuss all things audit.

18. RECOMMENDATIONS

The Quality Assurance Committee is asked to note the report.

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/23/08/177**
SUBJECT:	**Safe Staffing Report; 6 Monthly Acuity Review, July 2023.**
DATE OF MEETING:	8th August 2023
AUTHOR(S):	Ali Kennah, Deputy Chief Nurse
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.
EXECUTIVE SUMMARY	This report is the bi–annual Nursing and Midwifery Staffing review. It fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB 2016): How to ensure the right people, with the right skills, are in the right place at the right time. It provides an update to the Quality Assurance Committee in relation to the following: • Actions agreed in the Chief Nurse Annual Staffing Review April 2023 • Vacancy and turnover data for Nursing and Midwifery • Analysis of staffing establishments, using Safer Nursing Care Tool (SNCT) • Analysis of staffing and impact on patient outcomes • Planned and actual staffing fill rates • Care Hours Per Patient Day (CHPPD) figures The previous paper (November 2022 data) was presented to Quality Committee (QAC) and Trust Board in February and March 2023. **Areas of improvement:** • Health Care Support Workers (HCSW): A reduction of 51 (WTE) vacancies from 70 in November 2022 to 19 in June 2023, equates to 72%. • Maternity: A reduction of 7% vacancy rate since July 2022 which equates to 16 WTE less vacancies. • Numbers across all bands staff in post has increased, reaching a peak in June 2023 of 1133. • Reduction in turnover rates for Nurses and AHP's. • Predicted 7-8% over recruited = 40 WTE when all staff in pipeline are in post Winter 2023. Natural turnover will reduce this figure however pro-active

recruitment continues to ensure sustained workforce pipeline.

- 21 new starters to join the Emergency Department from July 2023 onwards.
- CHPPD figures and fill rates are showing an improvement.

To inform this report, the Safer Nursing Care Tool (SNCT) (acuity assessment tool) data collection took place in July 2023 and has been reviewed and analysed against current establishment alongside the existing Allocate Safer Care acuity tool completed twice daily.

The SNCT data collection does not include Intensive Care Unit (ITU) who align to the Guidelines for the Provision of Intensive Care Services (GPICS) staffing recommendations and Maternity who align their guidelines to Birth Rate Plus staffing recommendations. Emergency Department data collection is not included.

In accordance with the data collection for July 2023, the recommended Safer Nursing Care establishment figures compared to the number of staff in post, show there is a deficit of 41.15 WTE, an improvement on the last data collection in November 2022 which showed a deficit in post of 103 WTE (Figure 10).

The areas that require further review due to acuity are:

A7/A8/A9, where there was a difference in SNCT outcomes which concurs with professional judgement. This was also the case in the last data collection and as a result support for the establishment uplift has been approved for those areas.

AMU: National guidelines recommend a 1:6 nursing / patient ratio instead of the current 1: 8. Local evidence of the growing demand on this ward illustrates the requirement for an establishment review. A further review of this ward is recommended.

A2: The data captured for A2 has confirmed that the dependence of patients is far higher than that of AMU but again does not take into account the activity of patient admissions, discharges and transfers on or off the ward.

B3: SNCT data recommends a figure of 45.30 WTE against a funded establishment of 32.44 WTE. This is due to the increase in dependency and acuity of the patients

who are transferred from Warrington and breach the criteria for medically optimised.

The limitations of SNCT such as the lack of consideration for activity, ward layout and speciality must be recognised when considering the results as part of reviewing staffing establishments. Professional judgement, which is recommended within the SNCT process, must always be applied, and is seen as the 'gold standard' when determining safe staffing levels BMJ (2020).

Across both the November 2022 and July 2023 data collection there are similar differences in the deficit between what SNCT recommends and what the establishment figures are for A2, A7, A8 and A9. Across these four wards in July 2023 the total deficit in WTE funded establishment compared to recommendations from the SNCT data collection is 35.14 WTE.

The funding to support A7, A8 and A9 will reduce this figure by 10.64 leaving a deficit of **24.5 WTE**. It must be noted that only partial funding for A7, A8 and A9 was approved therefore leaving a gap in the numbers of staff required and a potential risk of harm.

The senior team within the Emergency Department completed a staffing review in March 2023. In recognition of the increasing pressures of caring for patients on the corridor, approval was gained for investment in the department increasing their WTE RN by 8. The approval was for partial funding which may result in increased incidence of harm, and reduced patient experience as a result of lower than required nurse staffing.

This report also provides an overview of the current nursing and midwifery staffing workforce data, which shows latest vacancy data from June 2023.

Overall Position

The overall picture is one of improvement. All vacancies are allocated to and WHH will be in a position of over recruitment against current establishment, which is positive for the Trust.

Hard to recruit to areas like the Emergency Department and Maternity have seen improvements and continue to work proactively to reduce turnover. B18, A7 and Acute

	Coronary Care Unit (ACCU) are areas that have carried high vacancy numbers and have required focussed recruitment which has improved positions for B18 and A7 with their forecasted new starters. The SNCT data compares well when applying professional judgement. The outcome from the data collection is consistent with the November 2022 collection and senior teams concur. In terms of the relationship between staffing rates and patient outcomes, there is correlation between areas of higher harms and not enough staff to meet demand. Whilst vacancy rates are reducing favourably, the staff are not yet in post and both skill mix and leadership contribute to the overall picture in terms of harm prevention. A newly repurposed safe staffing meeting will include clinical outcomes so the risks across workforce, clinical harm and people measures can be triangulated and addressed in a pre-emptive way to proactively support clinical areas to sustain improvements. The report gives an overview of the current workforce position for the Planned, Unplanned and Clinical Support Services Care Groups and a Maternity Services and Allied Health Professional (AHP) update, demonstrating processes and mitigation to ensure safe levels of care and an outline of recruitment and retention plans.			
PURPOSE: (please select as appropriate)	**Information** **X**	**Approval**	**To note** **X**	**Decision**
RECOMMENDATIONS:	It is recommended that the Quality Assurance Committee discuss and note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Submit to Trust Board			
FREEDOM OF INFORMATION STATUS (FOIA):	Release in Full			
FOIA EXEMPTIONS APPLIED: ***(If relevant)***	Choose an item.			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Safe Staffing Report 6 Monthly Acuity Review, July 2023	AGENDA REF:	QAC/23/08/177

1. INTRODUCTION

1.1. This paper provides the bi-annual comprehensive report to the Quality Assurance Committee on Nursing, Midwifery and Allied Health Professional (AHP) staffing. This report details the six-monthly review of nurse and midwifery staffing in line with the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016), and the NHS Improvement (NHSI) 'Developing Workforce Safeguards' guidance, published in October 2018. The guidance recommends that the Board of Directors receive a biannual report on staffing to comply with the CQC fundamental standards on staffing and compliance outlined in the well-led framework.

1.2. A triangulated approach to nurse workforce establishment planning is utilised at WHH in line with NQB recommendations. This includes:

- Twice-yearly review of nursing establishments using an evidence-based decision matrix, the Safer Nursing Care Tool (SNCT)
- Daily analysis of Safe Care results, which provide a twice daily breakdown of patient acuity, completed by a senior nurse
- Annual Chief Nurse led review of staffing establishments
- Monthly analysis of Care Hours Per Patient Day (CHPPD)
- Daily monitoring of staffing capacity versus demand with a review of harm data and the relationship to staffing

1.3. As per the NQB guidance, this bi-annual report will provide the results and analysis from the SNCT data collection which took place in July 2023 and details next steps. The report also includes the current Trust nursing and midwifery workforce position and a summary workforce position for the Care Groups and Allied Health Professions (AHP) workforce.

2. NATIONAL/LOCAL CONTEXT

2.1. Nursing and midwifery workforce supply continues to be a significant challenge nationally with the shortfall in registered nurses well-documented across all NHS organisations and oversight bodies. According to NHS workforce statistics, the total number of vacancies in the medical and nursing sectors of the NHS has increased. The latest NHSE vacancy data for March 2023, across all sectors for nursing shows a vacancy rate of 9.9% equal to over 40,000 vacancies.

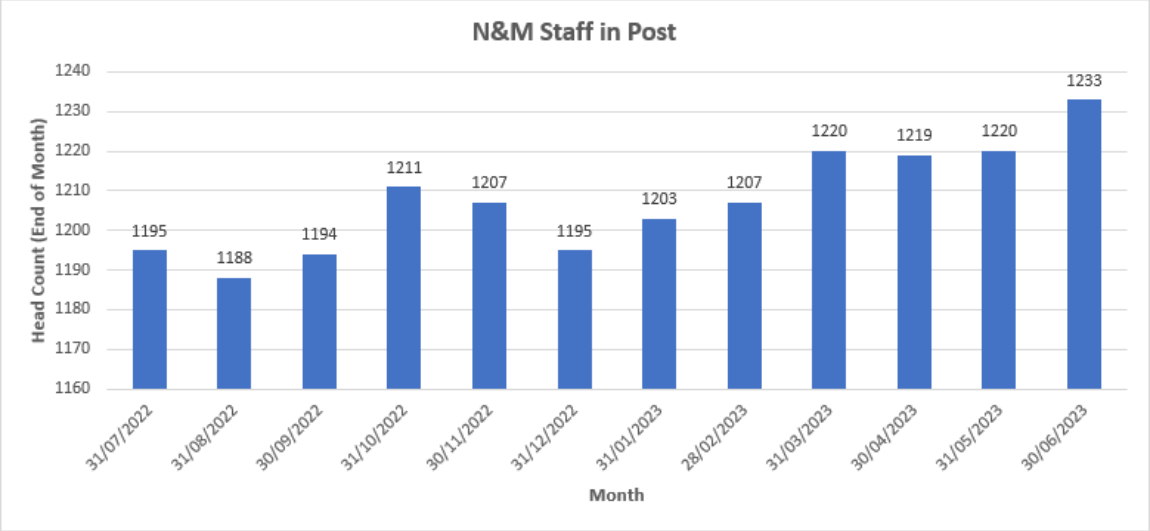
2.2. Students entering healthcare programmes has fallen by 9% in 2022 when compared to 2021, despite the rise in interest compared to pre-pandemic levels. This has a significant impact as the numbers of applications to the University of Chester, the main provider of healthcare

students for WHH, has fallen in line with national statistics. Moreover, applications from mature students have declined nationally with a 25% drop in the number of nursing applications from those aged 30 to 34, and a 24% decline in those aged 25 to 29, in accordance with data from National University and Colleges Admission Services (UCAS, February 2023). The University of Chester receive many applications from mature students; therefore, work is underway between WHH and the University of Chester to attract younger students to programmes and the Trust is working with other provider including Liverpool John Moores (LJMU) and Edgehill (EHU) universities to increase their student placement capacity here at WHH. Placement capacity is managed through a system called 'In Place'. Work has commenced by the Clinical Education Team to reassign placement capacity to EHU and LJMU on In Place.

2.3. The impact of ongoing emergency pressures combined with the current challenges faced across the NHS, continues to influence some of the detailed actions and outcomes contained within the report. There is robust professional leadership in place by the senior nursing team, supported by safer staffing governance frameworks and clear escalation guidance and accompanying actions. It is clear however, that the staffing situation remains challenging due to high bed occupancy, increased patient acuity and dependency, and the continued focus on delivering the highest possible standard of care.

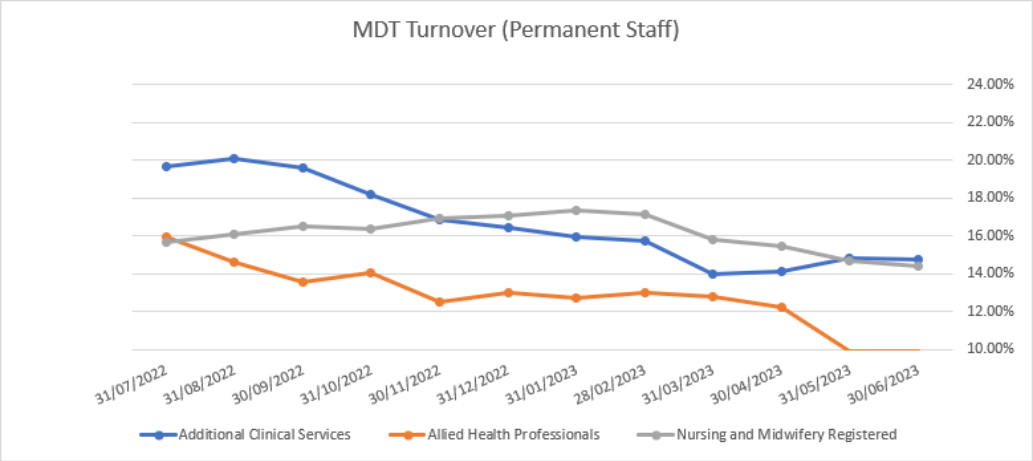
3. TRUST WORKFORCE & TURNOVER POSITION

Fig. 1 Nursing and Midwifery Staff in Post



3.1. An increasing trend can be seen for the numbers of nursing and midwifery staff in post across the last 12 months, with a level of sustainability since December 2022. Recruitment and retention planning is fundamental to ensure this improvement is maintained. Further information for WHH recruitment and retention planning is described in section 5.2.

Fig. 2 Trust Turnover Nursing, Midwifery, AHP



3.2. In general, turnover rates are reducing favourably against the Trust target of 13% and the national median of 13.1% with significant improvement across nursing, midwifery, AHP and Health Care Support Workers (HCSW's).

3.3. Higher turnover rates for the last 12 months are reported for the Emergency Department, B18 and A7, with peak rates of 35%, 18% and 23% respectively. Work has been completed to support recruitment to those areas and significant reductions are reported for B18 and A7. ACCU and ED remain as outliers for turnover rates. There are some indications of reducing trajectories with ED peaking in January 2023 at 35% which has since shown a reduction. Focussed work continues to improve the position on ACCU.

Fig. 3 Pressure Areas for Turnover

Wards	Turnover rates July 22	Turnover rates June 23
A7	23%	5.9%
B18	18%	8%
ED	24%	29%
ACCU	22%	27%

3.4. **Vacancy Position**

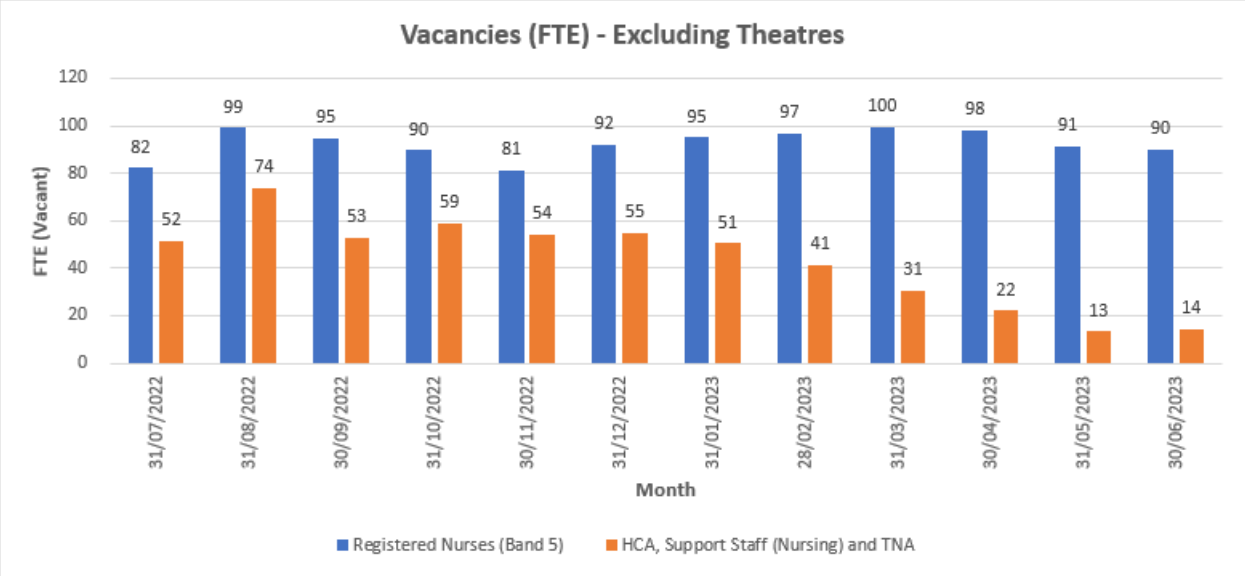
3.4.1. A proactive recruitment drive across domestic and internationally educated nurses has resulted in a forecasted over recruited position of 7-8% (40) WTE band 5 vacancies, which will reduce to approximately 20 WTE due to natural turnover (5-6 band 5 WTE leavers per month.) The figure includes nurses not yet in post but who are arriving at the Trust between August and November 2023, made up of 30 students ready to qualify into a band 5, and internationally educated nurses who are paid at band 3 until they receive their registration which moves them into a band 5 position, 2-3 months post arrival.

3.4.2. An over recruitment paper was approved by the Executive Team in December 2022 as recognition of the recruitment work undertaken and the requirement to ensure a sustainable pipeline of nurses is available to provide safe care.

3.4.3. The data source for this report is WHH externally report Provider Workforce Return (PWR) which is reported each month to NHS Digital. To provide clarity, this data is driven by the number of staff paid in month, so whilst the PWR data shows whole time equivalent (WTE) vacancies, as highlighted, a large number of these vacancies have already been assigned and therefore are not truly vacant posts but remain gaps in establishments until staff arrive.

3.4.4. Monthly meetings are held between the Finance Department, Human Resource Workforce Team, and Trust Workforce Lead to compare data and ensure correct reporting.

Fig. 4 Registered Nurse Band 5 and Health Care Support Worker Vacancies (excluding theatres)

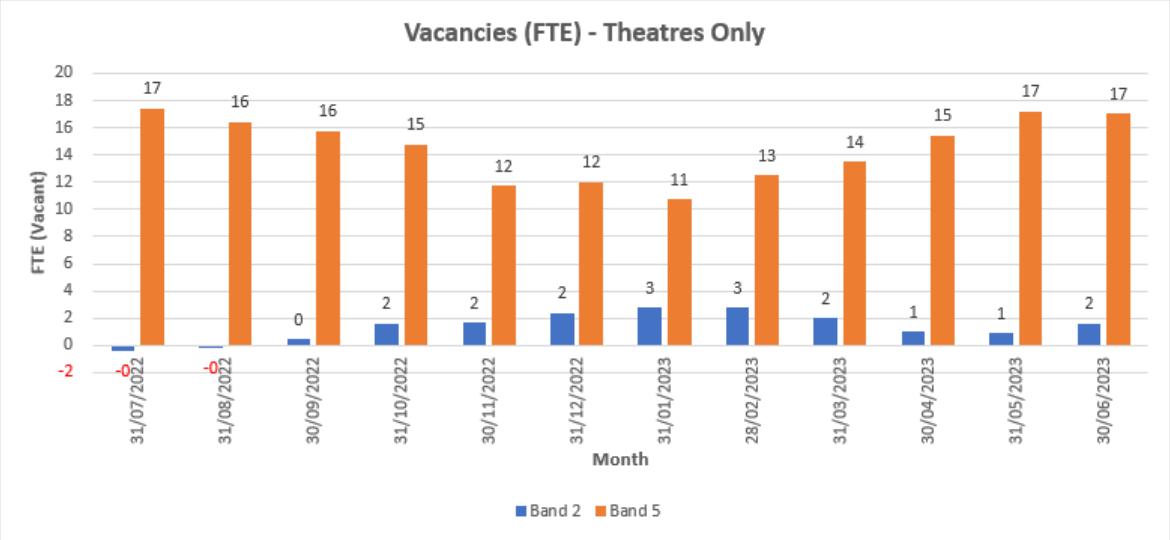


N.B. Theatre staff are excluded due to the job titles of their staff in post- they are demonstrated separately below in Fig 5

3.4.6 Whilst a forecasted position of over recruitment to band 5 is reported there are areas within the Trust that currently sit with higher numbers of nursing vacancies. These areas are ED, ACCU and B18 as highlighted in section 3.3. of this report.

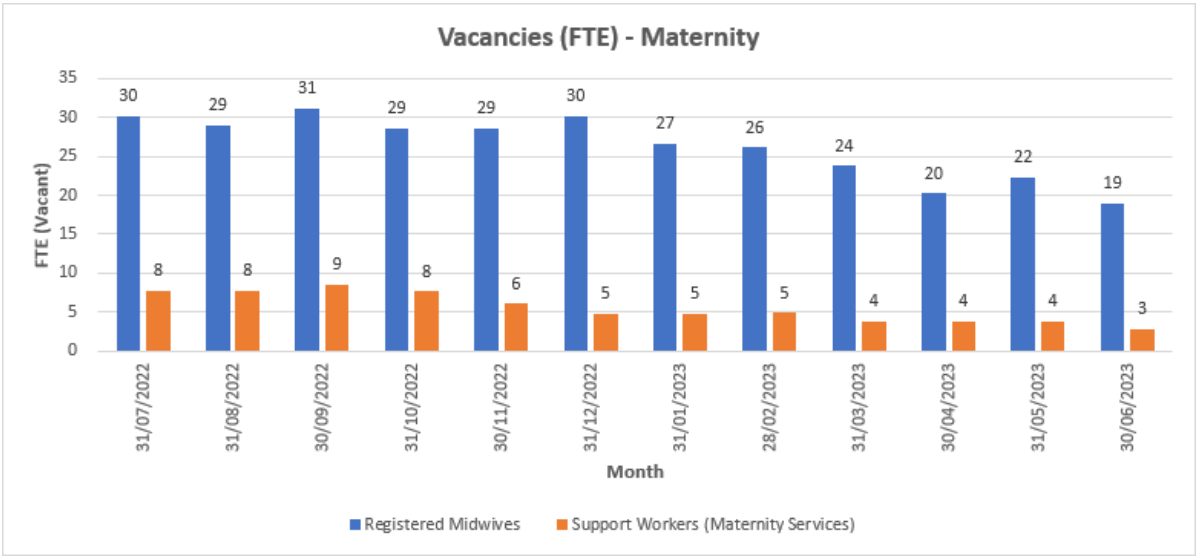
3.4.7 There has been continued focus on recruitment of HCSWs. It remains challenging to achieve a sustained operationally zero vacancy position. Pro-active recruitment has supported a positive reduction in HCSW vacancies, particularly over the last 6 months where a 75% reduction has been achieved.

Fig. 5 Theatres Band 5 and Band 2 Vacancies



3.4.8 The data shows and increase in Theatres vacancies however, new starters are in pipeline.

Fig.6 Midwives and Maternity Support Workers Vacancies



3.4.9 The vacancy rate for registered midwives has reduced from a peak of 23.25% in July 2022 to 17.24%, this is a slight increase from 15.49% in April 2023. This is due to internal promotions and two retirements. Local data confirms 17. 55 WTE vacancies with 17.17 WTE in recruitment pipeline, posts will not be filled until Autumn 2023.

3.4.10 All Band 7 Specialist and Ward Manager roles are now recruited into alongside two Matron posts.

4. CHIEF NURSE ANNUAL STAFFING REVIEW

4.1 Skill mix requirements form part of the triangulation of data as recommended by the 'Developing Workforce Safeguards' (2018) guidance gathered from the evidence-based tools

used for establishment setting and professional judgement. Skill mix reviews are conducted as part of the annual nurse staffing reviews or if a ward has altered from their primary function.

4.2 The annual Chief Nurse staffing review was completed in April 2023, with associated actions developed. All ward managers presented a robust plan of their clinical area.

Key points:

- Support for the revenue request to increase registered nurse staffing establishment in the Emergency Department

  Approval of partial funding of revenue request for increase in nurse staffing for the Emergency Department, to support safety for patients nursed on the corridor, support the response to high patient volume and the provision of continuous flow. This has resulted in plans to recruit 8 WTE registered nurses

- Support for the revenue request to increase HCSW's on wards A7, A8 and A9

  Approval for the progression of funding of revenue request for increase in HCSW staffing to support the acute areas with the impact of increased enhanced care needs and patients with complex mental health needs. Planned for Trust Executive approval 8th August 2023

- The commissioning of an agency "switch off" on wards of minimal usage with a progress plan to roll out across the Trust

  This work commenced in April 2023 with a breakdown of progress in section 5 of this report

- Support for over recruitment to ensure nursing workforce pipeline maintained

  Forecast to be in over recruited position of 7-8% (40 wte) by November 2023

5. TEMPORARY STAFFING

5.1 Temporary Staffing

5.1.1 WHH are contracted to work with NHS Professionals (NHSP) for the provision of temporary bank and agency staff. Systems are in place to monitor usage and work is ongoing to reduce the use of agency staff. Monthly meetings are held with NHSP colleagues to review key performance indicators.

5.1.2 The use of temporary staffing via a "nurse pool" was utilised for the Easter period 2023 with positive effect. The migration of staff across from agency to NHSP continues to be a focussed piece of work with the successful transfer of 31 since April 2023 and 51 new starters joining NHSP in June 2023.

5.1.3 Work to reduce the reliance on agency continues with a 24% reduction in agency reliance for June 2023.

5.1.4 An Agency Reduction Plan is in place reported through nurse staffing governance processes. The overall reduction cost for Q1 23/24 when compared with the same period last year is £470k. The "switch off" from agency as a risk-based approach has positively reduced the use of agency, not only making a saving but the potential to improve patient outcomes as the higher reliance on agency staff is linked to reduced experiences for staff and patients.

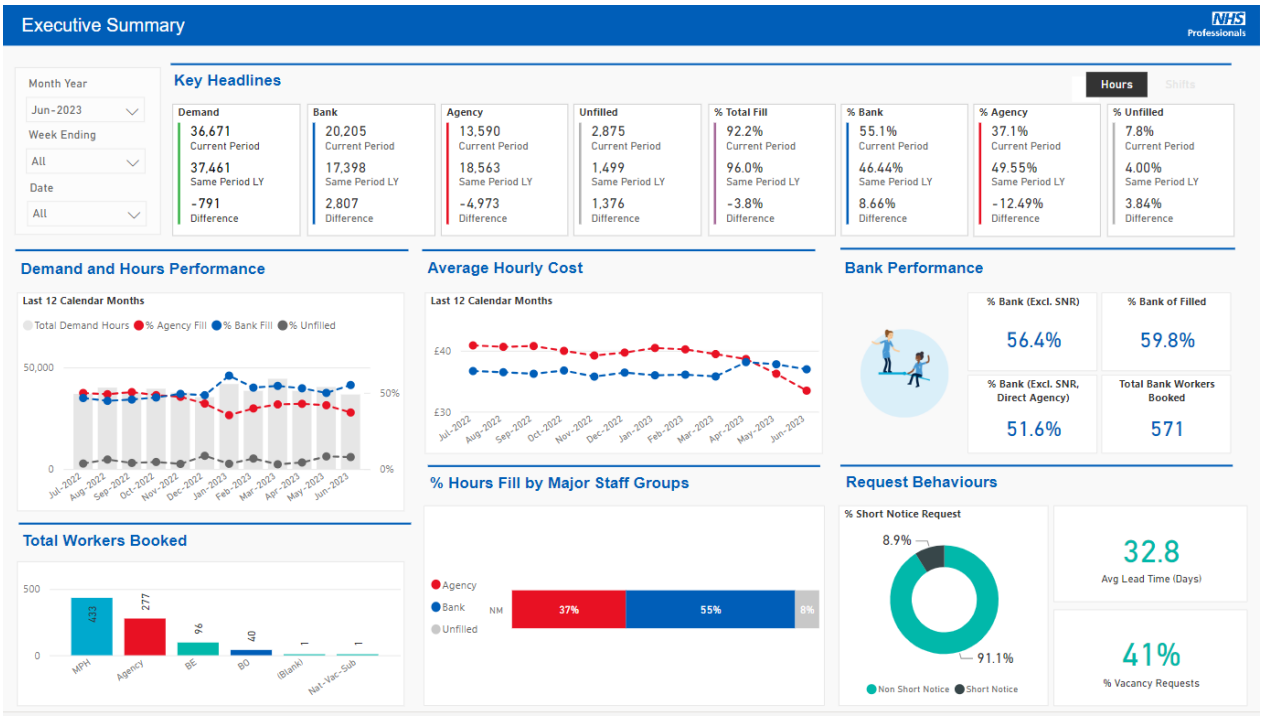
Fig.7 Agency 'Switch Off' May 2023

Ward	May-23	Jun-23	Total Agency Spend
Acute Care Team	£0.00	£0.00	£0.00
SDEC	£373.00	£0.00	£373.00
UTC	£0.00	£0.00	£0.00
FAU	£0.00	£0.00	£0.00
PIU	£0.00	£0.00	£0.00
Pre-op	£0.00	£0.00	£0.00
PACU	£0.00	£0.00	£0.00
Interventional radiology	£0.00	£0.00	£0.00

Fig.8 Agency 'Switch Off' June 2023

Ward	May-23	Jun-23	Total Agency Spend
A6	£7,367.00	£5,017.00	£12,384.00
AMU	£7,564.00	£5,461.00	£13,025.00
B12	£1,936.00	£1,066.00	£3,002.00
B14	£4,083.00	£1,105.00	£5,188.00
B4	£388.00	£0.00	£388.00
C20	£2,308.00	£2,237.00	£4,545.00
CSTM	£387.00	£0.00	£387.00
Fracture Clinic	£0.00	£0.00	£0.00
K25	£3,281.00	£366.00	£3,647.00
ODS	£0.00	£0.00	£0.00
Theatres	£923.00	£956.00	£1,879.00
Total	£28,237	£16,208	£44,445

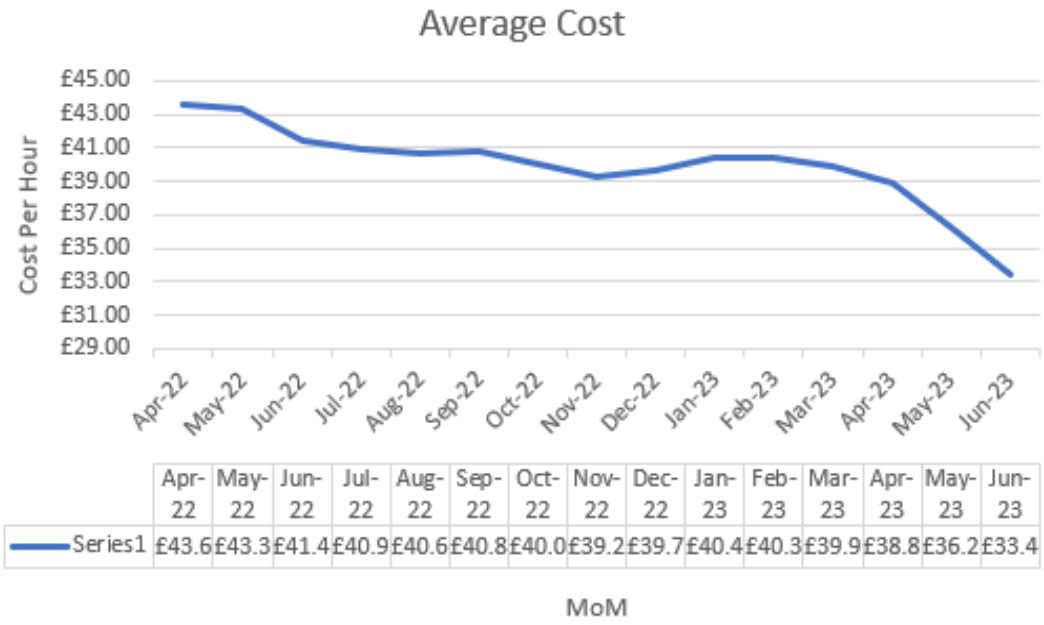
Fig. 9 Summary of NHSP Bank and Agency Usage for June 2023



5.1.5 The table above demonstrates improved total fill rates compared to the same period the previous year and a reduction in hours filled by agency workers. The data also demonstrates the reduction in average hourly cost for agency staff. This diagram highlights the lead time for booking shifts. For June 2023, WHH were the best performing Trust in Cheshire and Merseyside at 32 days. The Trust achieved 97% compliance for booking NHSP shifts automatically from rosters rather than direct demonstrating good roster management.

5.1.6 Figure 10 below demonstrates the reducing cost of agency workers based on savings of £3.29 per hour that totals a cost avoidance of £804k since the introduction of Centrally Agency Managed Service (CAMS) via NHSP.

Fig.10 Average Cost of Agency Per Hour Since April 2022



5.1.7 Figure 10 above demonstrates the reducing cost of agency workers based on savings of £3.29 per hour that totals a cost avoidance of £804k since the introduction of Centrally Agency Managed Service (CAMS) via NHSP.

5.1.8 Due to the continued use of up to 25 escalation beds across the Trust until June 2023, it was necessary to utilise 'off framework' agency workers. Thornbury Agency have not been used since February 2023 with a clear directive that they should not be used. Greenstaff are another 'off framework' agency that are approved for use only by the Chief Nurse, Deputy Chief Executive or the Deputy Chief Nurse after a comprehensive site review of the staffing position has taken place and all other alternatives explored as detailed in the staffing escalation plan. Since the last biannual report, 17 shifts have been used in times of escalation.

5.2 WHH Recruitment and Retention:

A number of initiatives are in place to support recruitment and retention and are reported via the monthly Staffing Assurance Report to Trust Board and Strategic People Committee.

Examples of Key points:

5.2.1 **A Trust Recruitment and Retention Action Plan is in place,** monitored via the Workforce Review Group. Retention planning is supported by the Cheshire and Merseyside HEE Retention Lead, work continues with Trust Workforce Lead and the Clinical Education Team to ensure progress with this workstream continues to move forward.

5.2.2 **The NHSE Nursing and Midwifery Retention Self-Assessment** is due for completion and will be shared with the Integrated Care Board (ICB) Lead. This will facilitate development of high impact actions and inform future work plans.

5.2.3 **Monthly generic recruitment** for band 5 RNs continues with bespoke recruitment where required and larger recruitment events planned every 3 months, held off site with the next event planned for November 2023.

5.2.4 **Legacy Mentoring:** Successfully bid and award of 12 months funding from HEE for a Legacy Mentor role to focus attention on nursing and midwifery staff within the first 24 months of their working life in the NHS with the intention of improving their experience and reducing attrition.

5.2.5 One of the most successful initiatives is the international recruitment programme, with 226 nurses having joined WHH to date with a further 24 to arrive by November 2023. There will be no further allocation of internationally educated nurses after the arrival of cohorts 13 and 14 in October and November 2023. Due to the large numbers of international nurses across the Trust, investment in the reintroduction of a pastoral role is in progress supported by continuing professional development (CPD) funding to support the wellbeing and development of this group of staff. The post will run until March 2024.

6. SAFER NURSING CARE TOOL DATA COLLECTION

6.1 The Safer Nursing Care Tool (SNCT):

6.1.1 In line with NQB recommendations, the Safer Nursing Care Tool (SNCT) was developed to ensure the right staff, with the right skills are in place to support safe patient care. Originally developed by The Shelford Group and utilised for adult inpatient wards, it has recently been adapted nationally for the assessment of patients in the Emergency Department (ED). Recommended to be undertaken twice yearly, the first of these data collections for 23/24 was competed in July 2023.

6.1.2 The twice daily data collection is entered into to the SNCT calculator which indicates the number of staff required for patient care based on acuity and dependency.

6.1.3 The Safer Nursing Care Tool (SNCT) is one method that can be used to assist senior nurses to ensure optimal nurse staffing levels. Nursing workload and the ability to provide safe care is influenced by many variables including patient acuity and dependency, as evidence has shown that low staffing levels and skill mix ratios have an adverse effect on patient outcomes. Triangulating data from Nurse Sensitive Indicators (NSIs) such as infection rates, complaints, pressure ulcers and falls is essential in determining staffing levels. Additionally, when reviewing staffing levels and NSIs competence, leadership, morale, and compliance needs to be considered. Professional judgement must also be applied in addition to measurement tools.

6.1.4 In accordance with national guidance a minimum 20-day data SNCT capture was undertaken across 19 wards. The data does not include ITU who align to the Guidelines for the Provision of Intensive Care Services (GPICS) staffing recommendations. Maternity aligns their guidelines to Birth Rate Plus staffing recommendations and are therefore not included.

6.1.5 ED data was not captured in this review as a full staffing review was undertaken by the Associate Chief Nurse for Unplanned Care resulting in a revenue request to increase their establishment for nursing staff. Approval was given for partial funding and will increase their

establishment by 8 WTE nurses. ED will be included in the second collection planned for November this year.

Fig.10 SNCT July 2023 data collection

SafeCare Required WTE Nurses vs Nurses in Post					
Ward	**SafeCare Required WTE**	**Budgeted Nursing Staff WTE**	**+/- Budget**	**Nursing Staff in Post WTE**	**+/- in-post**
AMU	46.80	57.56	10.76	57.77	0.21
A2	43.70	36.10	-7.60	35.69	-0.41
A4	48.40	48.16	-0.24	40.46	-7.90
A5 G	29.50	23.96	-5.54	22.50	-1.46
A5 E	17.10	18.75	1.65	18.75	0.00
A6	48.00	47.84	-0.16	44.30	-3.54
A7	51.80	39.46	-12.34	41.39	1.93
A8	51.40	43.46	-7.94	42.07	-1.39
A9	51.80	44.54	-7.26	45.79	1.25
B3	45.30	32.44	-12.86	30.21	-2.23
B12 FMN	36.80	47.13	10.33	49.13	2.00
B14	38.80	34.48	-1.92	34.00	-0.48
B18	41.40	59.44	18.04	51.65	-7.79
B19	43.40	37.06	-6.34	35.96	-1.10
C20	17.20	19.18	1.98	17.01	-2.17
ACCU	41.10	47.43	6.33	42.88	-4.55
C21	37.70	37.31	-0.39	30.79	-6.52
K25	29.80	26.61	-3.19	27.32	0.71
CSTM	12.90	31.28	18.38	23.57	-7.71
Total	**732.90**	**732.19**	**1.69**	**691.24**	**-41.15**

Key	
+/- Funded	This means more or less staff in the funded establishment than identified in the SNCT data results
+/- In post	This means more or less staff in post than the SNCT data results indicate

6.2 Analysis and Next Steps

In accordance with the data collection for July 2023, the recommended Safer Nursing Care establishment figures compared to the number of staff in post, shows a deficit of **41.15** WTE.

6.2.1 Analysis of the data shows there are 9 areas with significant differences in SNCT recommendations and funded establishment. Three of those areas B12, B18 and CSTM are considered to have the correct funded establishment based on assurance of safe staffing establishment figures from the Associate Chief Nurses and Lead Nurse for Workforce. Narrative to support this is outlined below.

6.2.2 **B12**: The ward has a layout of 3 bays and 4 cubicles, this means staff need to be allocated into bays and cubicles to support the patients, who are living with dementia, to maintains safety. Therefore, more staff are required than recommended as SNCT data does not consider the practice environment, which is seen as one of its limitations (BMJ 2020). SNCT recommends 36.80 WTE, the actual establishment is 47 WTE which is correct.

6.2.3 **B18:** This ward was refurbished and designed to accommodate patients with higher acuity, patients who require closer nursing (level 2 patients). The layout of the ward is significant in consideration of staffing establishments, these are unmeasured influences on demand that could have a substantial influence on the staffing requirements. SNCT recommends 41.4 WTE, the actual establishment is 56.8 WTE.

6.2.4 **Captain Sir Tom Moore (CSTM):** SNCT recommends 12.9 WTE staff are required, and the actual funded establishment is 31.28 WTE which is accurate. The SNCT results are unreliable due to estates work for IPC precautions which have effectively separated two areas of the ward, therefore staff are not able to cross over into the neighbouring area, resulting in a requirement for increased staffing. Additionally, staff are required to leave the ward to support the Urology Investigation Unit which is away from the ward area on another level of the building.

6.2.5 Following the previous bi-annual staffing report in February 2023, support for an establishment uplift has been approved for A7, A8 and A9. These wards have approval to progress with a revenue request to uplift staffing, partial funding of the initial request has been “ring fenced” ahead of the revenue request to be taken through financial governance processes. The outcome of the uplift will mean a total adjusted establishment across the three wards of 10.64 WTE leaving a shortfall against SNCT recommendations of 16.9 WTE, which may result in an increased risk of harm across those areas associated with incorrect staffing numbers.

6.2.6 **AMU**: SNCT doesn’t reflect the functionality of the unit as an assessment area. With high volume of patient turnover, discharges, and transfers, alongside attendance to diagnostics. The SNCT solely focuses on acuity and not activity. Therefore, the significant number of nursing care hours spent doing these tasks is not reflected in the SNCT dataset. Additionally, given the high volume of activity, there is the requirement to have a senior nurse co-ordinator on every shift, which is not considered within the SNCT results.

6.2.7 The functionality of the ward as Medical Assessment Unit has a key role in supporting flow for the Trust, at pace. A recent review of activity on AMU showed that there were over 600 patients admitted to AMU in the months of May 2023 and June 2023. On average, AMU are admitting 25 patients a day which equates to 50 patients in and out of the ward within a 24 hour period. This illustrates the need to consider an increase to the establishment to ensure that safety and quality in relation to patient care, including safe and efficient transfers/discharges/flow.

6.2.8 The guidance from the Society of Acute Medicine and the "Getting it right first time" document released in April 2022 informs us that the required ratio for an Acute Medical Unit (considering acuity and activity) is 1 RN:6 patients in the day and 1 RN:7 patients overnight. The current ratio is 1:8 on a long day and on a night shift. Therefore, the recommendation is that an establishment review is undertaken.

6.2.9 **B3:** SNCT data recommends a figure of 53.9 WTE against a funded establishment of 16.51 WTE. This is due to escalated beds in operation and the type of patients in those beds who breach the criteria for medically optimised. On analysis the senior clinical team can confirm that when B3 was functioning as it was intended to, the current establishment figure is correct. Despite the recent closure of the escalated beds in May 2023, the ward continues to receive patients who breach the criteria and therefore the staffing establishment may need to be reconsidered in line with the increased acuity and dependency of patients at WHH and the difficulty in identifying medically optimised patients at WHH.

6.2.10 **A2:** The data captured for A2 has confirmed that the dependence of patients is far higher than that of AMU but again does not take into account the activity of patient admissions, discharges and transfers on or off the ward. The current establishment is 4RN +AP/RNA + 4HCA on a long day and 3RN +3HCA on nights. The current ratio is 1:7:8 on the long day. Overnight the ratio increases to 1:10.

6.2.11 Based on the data captured, the establishment would need to increase to reflect this acuity and dependence of patients. The November 2022 data collection showed Level 1b patients being the majority, higher dependency and acuity, which is shown again in the latest data collection (Level 0 average 7.15, Level 1a average 2.5, Level b average 18.85). A2 also has multiple ITU step-downs, with many patients brought back to the acute ward if they are unwell on other wards in the organisation. The ward also cares for patients with complex diabetes with multiple infusions. Similarly, there are very complex patients admitted with increased length of stay, alongside the increase in patients admitted with poor mental health.

6.2.12 SNCT does not differentiate between qualified and unqualified groups of staff and as such it requires a very good understanding of patient groups and nursing requirements, hence the requirement to overlay the SNCT data with professional judgement, as factors such as ward layout, turnover and speciality are not directly considered in the patient classifications, yet they may influence the outcome. Therefore, SNCT must be used in conjunction with a professional judgement model, seen as the 'gold standard' in determining safe staffing requirements (BMJ 2020).

6.2.13 Further analysis of the data using the SNCT, and professional judgement modelling shows that for the November 2022 and July 2023 data collection, there are similar differences in the deficit between what SNCT recommends and what the establishment figures are for wards A2, A7, A8 and A9. Concerns regarding higher dependency on those wards have been highlighted in the staffing updates to Trust Board throughout 2022 and 2023, particularly A7, A8 and A9 which has resulted in an approval for progression of a revenue request.

6.2.14 Overlaying SNCT with professional judgement confirms A2 require a higher staff to patient ratio than allows in the current funded establishment, particularly as this was highlighted in the last

report in February 2023. Reports of higher dependency, enhanced care requirements and increased harms are escalated regularly to the senior nursing team and continue to do so.

6.2.15 In summary the required uplift for A2 is 7.6 WTE, however regard must be given to the difference in the "ring fenced" funding that was less than was initially requested for A7, A8 and A9, which leaves a deficit of 16.9 WTE therefore the total deficit in WTE staffing following this SNCT is **24.5 WTE.**

6.2.16 A review of the criteria for patients who can be cared for on B3, or a review of the staffing establishment is needed to align the staffing requirements correctly against the level of acuity and dependency of the patients who are transferred to B3.

6.2.17 Further review of AMU will be undertaken with a strong possibility of the requirement to increase establishment to support the activity and national recommendations for safe staffing within that department.

7. STAFFING AND HARM

7.1.1 Red flag data is reviewed daily by the Senior Nursing Team and reported as part of the daily staffing briefing. The Senior Nursing Team review the data twice daily to ensure appropriate escalation plans are in place to support staffing decisions to meet the needs of the operational demands so that safe care can be provided on inpatient wards. Any potential care issues associated with staffing are also recorded here using the Red Flag system. Red Flags are reviewed and acted upon/mitigated where possible in real time and remain open until resolved during the staffing meetings, reports are sent to Lead Nurses and Matrons on a weekly basis to allow them to review their trends and themes. Frequency and themes inform responsive and planned nurse staffing reviews and inform future establishment requirement.

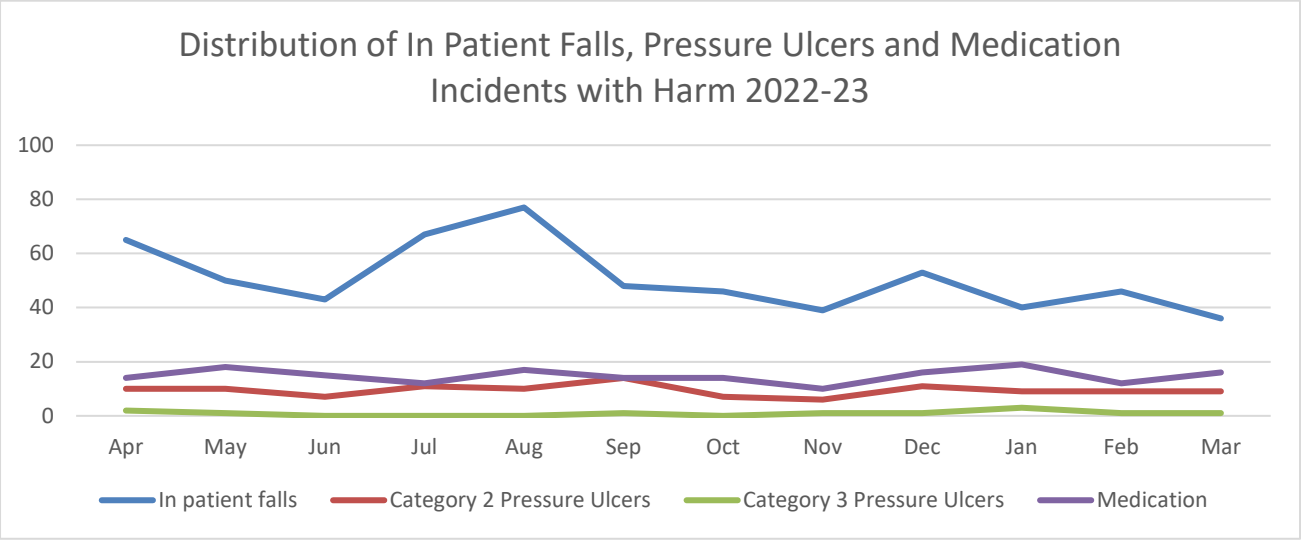
7.1.2 A monthly report is also shared with the senior nurses that triangulates staffing incidents, staffing red status, red flags and patient harms. The table below shows how many red flags reported and how many occasions wards showed a red staffing status.

Fig.11 Red Flags Reported and Number of Occasions Wards Showed a Red Staffing Status.

Time Period	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
No. Red Flags opened	976	1340	1180	1214	1030
Red Status reported	834	575	682	495	345

7.1.3 The reduction in red flags for Q1 23/24 and red flag status when triangulated against staffing fill rates, shows a correlation between reduced red flags and increased fill rates for April and May 2023, this aligns to the increased staff in post as seen in fig 1 in this report.

Fig.12 Distribution of Harms Across 2022/2023



7.1.4 Falls with harm were reported on 9 wards, with ED reporting the highest number (4) A7 (3), C21 (3) and A8 (2), B14, K25, ACCU and CSTM all reporting 1.

7.1.5 It is understood across the Trust that ED nursing establishment does not meet the current demand with the increased number of patients consistently nursed on the corridor. This is a known risk to patient safety and patient experience and has contributed to harm in the number of falls with harm recorded in the department.

7.1.6 C21 recorded more than 1 fall with harm. Cross referencing the data shows C21 having a very high number of requests for extra staff from NHSP for enhanced care at 398 since April 2022. This is the second highest number of requests made for the time period, behind B19 at 1145, due to escalated patients for long periods.

7.1.7 A6 reported the highest number of hospital acquired pressure ulcers with 19 reported since April 2022, 3 of those being category 3 harms. A7 have reported 17 (2 cat 3), A8 have reported 13 (2 cat 3) and B18 have reported 13, no category 3.

7.1.8 Escalation of concerns about staffing are known for both A7 and A8. Both wards record a deficit on the SNCT data collection for November 22 and July 2023 and professional judgement supports the requirement for increased staffing. Increased harms are recorded for both pressure ulcers and falls with harm. High numbers of requests for enhanced care have been reported and the wards recorded red status on 287 occasions since April 2022 and 1133 red flags, the highest reporters with 20% of all red flags reported across the time period, showing a correlation between lower numbers of staff and the incidence of harm.

7.1.9 Whilst A6 do not flag on the SNCT data for a large staffing deficit, their vacancy percentage peaked in 2022 at 21%. Earlier this year there was no ward manager in post for 6 weeks which has impacted on the levels of harm reported for that ward. The rates of reporting red flags is high, 3rd highest reporter 2022 and 4th highest in 2023 to date. A6 have also reported the 3rd highest number of medication incidents, with the themes being missed/ omitted medicines. More recently there has been a supportive intervention on A6 from the Deputy Chief Nurse in relation to the occurrence of harm and close oversight and monitoring of practice is in place. The current vacancy situation for A6 shows an improved position with a vacancy rate of 14%.

7.1.10 B18 have carried a 40% vacancy for a significant time. Their patients have very high acuity including patients who require level 2 care, normally nursed on ITU. The pressure ulcers reported for B18 are lower harm and related to medical devices in the main. The ward report high numbers of requests for additional staff due to enhanced care requirements.

7.1.11 The Terms of Reference for the monthly safe staffing meeting have been reviewed to expand the function of the group to include clinical outcomes. Attended by Ward Managers, Matrons, Lead Nurses and Associate Chief Nurses, the new group will review harms against staffing and other indicators such as sickness for the clinical areas to determine what level of interventional support is required, ranging from no support required to high level monitoring. At present wards A6, A7, B18 and ED have action plans in place to support the reduction of harms overseen by the senior nursing teams.

7.1.12 The purpose of the group is to be pre-emptive and look forward utilising prospective workforce data and historical harms reported, rather than reactive which has been how areas of concern have been previously highlighted.

7.1.13 In summary, a relationship between harm occurrence and low staffing numbers has been seen across the wards highlighted above. Other factors have also contributed such as skill mix and leadership, therefore addressing the concerns needs to be a multi layered approach with the focus on filling vacancies, quality improvement and development and support for staff in practice.

8. EVIDENCE BASED STRATEGIC WORKFORCE PLANNING

8.1 Staffing Fill Rates

8.1.1 Staffing fill rates are demonstrating an improving picture since February 2023 and are currently over the 90% standard for all 4 elements measured.

8.2 Care Hours Per Patient Day (CHHP)

8.2.1 Care Hours Per Patient Day (CHPPD) was developed and adopted to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatients wards. CHPPD monitoring and tracking can be facilitated alongside E-Rostering systems and supports the daily assessment of operational staffing requirements. CHPPD are monitored monthly via the Trust IPR and reported via the monthly Trust Board Staffing Paper. Across WHH performance has improved since February 2023, with latest data showing 7.7 which is just below the national target of 7.9.

9. CARE GROUP UPDATES

9.1 Planned Care

- Staffing fill rates are demonstrating an improving picture since February 2023 and are currently over the 90% standard for all 4 elements measured.
- Overall sickness HCSW has decreased to 8.23% in May 2023.

- The Director of Midwifery role has been substantively appointed to. This post and the Deputy Director of Midwifery will cover maternity only, therefore the senior nursing leadership structure for Paediatrics and Gynae services is currently being reviewed.
- Nutrition Specialist Nurse funding has been allocated, and the Job Description is scheduled for job-matching panel. A revenue request business case in progress to complete the approval process.
- Pre-Op skill mix review consultation continues.
- In Endoscopy the Cheshire and Merseyside Collaborative Bank project continues with full participation of WHH. There is not expected to be an impact on WHH endoscopy staffing.
- On Ward B3, the additional 6 beds has been de-escalated (26.05.23). This will reduce the temporary staffing requirement to cover the escalation bay and significantly reduce the pressure across the Halton site for staff moves to maintain a safe site.
- An Ophthalmology revenue request business case in progress for increased nursing establishment to address increasing Age-Related Macular Degeneration (AMD) demand. A departmental Training Needs Analysis is planned for all nursing and HCSW roles to identify opportunities for staff development and retention.
- A staffing challenge continues on A5 Gastro due to vacancy/long term sickness in senior posts however, this is an improving picture.

9.2 Unplanned Care

- Overall, the current vacancy excluding AED is 74.39 WTE compared to 81.68 WTE last month.
- B18 and ACCU have significant vacancies, however targeted recruitment and open days has led to B18 being projected to be fully established by September 2023.
- A significant piece of work is underway reviewing ITU staffing. The service has just appointed 2x band 7s and 5x band 6s (previously filled with people on secondment). This leaves band 5 vacancies only.
- C21 are now fully established apart from 2.0 WTE HCSW vacancies which are in pipeline.
- A2 are fully established for RNs with 0.98 WTE HCSW vacancy which is also in pipeline.
- A review has commenced of all staff on secondment across the Care Group.
- Over-recruitment is taking place in high turnover areas.
- New Dementia and Delirium Nurse Consultant appointed and commences in August 2023.

9.2.1 ED Workforce Update

- There have been two RN resignations in ED in the month of May 2023.
- A new Matron has commenced in post.
- A new Department Manager has commenced in post.
- Development plans are in place for all staff. An extended supernumerary period is in place for all new starters including an “ED training week” and a dedicated Practice Educator for preceptees.
- ED Paediatric Department is now over recruited against establishment to offset cost of agency spend of increased requirements due to demand.
- Significant vacancies at band 5 have led to an over-recruitment to pipeline acknowledging potential attrition rates.

- 21 new starters expected June - August 2023.
- Ring fenced revenue for £450,071. A revenue request is being developed and due to go to August 2023 Board. Approval to submit ECF's now.

9.3 Maternity Services: Registered Midwives and Healthcare Support Worker Vacancies

- The vacancy rate for registered staff has reduced from a peak of 23.25% in June 2022 to 17.24%, this is a slight increase from 15.49% in April 2023. This is due to internal promotions and two retirements.
- As at 22 June 2023 there are 13.26 WTE registered staff in pipeline to start. This includes six newly qualified midwives (NQM) who will commence in the Autumn 2023. Further NQM recruitment will commence in July 2023 and targeted recruitment campaigns for vacancies in Maternity Triage and the Nest Midwifery Led Unit are also underway. The midwifery team has been allocated five international recruits via the regionally led IR project who will join the service across the remainder of 2023. The first recruit will commence in August 2023.
- Midwifery staffing is reviewed daily, with a seven day look ahead, and each shift is RAG rated. Amber and red shifts are escalated via the Maternity Matrons and actions to improve are implemented. This includes adjusting staff rosters, ensuring all shifts are pushed via NHSP and where challenges persist the offering of enhanced rates of NHSP.
- A dedicated Microsoft Teams group has been established to facilitate communication of short notice changes to staffing which allows the ream to respond promptly to notifications of absence and other matters related to safe staffing.
- The vacancy rate for non-registered staff has reduced similarly, from a peak of 29.95% in September 2022 to 13.78% May 2023. There are 2.1 WTE non-registered staff in the recruitment pipeline.
- Overall, registered staff turnover continues to improve. Turnover for all permanent staff has decreased from 29.49% in August 2022 to 17.03% in May 2023, for registered staff this figure has reduced from 30.15% in August 2022 to 19.86% in May 2023. For non-registered staff, turnover is 7.77% which is below the Trust target of 13%.

9.4 Paediatrics and Neonatal Unit (NNU)

- The Neonatal Unit has successfully recruited fully into the band 6 and band 7 establishment. Band 5 interviews are taking place week commencing 26 June 2023 expecting that the unit will then be fully established. NNU are also in discussion with the workforce recruitment lead regarding the recruitment of an international nurse with extensive NNU experience.
- Neonatal Critical Care Review Funding: The NHS Long Term Plan has committed major investment in recent years to expand and develop the neonatal workforce. Since 2021, nationally there has been a significant investment to enable recruitment to neonatal nursing and allied professional roles. In 2023 the final allocations from the NCCR funding were made. This funding was made available for nurse quality roles, namely education and governance. The funding allocation for WHH NNU unit was 1 WTE for Education and Governance, recurrent funding. A comprehensive nurse staffing paper is being developed to align to NWNODN recommendations.
- B11 will be fully established for registered staff in August 2023 this includes the services two Registered Nursing Associates who will have completed their Registered Nurse Degree Apprenticeship top up programme in August 2023.

9.5 Allied Health Professional (AHP) Update

- Registered AHP turnover is at its lowest percentage at 9.99%.
- AHP Clinical Support Worker sickness rates continue to fall month on month with May at 8.06%.
- PDR rates are improving and is currently at 82.61%.
- Therapy accommodation refurbishment of staff room completed.
- Recruitment and retention of Occupational Therapists, Mammographers and Sonographers remains a concern, all of whom are on the national shortage list, increasing demand (e.g., CDC opening imminently).
- AHP degree apprenticeships – challenge for ODP staff to take up.
- Prospective junior workforce amongst Occupational therapists and Physiotherapists. Several band 6 posts converted to band 5 and recruitment internationally. Proactive planning underway to manage this risk to prepare for winter 2023/24.
- E Roster for AHP's requires a coordinated approach and forward planning for 2024/25.

10. OVERALL SUMMARY

10.1 Improvements have been seen in recruitment across staff groups with a positive trajectory of over recruitment going forward. This is further supported by a positive reduction in turnover. Work continues to focus on retention and to proactively recruit to maintain a consistent workforce pipeline.

10.2 Staffing capacity and the impact on safe care is recorded on the Board Assurance Framework, with a current high-risk rating of 20. The Lead Nurse for Workforce continues to work with the Care Group and CBU nursing leads to support the recruitment and retention plans in place, overseen by the Deputy Chief Nurse and monitored via the Trust Workforce Review Group.

10.3 A robust ward staffing establishment review has been undertaken using a mixed methodology of approaches in line with the recommendations from the NQB, NICE guidance and the RCN Nursing Workforce Standards.

10.4 Overall, the staffing establishments remain appropriate and within recommended guidelines, there are some key exceptions where acuity and dependency levels and growing demand continue to overtake the nursing ratios. Recommendations for uplifts are highlighted within the paper and will be considered at the review meeting with the Chief Nurse, Deputy Chief Executive in October 2023.

10.5 Safe staffing and staffing escalation are monitored and utilised and is always a priority for the clinical teams. These processes remain in place to support staff and protect the safety of patients at WHH.

10.6 The Agency Reduction Plan in place has resulted in 20 areas being switched off to the use of agency.

10.7 The category of 'mental health' has been added as a booking reason on NHSP to monitor the increase of patient mental health related carer shifts monthly.

10.8 There is a clear process in place for booking mental health experienced HCSW for wards when required via NHSP.

11. RECOMMENDATIONS

11.1 It is recommended that the Quality Assurance Committee members discuss and note the progress to date and the contents of the report.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/23/09/193**			
SUBJECT:	**Learning from Deaths Report Q1 2023-2024**			
DATE OF MEETING:	12 September 2023			
ACTION REQUIRED:	For noting			
AUTHOR(S):	Dr Lalitha Chinnappan, Consultant Gastroenterology and Trust Mortality Lead. Dr Judith Raper, Palliative Care Consultant and Deputy Y Emily Barnett, Clinical Effectiveness Manager			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This paper summarises 'Learning from Deaths' for Q1 2023 / 2024, for noting and scrutiny, incompliance with National Guidance requirements on Learning from Deaths.			
PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
RECOMMENDATION:	Quality Assurance committee is asked to note the contents of the paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Learning from Deaths Report Q1 2023 / 2024	AGENDA REF:	QAC/23/09/193

1. BACKGROUND/CONTEXT

The National Guidance on Learning from Deaths requires all Trusts to have processes and systems in place to review, investigate and learn from deaths that occur with due focus on:

- Governance and capability.
- Improved data collection and reporting.
- Death certification, case record review and investigation.
- Engaging and supporting bereaved families and carers.

The Trust is committed to learning from both positive and negative aspects of a patient's care with clear processes in place for completing mortality reviews. Learning identified during mortality reviews allows individual specialties to improve their processes; collated learning provides corporate themes for larger quality improvement projects. The Trust is committed to systematically investigating, reporting and learning from deaths.

This report provides an overview of the processes and systems that are in place to ensure that deaths are reviewed appropriately and summarises the data for this quarter.

2. KEY ELEMENTS

WHH uses the HED (Healthcare Evaluation Data) system to assess overall mortality data, highlighting any themes or trends that support the requirement for reviews of deaths. The HED report also enables benchmarking against other Trusts.

Using both the HED and the Datix Risk Management system to obtain data, this report includes:

- The total number of deaths of patients.
- The number of reviews of deaths.
- The number of investigations of deaths.
- The themes identified from reviews and investigations.
- The lessons learned, actions taken, improvements made.

The Mortality Review Group (MRG) at the Trust reviews the HED report monthly. Deaths subject to a Structured Judgement Review (SJR) as per the criteria defined in the Learning from Deaths policy are reviewed at MRG to identify learning and improvement actions.

3. MEASUREMENTS/EVALUATIONS

A Structured Judgement Review will be completed if a patient death meets one or more of the below criteria:

- All deaths of patients subject to care interventions with elective procedures.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust.
- Death of a patient with severe mental health needs.
- Death of a patient who had a 'standard' DOLs in place during their admission. A 10% random selection will be made for any death of a patient with an 'urgent' DOLs in place during their admission.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality review process.
- At the request of the Medical Director or Chief Nurse.

NB: If a death is subject to a Root Cause Analysis (RCA) an SJR is not undertaken.

MRG – Forward planning

1) Full review of workstream continues to be undertaken ensuring that any issues identified are addressed with the aim to bring about clinical changes and positively impact both patient care and trust mortality. When further issues are identified new work streams are created. The current list of workstreams are as follows:
   - DNACPR.
   - Patient Transfers
   - Specialty Input
   - DoLS/ Capacity
   - SAFER
   - Trainee
   - Good practice.

2) The following changes have been made to reduce the backlog of SJRs:

- Only a 10% random selection of 'standard' DOLs cases will be referred for SJR.
- The Clinical Effectiveness Coordinator liaises weekly with the Safeguarding Team weekly to gain clarification on the correct DOLs cases.

These changes have seen a positive reduction on the number of deaths that require SJR. Which has impacted the service in a positive way as this has not only reduced but removed the back log of SJRs requiring allocation and also enabled MRG reviewers the capacity to work on focused reviews.

3) Learning from MRG is taken quarterly to the Palliative and End of Life Care Steering Group and hence informs developments including review of P&EOLC Strategy to encourage timely referral to specialist palliative care, recognition of dying, and early Treatment Escalation Planning, and the CPR Decision Making and Discussions Workstream and associated education.

4) Speciality M&M Meetings have commenced and take place during the Speciality Governance meetings. Every month, each Speciality is provided a death report for their area and any specific learning that may have been identified during the MRG meeting will be shared to ensure learning is widely disseminated and as a Trust we are making those improvements to better our patient safety, quality and experience.

5) Good practice is now highlighted by MRG certificates being issued to members of staff who have been noted during review of a SJR to have excellent documentation within the patients records.

6) SJR training has been arranged for 15 WHH staff members provided by national training group to ensure standardisation of mortality reviews, that as a Trust we are all working the same way and the correct way. This is scheduled for Thursday 28th September 2023.

During Quarter 1 there were between 10 - 25 deaths per month that were flagged as requiring an SJR to be completed. Therefore, the average deaths requiring a SJR per month are 17 which is a decrease of 13 from the last reporting period. Currently we have 8 Mortality reviewers, with 7 of them being allocated 5 cases per month and 1 being allocated 6 per month, leaving a total monthly allocation of 36 SJRs – This will change from October 2023 onwards with only 35 being allocated per month due to a change in mortality reviewers.

Currently we are up to date in the allocation of SJR's. This is due to the changes as mentioned above and has allowed for more focused learning to be shared with the relevant teams to better improve our Quality of Care.

3.1 Mortality Review Data Q1 2023/2024

- During Quarter 1, 53 deaths met the criteria to be subject to a Structured Judgement Review (SJR). A reduction of 38.
- During Quarter 1, 94 deaths were allocated to a review for a Structured Judgement review.

- 93 SJRs have been completed in Q1, which is a reduction of 40 from Q4 2022 / 2023 – This is due to the reduction of SJRs being allocated.
- Of the 93 SJRs completed, 67 were allocated in Q1 2022 / 2023 and 25 were allocated in previous quarters.

Fig. 1 – Key Mortality Data

Total deaths in Q1	Total LD Deaths Q1	SI investigations commenced in Q1 relating to patient deaths	Those meeting SJR criteria Q1	Number of SJR reviews completed in Q1	Number of SJR Reviews that were allocated in Q1 23/24 and completed compared to Q4 22/23	
271	1	0	78	93	Q4 22/23 Total SJR Completed – 133 SJRs were completed on 86 out of the 124 assigned in Q4 69%	Q1 23/24 Total SJR Completed – 93 SJRs were completed on 67 out of the 93 assigned in Q1 72% ↑

Cases rated by reviewers as *1:* ***overall care very poor*** or *2:* ***overall care poor*** are reviewed by MRG to agree the overall care rating and then referred to the Governance Department if the consensus rating is Very Poor/Poor for further investigation.

A sample of cases rated as *3:* ***Adequate*** are referred to MRG for further discussion to identify themes for learning and improvement.

Cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Specialty Governance meetings, a sample of these are also brought to MRG to highlight good care.

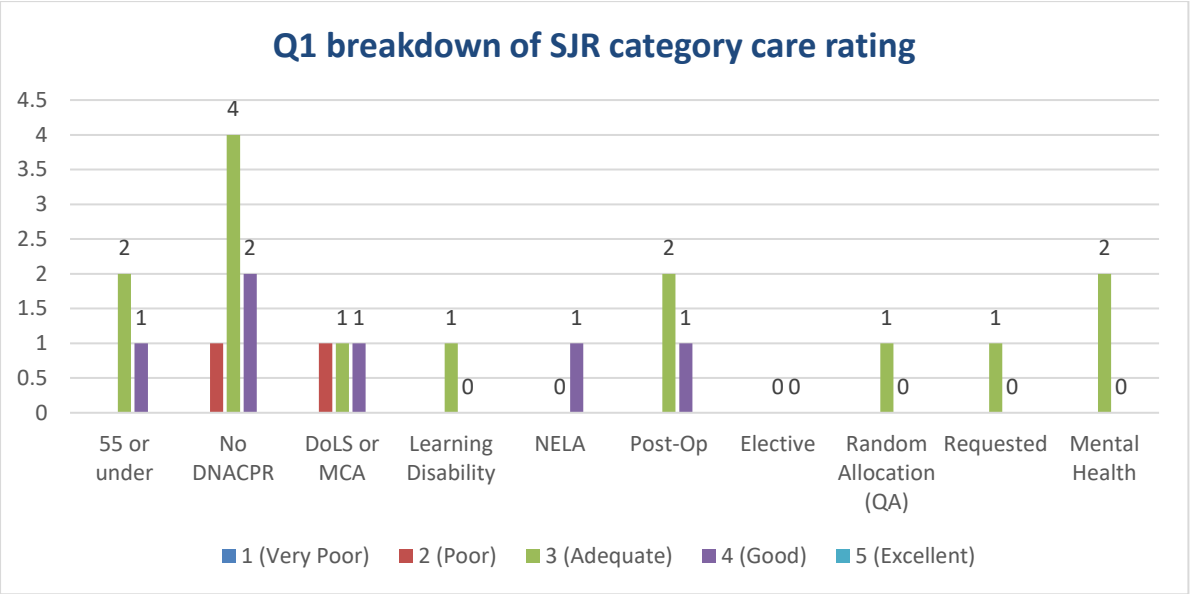
Fig. 2 – Shows the overall and phase of care ratings of the 93 SJRs completed in Quarter 1.

Phase of Care *	N/A	Very Poor	Poor	Adequate	Good	Excellent
First 24 hours/admission	1	0	4	17	68	3

Ongoing care	17	0	1	25	49	1
Care during procedure	76	0	0	2	15	0
End of life care	57	0	0	13	22	1
Patient records/documentation	0	0	1	24	67	1
Overall care	**0**	**0**	**1**	**28**	**61**	**2**

- In SJRs completed within Quarter 1, there has been no very poor care at any stage of admission.
- 1 overall were noted as 'poor' care.
  - 13257: This case is due to be discussed at September 2023 MRG meeting.
- All phases of care and documentation records including overall care had a majority of 'good' ratings.

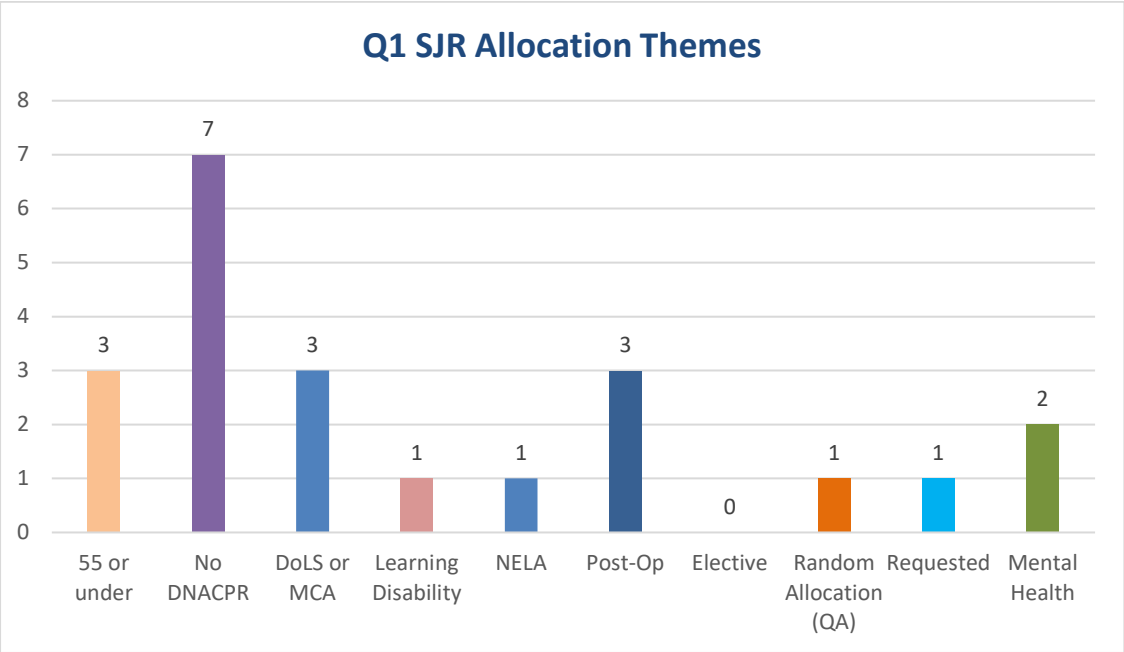
Fig 3 - Shows the breakdown of care ratings in each SJR category in Quarter 1



- All categories except for one allocation for 'No DNACPR' and one allocation of 'DoLs' are predominantly receiving good / adequate care.
- Random Allocation patient shown 'adequate' care. Random allocations are used by the Clinical Effectiveness Coordinator when screening deaths where they feel there could be an issue in care, but the patient does not fall into an SJR category.

NB Some care ratings are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

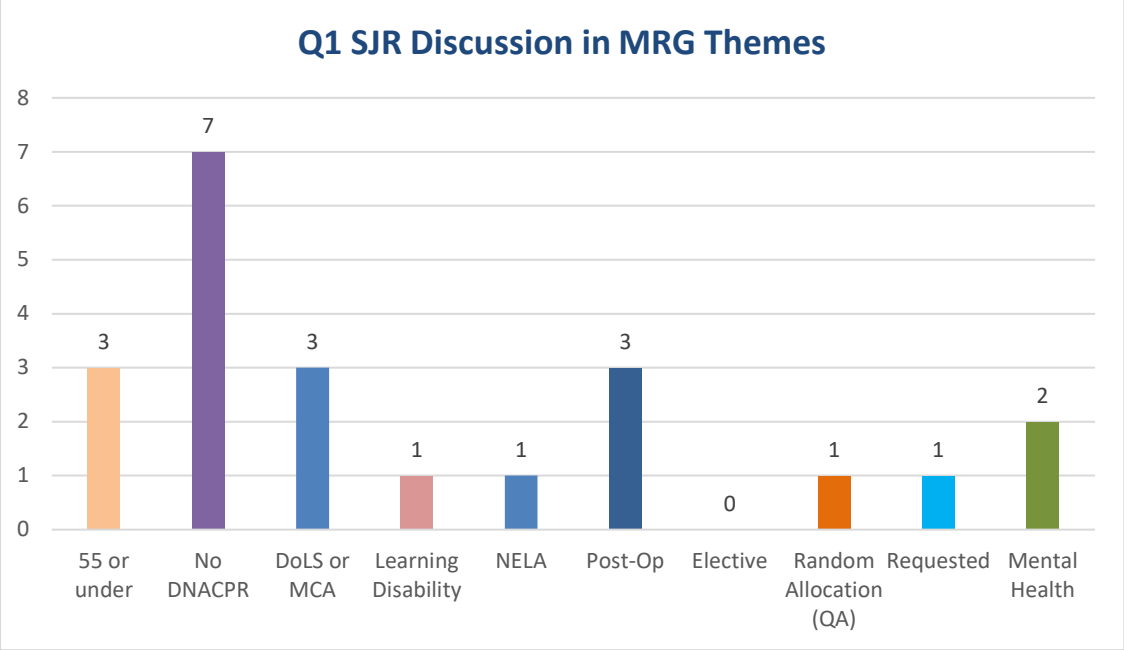
Fig 4 - Shows the frequency of each SJR category allocated to reviewers in Quarter 1



- 'No DNACPR' was the most frequently allocated category to reviewers in Q1.

NB Some allocations are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

Fig 5 - Shows the frequency of each SJR category presented at MRG in Q1



- The category with the highest number of SJR's requiring further discussion at MRG in Q1 is patients with 'No DNACPR'. This corresponds to the number that are allocated.
- There is DNACPR workstream within MRG to collate this learning for the Trust's DNACPR lead.

3.2 Learning from deaths

The below provides a sample of the learning following recent deaths and the actions taken.

Learning	**Action**
54-year-old patient admitted via AED. Unwell for one day with cough, Malaise, Diarrhoea, and shortness of breath. Past medical history – Type 1 diabetes and HTN. • Good evidence of communication with family • Consent for procedure not clearly documented. Reviewer could not find LOCCSSIP, the documentation to say trachea was done, was in the communication notes.	• Reviewer will feedback to ITU about LOCCSSIP • Will also be taken back to the trauma team governance re LOCCSSIP and re-launch existing electronic Lorenzo documentation
89-year-old nursing home resident admitted with shortness of breath and generally unwell. Patient was diagnosed with fast AF and CAP. Past medical history – Dementia and bed bound. • This patient could have benefited from the amber care package being implemented earlier. • work is being undertaken with the ICB to look at cases such as this and is looking at potential training packages. • Case would be beneficial to take the information discussed through Governance to (CQFG) to be cited externally in Primary care alongside suggestion of training packages within the ICB. • Noted there is a CQUIN in development for recording CFS (Clinical Frailty Score) to identify frailty in patients.	• Case to be taken forward to discuss with ICB surrounding hospices, nursing homes etc.
88-year-old patient with 2 recent admissions in previous two months with LRTI, Covid, progressive confusion and struggling after discharge. Patient had an Individual Plan of	• The question, "Could this admission have been avoided?" was raised and JR will look into this case outside of MRG.

Care for the Dying Person in place but improved enough to go home with daughter. • Given patient had IPOC in place, did this patient need to be admitted? • Palliative Care involvement • Overall care was adequate.	
Themes **Appendix 1** – Ensuring appropriate investigations and initial management plan in the first 24 hours of presentation. Newsletters are included on CBU and Specialty Governance agendas each month.	

3.3 Learning from Serious Incident investigations:

No SI's were reported during the quarter 4 period relating to a patient's death.

Mortality Indicators

The HSMR is calculated each month for each hospital in England. It includes deaths of patients with the most common conditions in hospital which account for around 80% of deaths in hospital. HSMR is the ratio of observed to expected deaths, multiplied by a 100, from 56 baskets of the 80% most common diagnoses. If the HSMR is above 100 then there are more observed deaths than expected deaths. Upper and lower confidence intervals are applied to HSMR. HSMRs with values between the confidence intervals are consistent with random or chance variation.

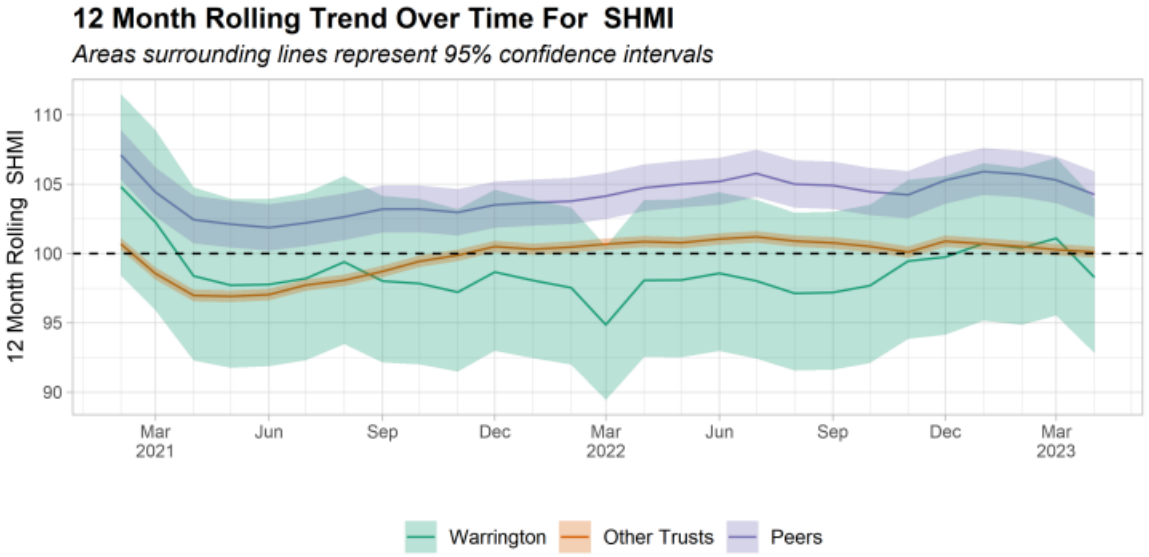
To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

The SHMI data is the ratio between the actual number of patients who die within 30 days following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of patients treated there.
The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected'

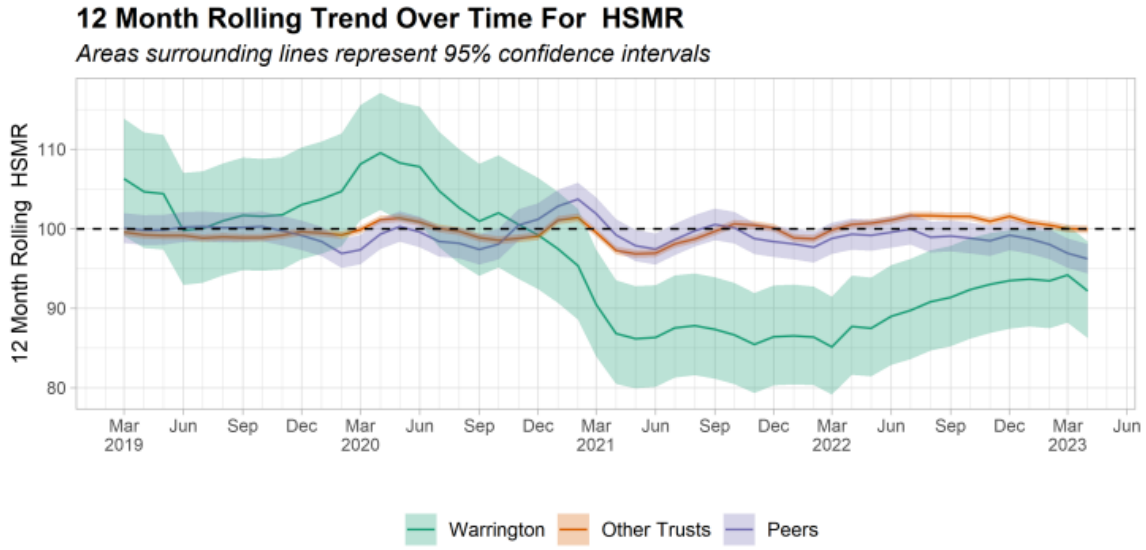
(SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.
HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents, and complaints data.

4.1 HSMR and SHMI indicators

Month	HSMR	SHMI	Total Deaths
April	93.53	99.52	81
May	93.52	98.98	95
June	93.10	99.38	95



HES SHMI (which is based on 12 months data up to and including April 2023) is 98.28. This result is not an outlier using an overdispersed funnel plot and is not an outlier based on the stricter Poisson method.



Standard 56 CCS group HSMR (which is based on 12 months data up to and including May 2023) is 93.17. This result is a low value outlier based on the 95% Poisson method.

- SHMI for Warrington is now on a par with other acute trusts on average, but lower than the average for the peer group.
- 12 month rolling HSMR for Warrington remains lower than for the peer group and other trusts on average, although the gap is now small.

Warrington's 12 month rolling SHMI for this diagnosis group on average is usually above both national and peer values. Care should be taken as numbers are small.

4. MONITORING/REPORTING ROUTES

Learning from Deaths is monitored by the MRG which reports monthly to the Patient Safety and Clinical Effectiveness Sub Committee, quarterly to the Quality Assurance Committee and annually to both the Quality Account and to the Clinical Commissioning Group via the Clinical Quality Focus Group.

5. TIMELINES

Ongoing - the Mortality Review Group meets monthly to review deaths that have been subject to a Structured Judgement Review.

6. RECOMMENDATIONS

The Quality Assurance Committee is asked to note this report.

MRG Newsletter

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

MRG Theme of the month June 2023

Ensuring appropriate investigations and initial management plan in the first 24 hours of presentation

53 year old female presented to the ED
- found on the floor by family, not having heard from her since the previous evening
- GCS 6 (E1V2M3)
- jaundiced
- background of alcoholic liver disease, with ascites, and portal hypertension with previous oesophageal varices
- COPD
- collateral history of black stool and abdominal pain for an unknown time course, Hb found to be 50g/L

Initial differential diagnosis of decompensated alcoholic liver disease/ upper GI bleed/ spontaneous bacterial peritonitis/ portal hypertension/ hepatic encephalopathy.

- GCS improved to 10 following transfusion and became incontinent of urine, restless and "aggressive" and trying to bite staff attempting to intervene
- developed headache and then suddenly GCS dropped again to 4, at which point escalation plans discussed with ICU and with family
- had CT head just before she died which revealed increase in previous sub dural haematoma with significant mass effect
- Died almost 4 days after admission of 1A Spontaneous subdural haemorrhage 1B) decompensated liver disease

Points Identified:

- Notes incomplete and did not explain plan for post investigations
- CT Head was requested on admission, however the wrong medical need and ward was documented
- CT request was not chased
- After initial treatment plan commenced, appropriate conversations and decisions about escalation of treatments including CPR
- Patient noted as "not arousable" whilst her GCS was low

Learning:

- Ensuring proper handover including in clinical record can help others follow your plan and chase up investigations as required
- Be cautious and double check when you are ordering investigations that the request is accurately completed- the simplest of things can make all the difference to the patient and to the team and the family's understanding of what is going on and how reversible it may be
- Continue to make appropriate treatment escalation decisions and discussions when recovery is uncertain or unlikely- including re CPR
- If your patient is not rousable and their GCS is low- that's all we need to know, please do not document (and for goodness sake do not check) whether they are "arousable"!!

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/23/08/174**
SUBJECT:	**Infection Prevention and Control Report Quarter 1**
DATE OF MEETING:	8 August 2023
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3: We will ... Work in partnership with others to achieve social and economic wellbeing in our communities.
EXECUTIVE SUMMARY	This report provides a summary of infection prevention and control activity for Quarter 1 (Q1) of the 2023/24 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. Healthcare Associated Infection (HCAI) cases in Q1 were: - • E. coli bacteraemia 22 cases against an annual threshold of 54 • Klebsiella Spp. bacteraemia 3 cases against an annual threshold of 18 cases • P. aeruginosa bacteraemia 2 cases against an annual threshold of 2 cases • C. difficile 4 cases against an annual threshold of 36 cases • MRSA bacteraemia 0 cases • MSSA bacteraemia 6 cases (no threshold) Inpatient Covid-19 cases for Q1 are: - • 153 (0-2 days) • 26 (3-7 days) • 35 (8-14 days – probable healthcare associated) • 51 (15+ days – definite healthcare associated) There were 5 inpatient Covid-19 outbreaks in Q1: - • 4 were mixed inpatient and staff outbreaks and 1 was an inpatient only outbreak. Outbreak Control Groups were established to manage the Covid-19 outbreaks with the Planned and Unplanned Care Groups

	The work plan for the year has been revised and activity increased to meet the objectives in the Infection Prevention Strategy.			
PURPOSE: (please select as appropriate)	Information	Approval	To note ✓	Decision
RECOMMENDATIONS:	The Quality Assurance Committee is asked to receive and note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Infection Control Sub-Committee		
	Agenda Ref.	ICSC/23/07/088		
	Date of meeting	20 July 2023		
	Summary of Outcome	Submit to Quality Assurance Committee		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control Report Quarter 1	AGENDA REF:	QAC/23/08/174

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control (IPC) activity for Quarter 1 (Q1) of the 2023/24 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) thresholds, continued response to Covid-19 cases and progress towards achieving the Infection Prevention Strategy.

There is a national ambition to halve Gram-negative bloodstream infections (GNBSI) by 2024. GNBSI include: - Escherichia coli (E. coli); Klebsiella species (Klebsiella spp.) and Pseudomonas aeruginosa (P. aeruginosa). NHSE set annual thresholds to minimise rates of *Clostridioides difficile* (*C. difficile*) and Gram-negative bloodstream infections (GNBSI). The thresholds set for WHH for 2023/24 are shown in table 1.

Table 1: WHH HCAI Thresholds for 2023/2024

HCAI	WHH Threshold 2023/24
C. difficile	≤36
E. coli	≤54
Klebsiella spp.	≤18
P. aeruginosa	≤2

GNBSI and C. difficile cases meeting the definitions below are apportioned to acute trusts:

- **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)

NHSE also set annual thresholds for all sub-Integrated Care Boards (ICB) geographical areas and these thresholds include all cases (comprising of the acute Trust and community cases). The Cheshire and Merseyside ICB thresholds for 2023 2024 are shown in table 2.

Table 2: Local ICB Sub-Group HCAI Thresholds for 2023/2024

C&M ICB	*C. difficile*	*E. coli*	*P. aeruginosa*	*Klebsiella spp.*
01X Halton	47	137	10	28
02E Warrington	45	130	5	37

The zero-tolerance threshold for avoidable cases of Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia remains in place. There is no threshold for Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia cases.

NHSE case definitions for Covid-19 are as follows with date of admission equalling day 1:

- Hospital-Onset Indeterminate Healthcare-Associated - First positive specimen date 3-7 days after admission to Trust
- Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Definite Healthcare-Associated - First positive specimen date 15 or more days after admission to Trust

A cluster of Covid-19 cases is defined as 2 cases arising within the same ward/department over a 14-day period. Further investigation is undertaken to assess if cases are linked, and if linked this is considered an outbreak and reporting is carried out in line with NHSE guidance.

2. KEY ELEMENTS

Healthcare Associated Infection Surveillance Data

RAG rating of Trust performance for HCAI by month is shown in Table 3.

Table 3: HCAI Surveillance Data

Indicator	Threshold	A	M	J	Total	Position in year
C. difficile	≤ 36	1	1	2	4	On trajectory
MRSA BSI	Zero	0	0	0	0	On trajectory
MSSA BSI	No target	1	2	3	6	No threshold
E. coli BSI	≤ 54	8	8	6	22	Over trajectory
Klebsiella spp. BSI	≤ 18	0	3	0	3	On trajectory
P. aeruginosa BSI	≤ 2	0	2	0	2	Over trajectory

C. difficile: 4 cases reported in Q1 and on trajectory. Ribotyping of Trust apportioned cases continues and no links have been identified between cases within the Trust. The root cause analysis investigation tool is being revised to align with the Patient Safety Incident Response Framework (PSIRF). Study days have been planned for September and will focus on sharing learning from key themes arising from previous C. difficile investigations which include timely sampling, and isolation.

MRSA Bacteraemia: Nil cases in Q1 and no cases for a rolling nine months.

MSSA Bacteraemia: 6 cases in Q1. The likely primary sources include: 1 endocarditis, 1 possible surgical site infection and 4 with source unknown. Further review of the cases with unknown sources will take place to identify any areas for learning and improvement.

GNBSI: E. coli 22 cases, Klebsiella spp. 3 cases and P. aeruginosa 2 cases reported in Q1. E. coli cases are over trajectory and the P. aeruginosa annual threshold was reached in Q1. The GNBSI Prevention Group has revised its terms of reference and prevention action plan and next steps include: -

- Follow-up findings from the audit of hepatobiliary cases
- Revise GNBSI post infection review template and align to PSIRF to identify system contributing factors
- Work with the Quality Academy to introduce a nurse led protocol for urinary catheter removal

- Focus support to wards with higher number of urinary tract infection associated cases

Policy/Guideline/SOP Updates

The IPC Team have included a schedule of documents for review in the annual workplan and work has commenced to review and update these documents alongside the National IPC manual for England. The following documents have been updated and approved by the IPC Sub-Committee (ICSC): -

- CPE Screening and Patient Placement SOP
- Covid-19 Lateral Flow Device Testing for Patients
- MRSA Screening and Suppression Treatment for Elective Orthopaedic Procedures SOP

Audit

A programme of monthly visits is being introduced with all CBU Matrons. The purpose of this programme is to identify any areas for IPC improvement, to direct scheduling/prioritisation of full IPC audits where concerns are identified and to ensure ongoing monitoring of standards.

The full IPC audit tool has been revised and updated to ensure correlation with the National IPC manual for England. The programme of audits recommenced in June and two audits were completed with results shown in table 4: -

Table 4: IPC Policies Audit Data

Ward	B19	SDEC
Environment	81%	90%
Ward Kitchens	92%	88%
Handling/Disposal of Linen	100%	100%
Departmental Waste	100%	100%
Safe Handling Disposal of Sharps	84%	100%
Patient Equipment (General)	91%	76%
Personal Protective Equipment	100%	100%
Short Term Catheter Management	71%	100%
Care of Peripheral Intravenous Lines	67%	100%
Isolation Precautions	92%	100%
Hand Hygiene	96%	100%
Overall Compliance	88%	96%
Overall Compliance	88%	96%

Audit findings identified some dusty and cluttered environments and items stored on floors which has could impede cleaning. Areas for improvements in sharps safety include ensuring use of the temporary closure mechanism and the bins not being over filled. A Trust-wide audit of the sharps bins was completed in June by the sharps bin supplier and results will be shared with the CBUs once received. The improvement required for the ward kitchen related to fridge temperature monitoring and storage of opened food in pest proof containers. Improvements are required to labelling patient care items once cleaned in the Same Day

Emergency Care (SDEC) Department. For both peripheral cannula and urinary catheter management, improvements to insertion and on-going care documentation are required to support timely removal. As more audits are completed thematic analysis will be undertaken to identify system learning for improvement action.

Antimicrobial Stewardship

The Point Prevalence Audit conducted in April 2023 showed 91% compliance with the Trust Antibiotic Formulary which is an increase from the previous audit in January 2023 where compliance was 86%. This is above the Trust's internal minimum compliance target of 90%.

Table 5: Antibiotic Compliance with Formulary by Ward

Ward	June 2022	Sept 2022	Jan 2023	April 2023
AMU	77% (20/26)	95.8% (23/24)	69.2% (18/26)	80.8% (21/26)
A2	87.5% (7/8)	100% (13/13)	71.4% (10/14)	96% (24/25)
ACCU Ward	85.7% (6/7)	87.5% (7/8)	80% (4/5)	100% (5/5)
ACCU HC	100% (4/4)	100% (6/6)	75% (3/4)	100% (3/3)
A4	89.5% (17/19)	85% (17/20)	95.5% (21/22)	86.7% (13/15)
A5 Elective	0% (0/3)	100% (2/2)	100% (6/6)	100% (3/3)
A5 Gastro	86.7% (13/15)	100% (3/3)	90.9% (10/11)	92.3% (12/13)
A6	87.5% (7/8)	100% (10/10)	100% (9/9)	100% (9/9)
A7	87.5% (7/8)	88.9% (8/9)	100% (7/7)	100% (16/16)
A8	81.3% (13/16)	100% (8/8)	90.9% (20/22)	84.6% (11/13)
A9	82.4% (14/17)	100% (13/13)	75% (6/8)	76.9% (10/13)
A10			0% (0/2)	100% (1/1)
B12	100% (10/10)	100% (1/1)	75% (3/4)	100% (2/2)
B14	100% (4/4)	100% (6/6)	100% (6/6)	100% (9/9)
B18	82.8% (24/29)	95% (20/21)	85.7% (12/14)	92.3% (24/26)
B19	90% (9/10)	100% (9/9)	87.5% (7/8)	100% (6/6)
C20	100% (16/16)	100% (8/8)	88.9% (8/9)	90.9% (10/11)
C21	83.3% (10/12)	100% (11/11)	85.7% (6/7)	66.7% (2/3)
C23	100% (6/6)	66.7% (2/3)	100% (2/2)	100% (4/4)
K25	50% (1/2)	100% (2/2)	91.7% (11/12)	100% (7/7)
Cath Lab			50% (1/2)	
SDEC			100% (3/3)	75% (3/4)
ITU	100% (11/11)	100% (18/18)	94.7% (18/19)	100% (15/15)
CSTM PACU		0% (0/1)		
Halton B3	100% (2/2)	100% (1/1)	100% (2/2)	66.7% (2/3)
Halton B4			100% (2/2)	
CSTM			0% (0/1)	
B11	100% (4/4)	90% (9/10)	87.5% (7/8)	100% (4/4)
NNU	100% (4/4)			

Overall, across the two sites 185 (32.7%) patients were prescribed a total of 252 antibiotics. This is less than the previous quarter (January 2023) where a total of 212 (35.2%) of patients were prescribed a total of 270 antibiotics.

The Trust is participating in the national Commissioning for Quality and Innovation (CQUIN) CCG3 which is concerned with prompt switching of intravenous (IV) antimicrobial to oral route of administration (IVOS) as soon as patients meet switching criteria, which supports the antimicrobial stewardship objective in the IPC Strategy.

Key issues to address from the Point Prevalence Audit include:

- Ongoing assurance with Trust antibiotic guidelines and the need for clear documentation of an appropriate reason for deviation in the electronic patient record (EPR)
- Achieve and sustain 100% indication documented in the EPR by mandating documentation of indication on electronic prescription medicines administration (EPMA)
- Improvement of documentation of course length or review date and evidence of review of all antibiotics between 24-72 hours
- Consider amending criteria to include mandatory review of IV antibiotics within 48 hours of initiation and every 24 hours thereafter as per CQUIN CCG3
- Implementation of IVOS algorithm to aid prompt IV to oral switch in line with CQUIN CCG3
- Consultant Medical Microbiologist advice should be sought for patients who have received a prolonged course of broad-spectrum antibiotic therapy to ensure appropriate investigations and microbiological sampling is undertaken at point of antibiotic escalation
- Continual action to be taken to reduce Tazocin prescribing in line with national targets
- Antimicrobial Management Stewardship weekly ward rounds to focus on areas with high antibiotic use where compliance is < 90% (A1, A4, A8, A9) and potential patients who meet criteria for IVOS

Education and Training

Overall compliance with infection control mandatory training was 87% at the end of June 2023 (table 6). Mandatory training is available via eLearning, 2 taught sessions are provided each week and the training session is included at corporate induction.

Table 6 Mandatory training Compliance

IPC Mandatory Training	A	M	J
Level 1 – Non-Clinical	94%	96%	94%
Level 2 - Clinical	83%	84%	85%
Overall compliance	**86%**	**88%**	**87%**

The Infection Prevention and Control Team have offered additional sessions to support compliance improvements, including evening training sessions. The training package is being

shared with Practice Based Educators for local delivery. All CBUs have been asked to set trajectories to improve and progress will be tracked at ICSC meetings.

Environmental Hygiene

A programme of cleanliness monitoring is in place with frequency of auditing carried out according to the NHS Standards of Healthcare Cleanliness (2021). Audit results are emailed to ward/departmental managers and star ratings awarded according to scoring.

All areas are scoring 4-star or 5-star ratings (out of a 5-star rating). Areas with reduced scores are given a 2-to-4-hour timescale to rectify concerns in functional risk 1 (highest risk areas) and functional risk 2 categories. Work continues to establish a programme of cleaning efficacy audits, which will take a multidisciplinary approach.

Waste Management

Partnership working with the Head of Facilities and Facilities Manager (Contracts) is in place to implement the updated NHS Safe and Sustainable Management of Healthcare Waste (2022) guidance and NHS Clinical Waste Strategy (2023) which aims to improve use of resources and reduce carbon footprint. This includes an ambition to introduce a process that further segregates waste produced by the Trust by introducing arrangements for an offensive (tiger-stripe) waste stream.

All NHS providers have been set waste segregation targets of: -

- High temperature incineration – 20% (clinical waste: yellow bag and sharps waste)
- Alternative treatment – 20% (orange bag waste)
- Offensive – 60% (tiger-stripe waste bags)

Planning has commenced to introduce a trial on wards B3/B4 (Halton site) and AMU/A2 and C20/C21 (Warrington site). Additional education will be provided to support staff involved in the trial, which will cover what can go into the tiger-stripe waste bags at ward level and separate disposal carts for disposal of full bags. Engagement will take place with the provisionally named areas prior to commencing the trial and approval to proceed to trial agreed at the ICSC.

Incidents

Covid-19

Covid-19 continued to impact the Trust with details of all cases as shown in Table 7.

Table 7 Covid-19 Cases

Month	0 to 2 days	3 to 7 days	8 to 14 days	15+ days	Grand Total
Apr	44	14	14	22	94
May	51	6	13	18	88
Jun	58	6	8	11	83
Total	**153**	**26**	**35**	**51**	**265**

Covid-19 Outbreaks

Five Covid-19 outbreaks were reported in Q1 four of which affected both patients and staff. Outbreak Control Groups were established to manage the Covid-19 outbreaks with the Planned and Unplanned Care Groups with additional oversight of infection prevention and control precautions.

Norovirus

In June, Ward A2 Warrington Hospital reported 11 patients with symptoms of diarrhoea and/or vomiting and 4 staff with nausea symptoms. Investigations identified 1 patient with a positive norovirus result. Patient and staff movement was safely managed to prevent transmission, the ward was terminally cleaned and affected bays re-opened and no further cases were identified.

Carbapenemase Producing Enterobacteriaceae (CPE)

CPE are bacteria that are resistant to Carbapenem (considered last resort) antibiotics. A patient with CPE colonisation (not infection) was identified in a bay on ward B19. The patient had been hospitalised abroad and was not admitted into a side room as per usual process. Action was taken to isolate the patient. Follow-up screening of bay contacts and the whole ward identified one other patient with CPE from the same bay. Both CPE isolates were sent to UK Health Security Agency reference laboratory and typing confirmed they were the same, indicating transmission occurred. Both patients remained well and were discharged home and the bay was terminally cleaned following discharge of all other patients in the bay.

Awareness Raising Activity

World Hand Hygiene Day – May 2023

In May, the IPC and Facilities Teams jointly hosted awareness raising event for hand hygiene and to provide details on the waste strategy across both hospital sites. The event was well attended by staff and generated good discussion on appropriate use of gloves and sustainable IPC practices.





3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Infection prevention and control policies recovery plan
- Delivery of the Infection Prevention Strategy
- Provision of infection prevention and control expert advice to colleagues
- Review of escalations in infections jointly with the associated Care Group

4. IMPACT ON QPS?

- Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes
- P: Improved attendance at training assists staff in fulfilling mandatory training requirements
- S: Reduction in HCAI and involvement in procurement supports sustainability

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to UK Health Security Agency
- Surveillance of nosocomial Covid-19 cases/reporting Covid-19 outbreaks
- The Infection Prevention and Control Team monitor HCAI. Action is implemented in response to increased incidences of HCAI and infection control related incidents
- The Infection Control Sub-Committee meets monthly and discusses HCAI surveillance data and learning from HCAI incidents
- Review of HCAI incident investigation reports and audits and agree actions to support care improvements
- Healthcare Associated Infection data is included in the ward dashboard data

6. TRAJECTORIES/OBJECTIVES AGREED

IP Strategy Objectives

- Prevention of healthcare associated infections

Table 8 HCAI Thresholds 2023/24

HCAI	WHH Threshold 2023/24
C. difficile	≤36
E. coli	≤54
Klebsiella spp.	≤18
P. aeruginosa	≤2

- Strengthening Antimicrobial Stewardship – Participation in the IV Oral Switch CQUIN CCG3
- Improving standards of environmental cleanliness
- Implementing action in line with the NHS Waste Strategy

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to: -

- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted quarterly to the Quality Assurance Committee and Trust Board.

Verbal updates are provided to Trust Board monthly as part of the Integrated Performance Report.

The Director of Infection Prevention and Control Report is submitted to Trust Board annually and published on the Trust website.

Monitoring by the Senior Executive Oversight Group.

8. TIMELINES

2023 – 2024 Financial Year

9. ASSURANCE COMMITTEE

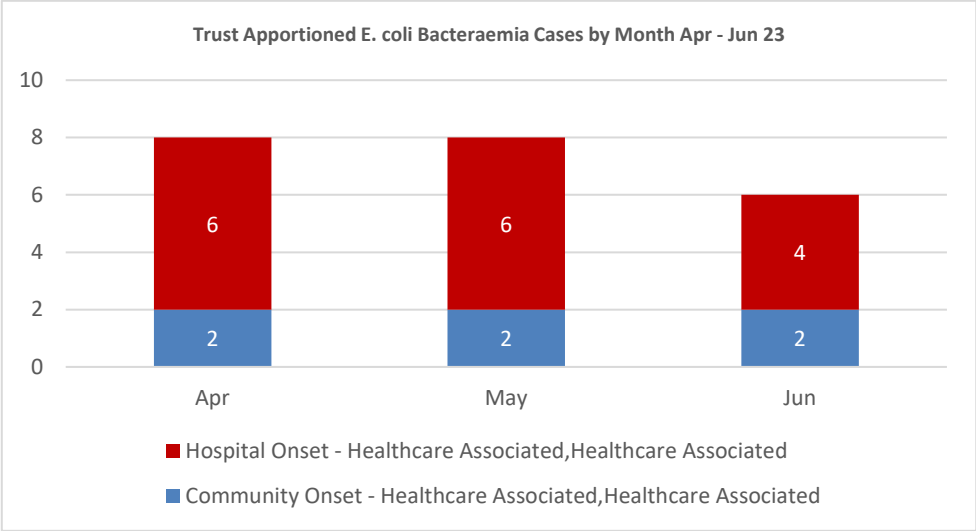
Infection Control Sub-Committee

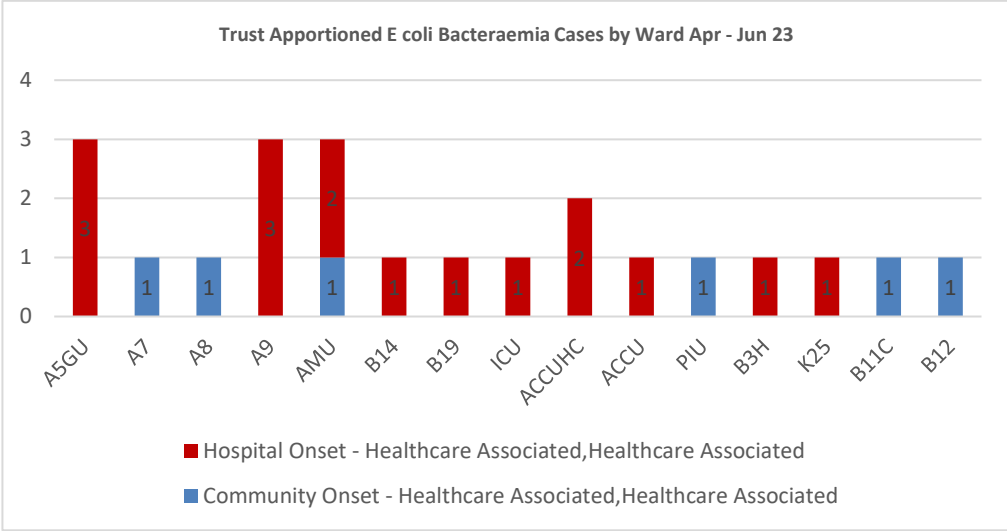
10. RECOMMENDATIONS

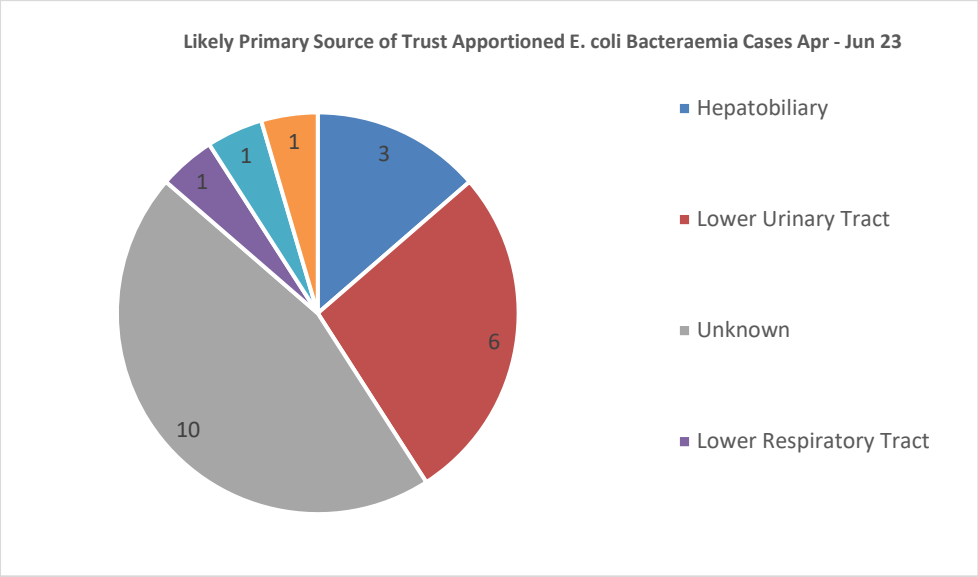
The Quality Assurance Committee is asked to receive the report, note the exceptions reported and progress made.

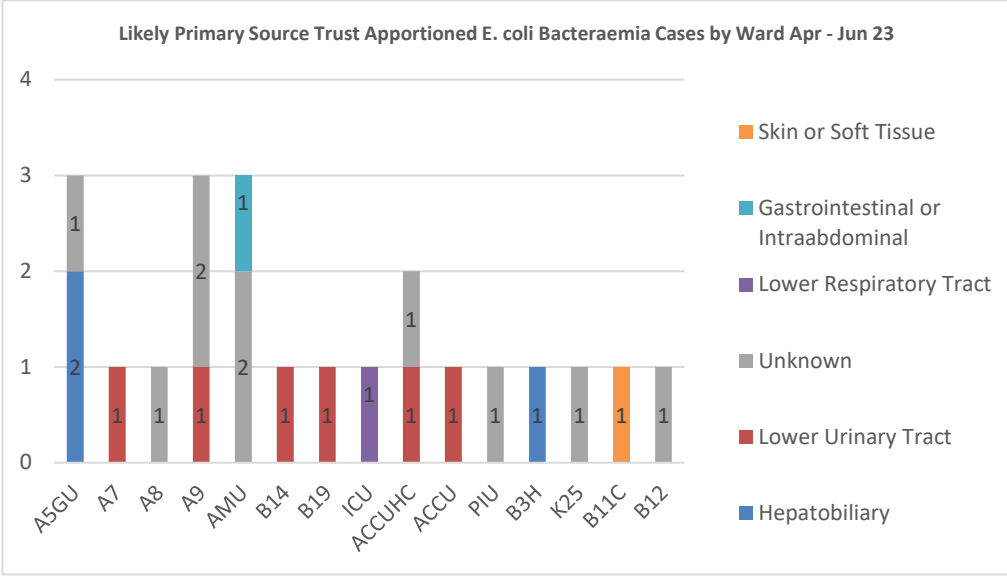
Gram Negative Bloodstream Infection: E. coli Apr – Jun 23

Threshold	54
YTD Total	22





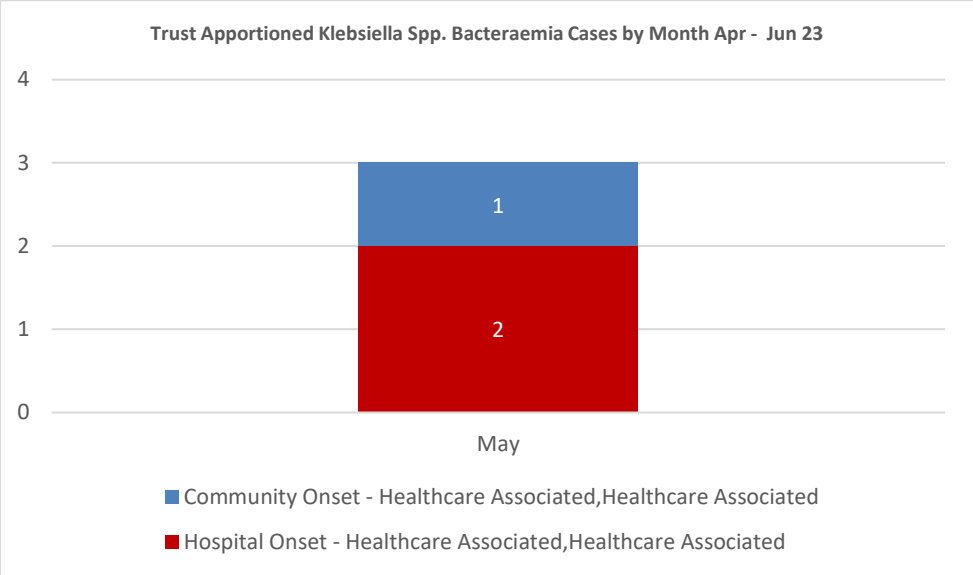


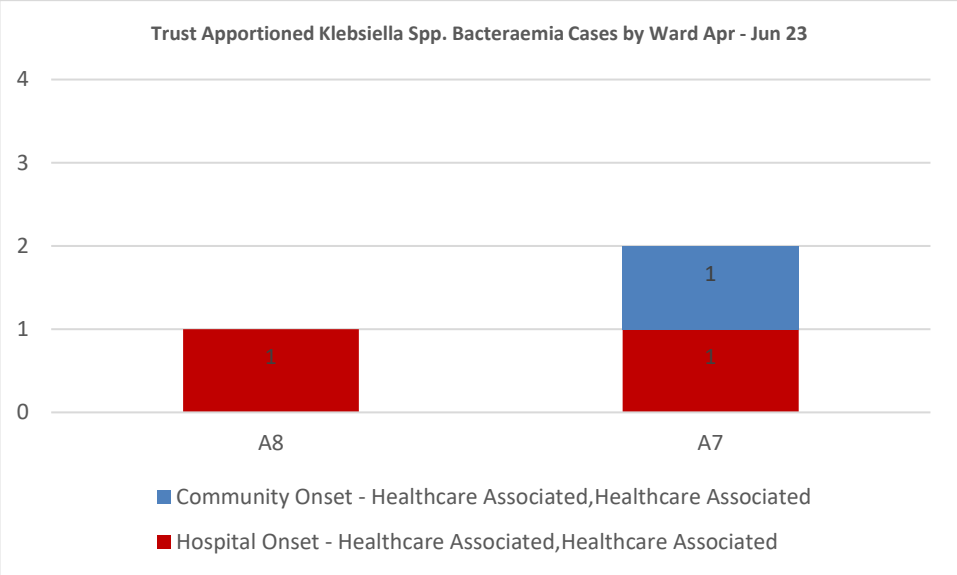


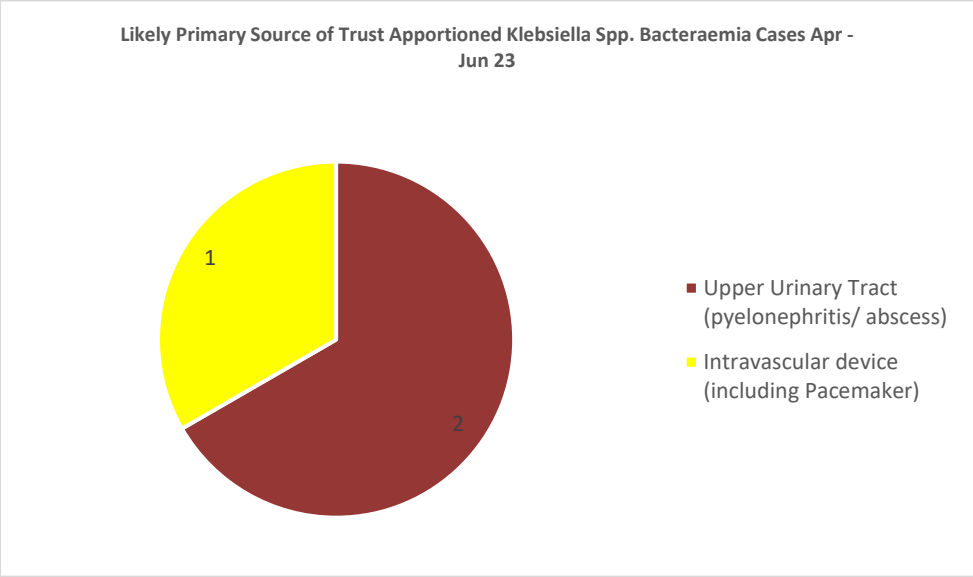
Report Date July 2023

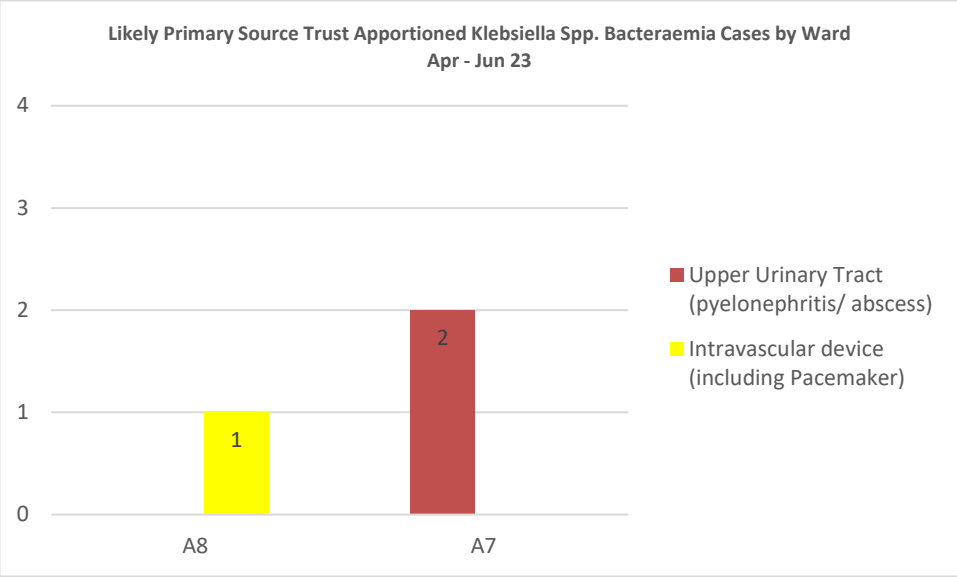
Threshold	18
YTD Total	3

Gram Negative Bloodstream Infection: Klebsiella spp. Apr – Jun 23





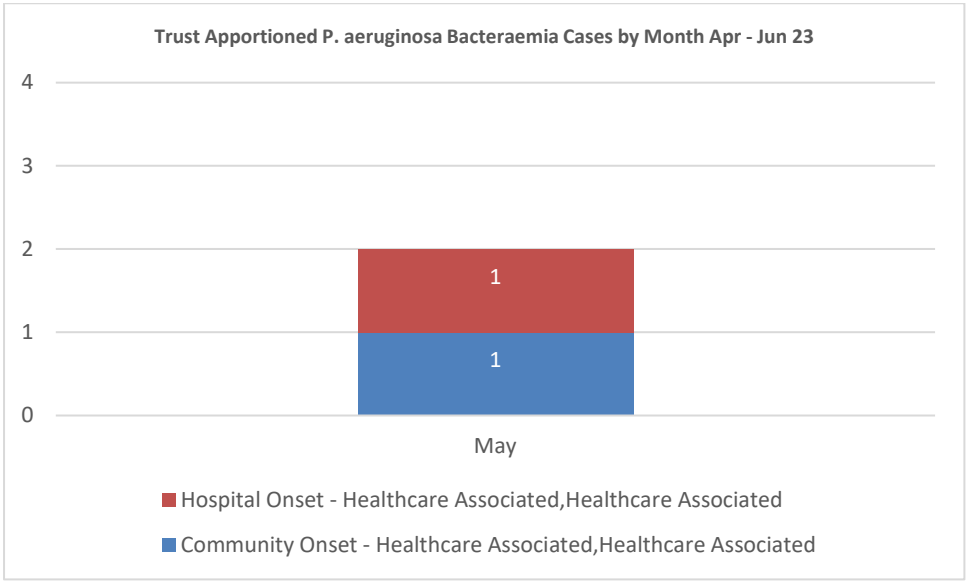


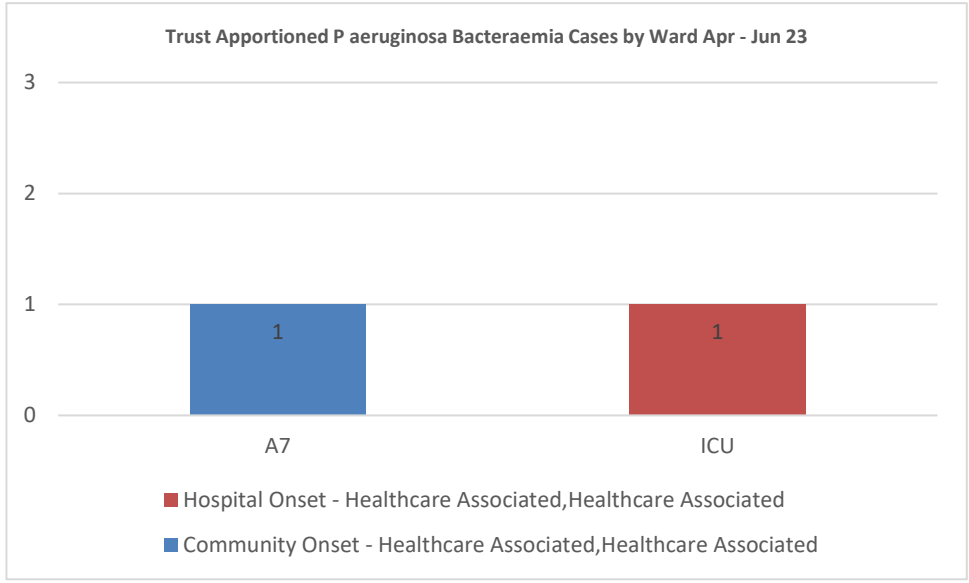


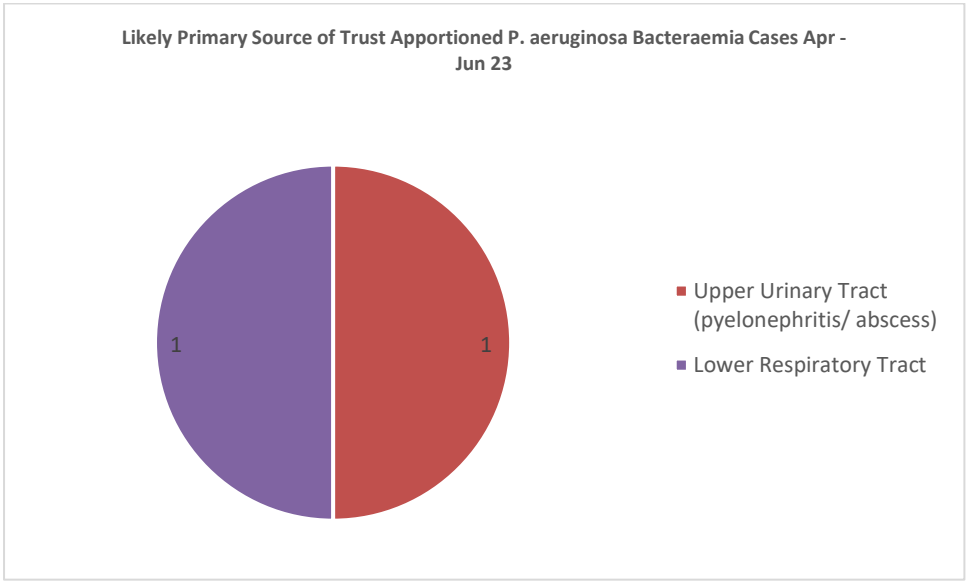
Report Date July 2023

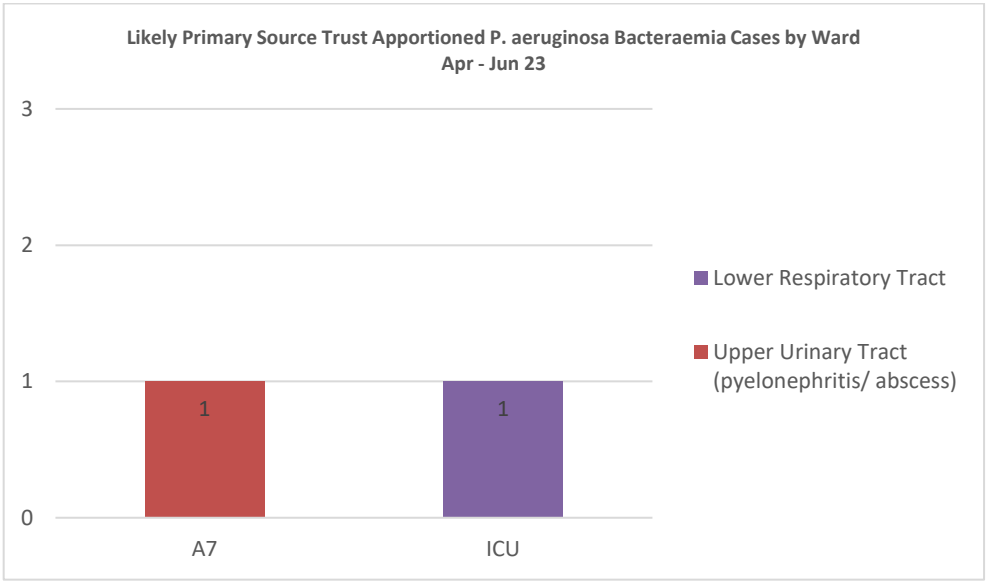
Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa) Apr - Jun 23

Threshold	2
YTD Total	2









Report Date July 2023

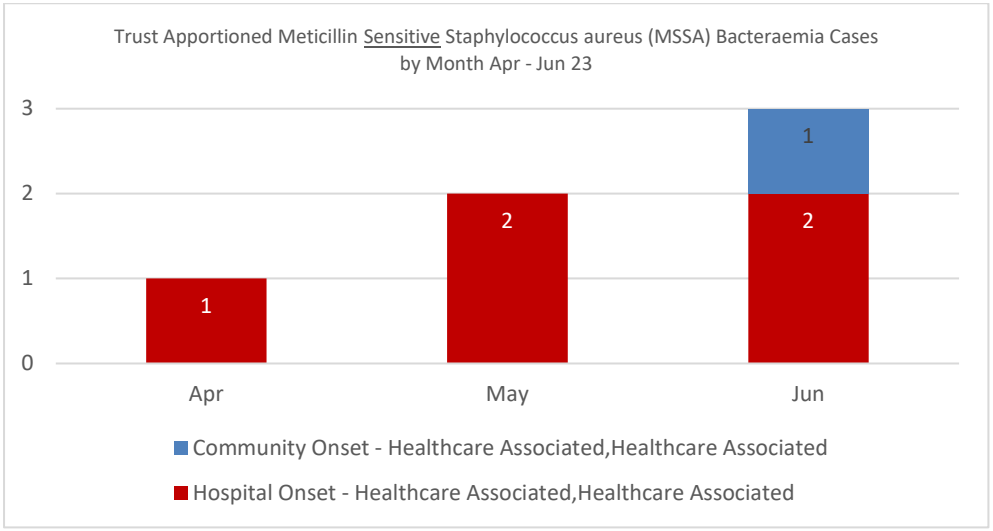
Gram Positive Bloodstream Infection: Meticillin-resistant Staphylococcus aureus Apr – Jun 23

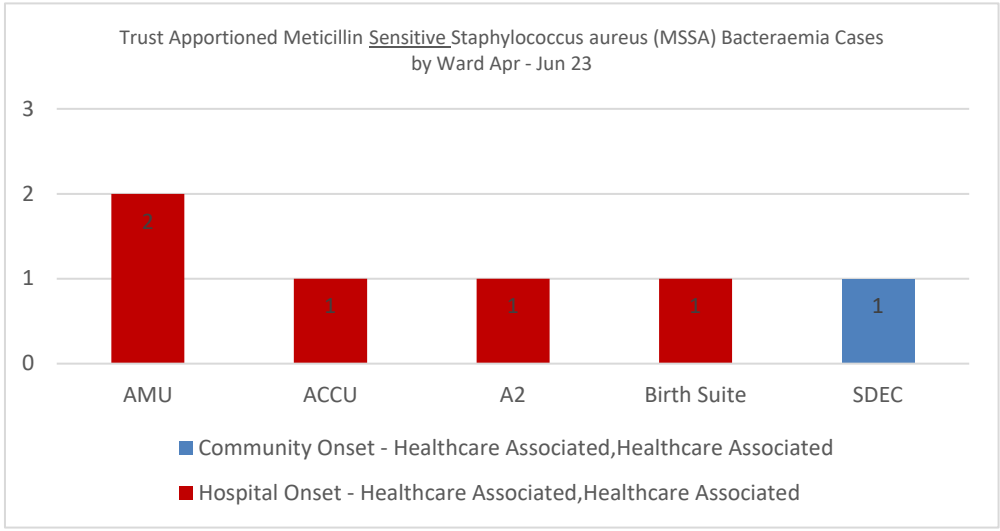
Threshold	0
YTD Total	0

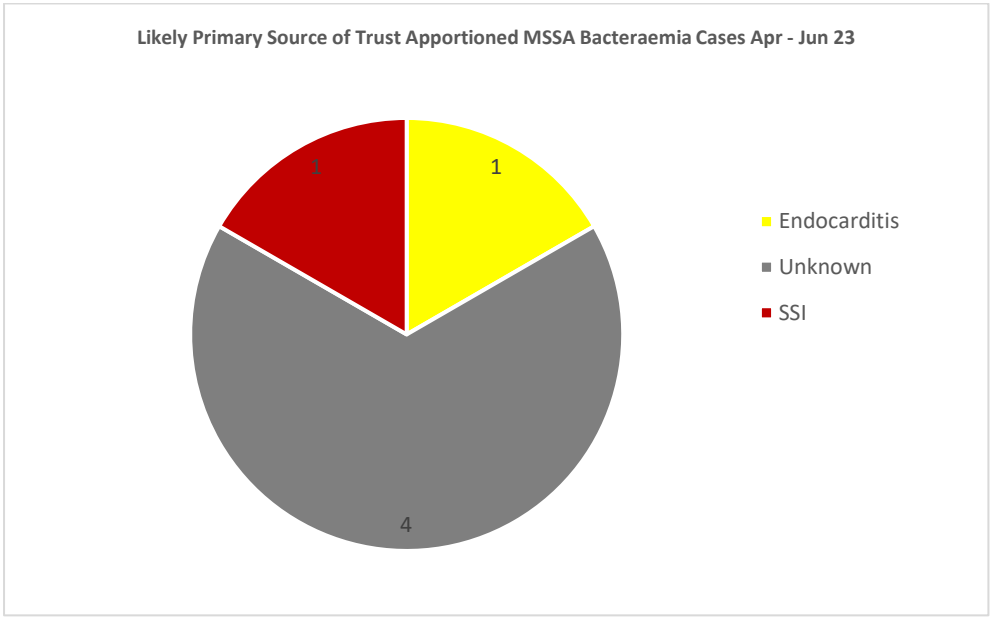
Report Date July 2023

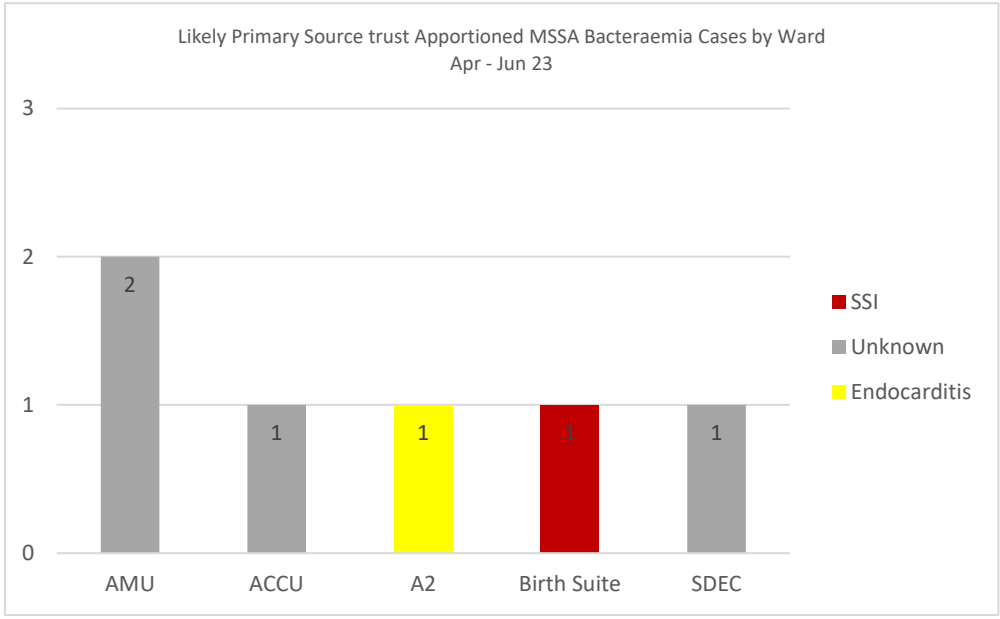
Gram Positive Bloodstream Infection: Staphylococcus aureus Apr - Jun 23

No Threshold	
YTD Total	6









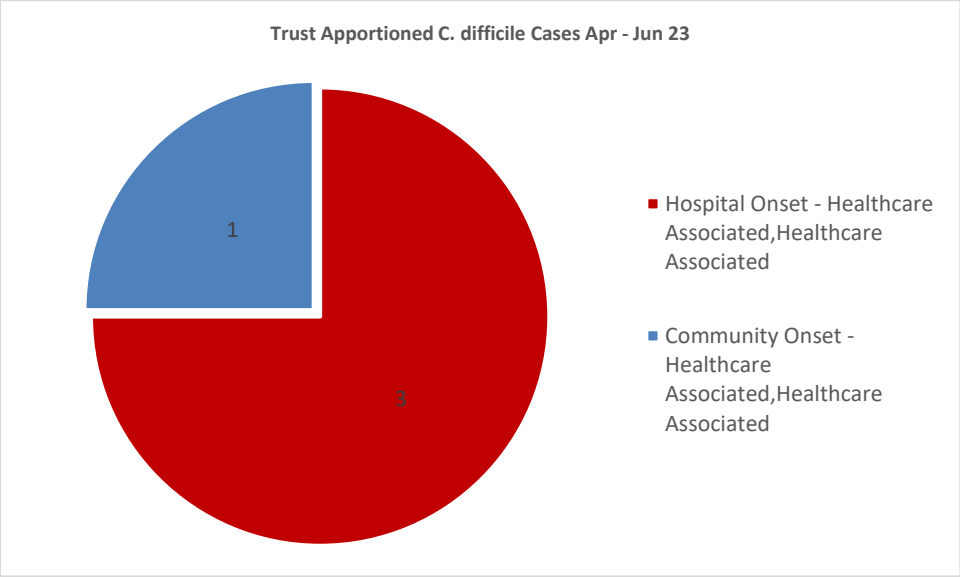
Report Date July 2023

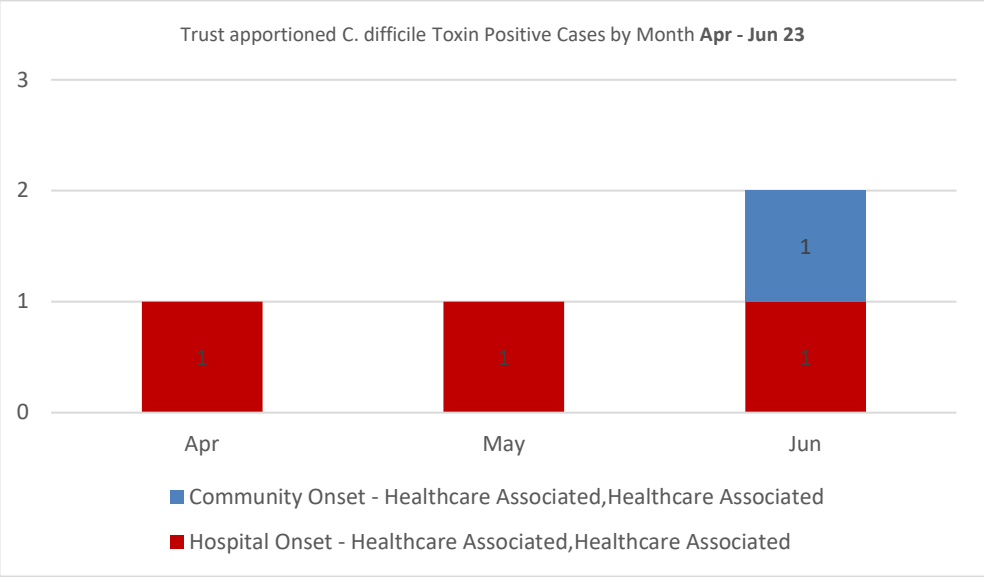
We are WHH & We are PROUD to make a difference

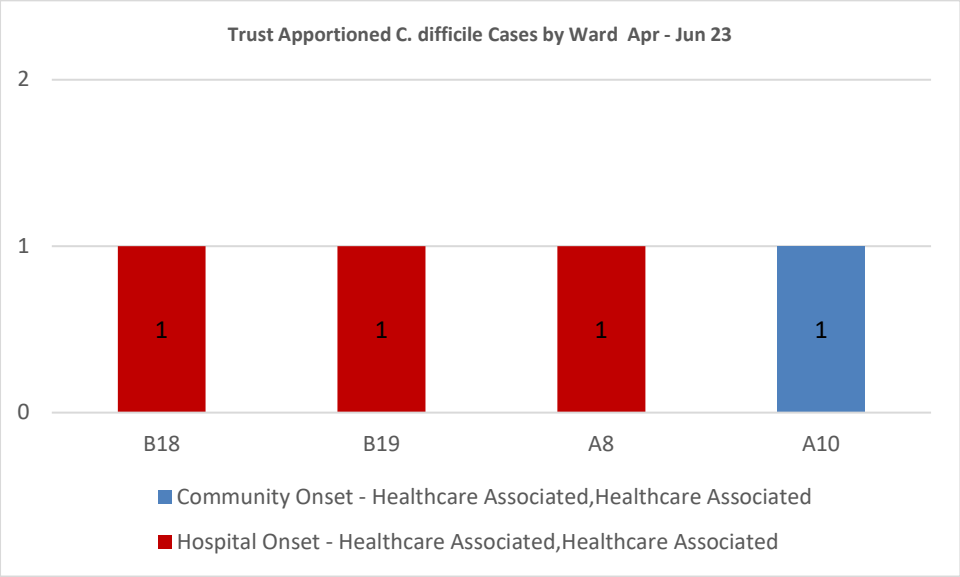
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

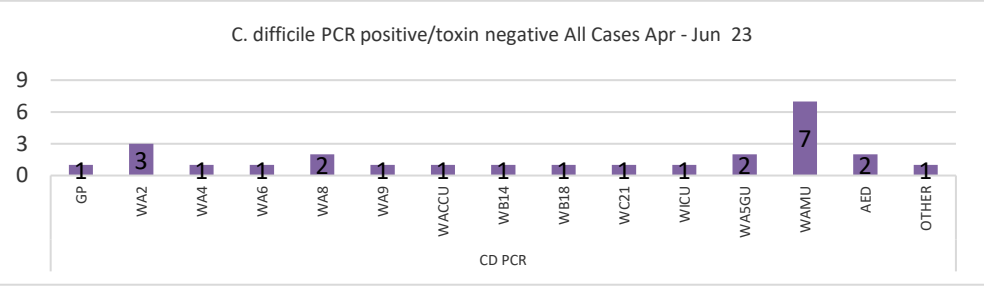
Clostridioides difficile (C. difficile) Toxin Apr - Jun 23

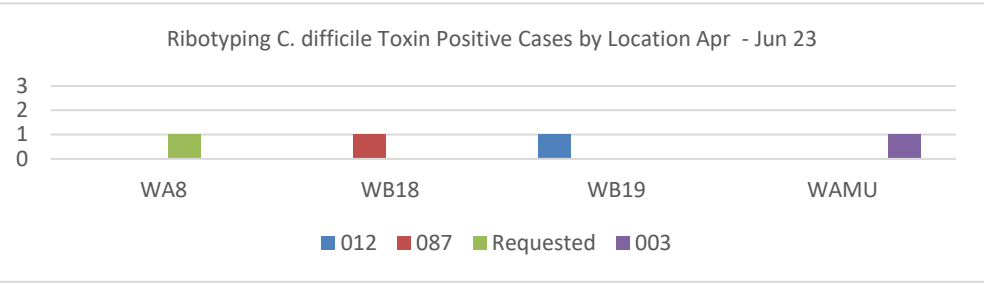
Threshold	36
YTD Total	4







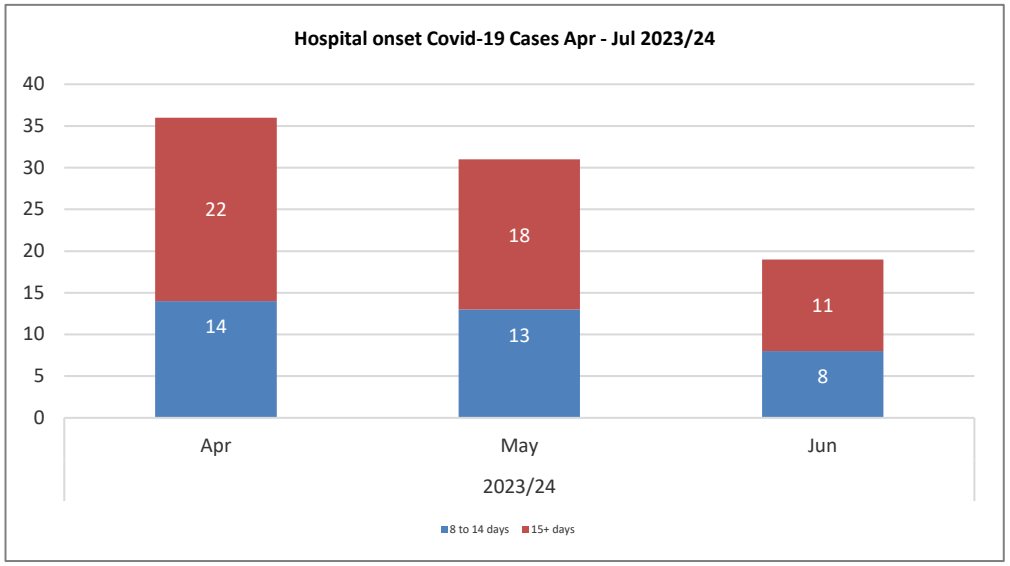


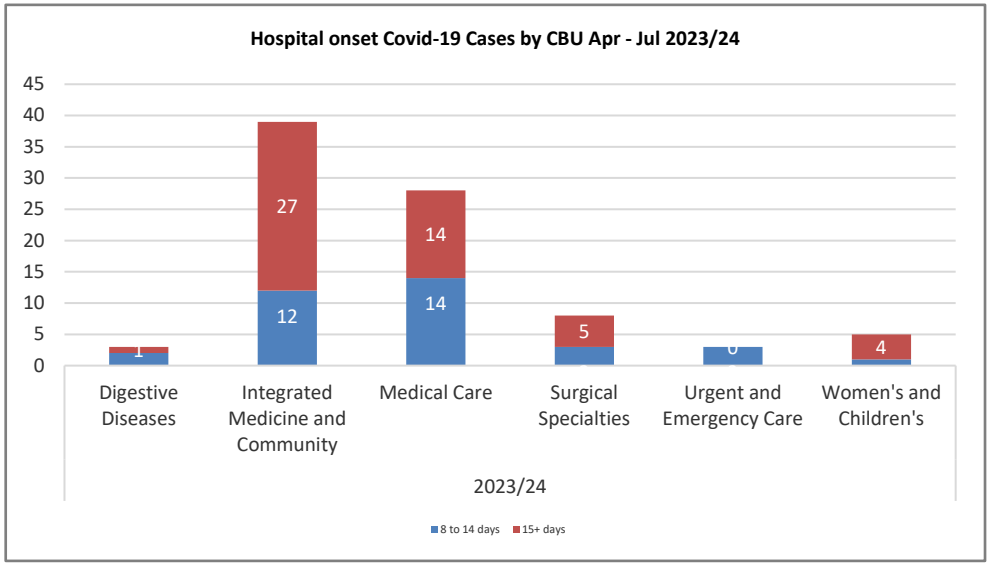


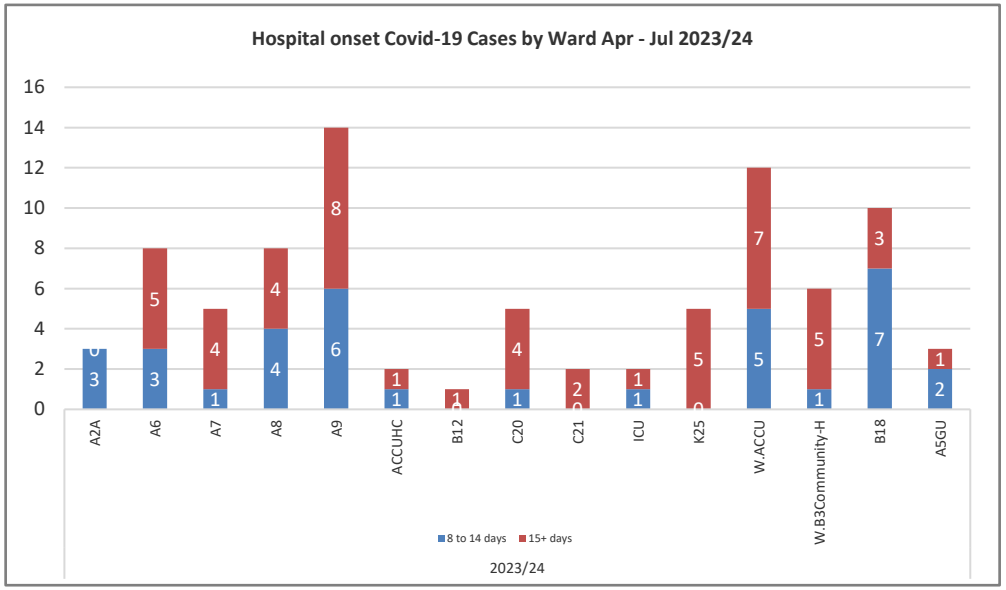
Report Date July 2023

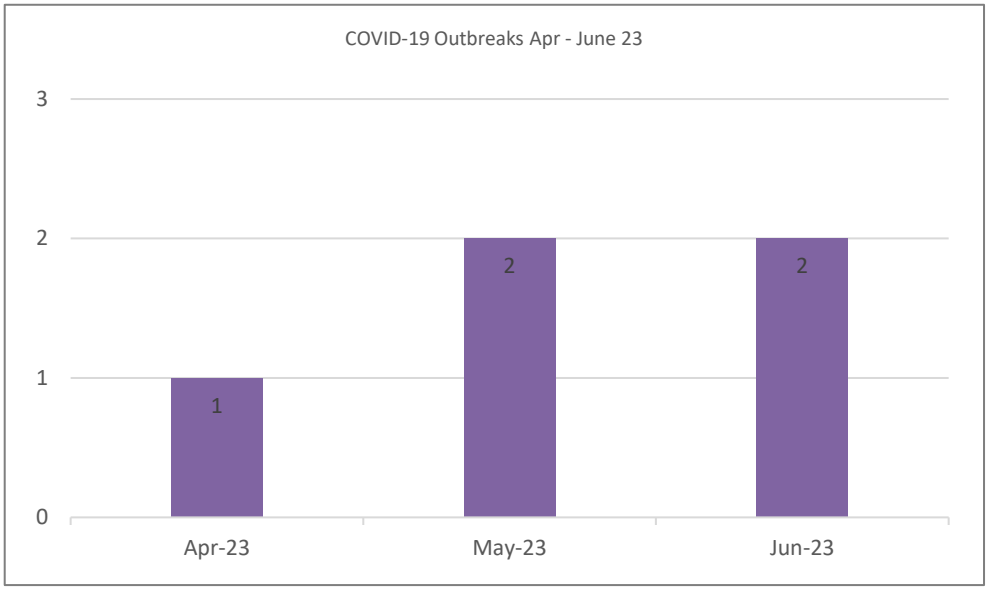
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Covid-19 Surveillance Data Apr - Jun 23









Report Date July 2023

Warrington and Halton Teaching Hospitals NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/23/09/125**			
SUBJECT:	**Digital Strategy Group (DSG) update**			
DATE OF MEETING:	27 September 2023			
ACTION REQUIRED:	**To note**			
AUTHOR(S):	Tom Poulter, Chief Information Officer			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			√	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The Digital Strategy Group (DSG) met on 11th September 2023. This report provides a summary of the updates received from the DSG feeder groups, providing the following assurance status for key delivery areas: ○ **Digital Transformation Highlight Report** Moderate Assurance ○ **Digital Service Delivery Highlight Report** Moderate Assurance ○ **Digital Analytics Highlight Report** Moderate Assurance ○ **Digital Care Delivery Highlight Report** Moderate Assurance **Items for escalation to Finance and Sustainability Committee** (for information only): ○ Digital Strategy 2023 – 2025 approved by Trust Board. Comms campaign and further stakeholder engagement to follow, with senior clinical and operational leadership roles being assigned to PEP, eBCMS and EPR readiness programmes ○ New digital policies to be produced (e.g., print reduction) and DSG highlight reporting to be updated to ensure full coverage of digital assurance			

	○ New format of strategic programmes update. ○ Antivirus roll out – cybersecurity.			
PURPOSE: (please select as appropriate)	Information √	Approval	To note	Decision
RECOMMENDATION:	The Finance and Sustainability Committee is asked to note the contents of the report, including assurance levels.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests			

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Digital Strategy Group update	AGENDA REF:	FSC/23/09/125

1. BACKGROUND/CONTEXT

This report provides an update on the status of the portfolio of programmes supporting delivery of the Trust's Digital Strategy and "business as usual" service delivery activities in Digital Services and Digital Analytics, providing the Board Committee with the latest internal assurance assessment for each area.

2. KEY ELEMENTS

Digital Strategy Update

The new Digital Strategy was presented to trust board at the board developments day on 6th September. This has been signed off and approved to implement. This is important and we will need to align our highlight reporting initially to ensure were reflecting the priority initiatives.

The Trust approved our proposed digital vision in early 2023, linked to the national "What Good Looks Like" standards for digital and the ICS Digital & Data Strategy for Cheshire & Merseyside

The new Digital Strategy provides a continued focus on replacing Lorenzo with a new EPR system and refreshing our technology infrastructure – but a wide range of other digital programmes too, including patient-facing solutions and quality and safety developments.

Working with Channel 3, we have engaged with over 100 clinical, operational, and corporate staff over the last 4 months in developing future state goals, a range of initiatives to deliver the goals, a roadmap, high-level indicative costs and benefits, and a delivery approach.

Priorities for 23/24 include:

- EPCMS Preparedness/Business Case
- Procure and Implement PEP
- Clinical Digital Safety Compliance
- Accelerate Paperless review programme.
- Launch a new workforce engagement platform.
- Electronic book/capacity management system

Digital Transformation Delivery Highlight Report (Moderate Assurance)

- Meeting stepped down as weren't quorate.

- Paperless Care - Excellent progress with the phlebotomy app, Go live is due 25th September. Working closely with the integration team and a Pilot with 3 Gp, will go live as processed.
- Prioritisation would like to go to clinical care group to do that impact assessment and reprioritisation to create room for the EPCMS workstreams.
- EPCMS Preparation – Trust Board held 2nd August 2023 approved funding for final 2 years of Lorenzo contract (November 2024 – November 2026)
- Investment Agreement to be submitted to Frontline Digitisation Programme 6th September 2023 for funding, expected to receive funding mid-October 2023.
- The statuses of our all of our projects been ratified and assured that any paths are green, mitigations where applicable will be picked up.

- Electronic Bed Capacity Management System (eBCMS): Met with NHSE following Deep Dive and currently awaiting details on approach and funding from NHSE Colleagues.
- Digital Diagnostics: CAMRIN migration plans still being agreed dates will be agreed through event planning governance/processes – Technical Pre-Requisite has been completed by WHH and returned to Network team. WHH are scheduled to migrate February 2024.
- Patient Engagement Portal (PEP): All demo's took place during w/c 28th August. Currently working with procurement reviewing the financial elements of vendor bids as all submitted different costs regarding printing and SMS messaging so we've streamlined and just waiting on clarification questions.

Digital Service Delivery Highlight Report (Moderate Assurance)

- Stats for August 2023: 2840 tickets opened in August. Closed 2626 within 85% SLA, closed 74 which missed SLA, 85 still open within SLA and still 55 open breaching SLA (passed the recommended fix date)
- Test was performed to ensure the track its server could manage numerous tickets being submitted at one time, No major impact displayed therefore needs integrating site wide.
- Discussion to be held surrounding the Printer Reduction Policy to review draft and work through the issues and fill gaps. Ideally policies will have been approved and implemented before formal launch for SLAs from 01/10.
- There are no new high cyber alerts reported last month by NHS England.
- Vendor Management routine meetings are taking place for Service reviews and outstanding issues.

Items for escalation from the Digital Service Delivery Group

- The final 2008 server migration for eoutcome and SharePoint are progressing and moving forward, the SharePoint date is October, and eoutcome meeting is next Monday.
- Highlight that all go lives and digital (IT) changes must go through CAG (ref. SOLUS example)
- We plan to include Synanetics as TIE supplier/support for the trust.

- To note that we will be changing the trusts desktop AV system over coming weeks (McAfee to MS Defender) and rolling out a self-service ticketing solution for the Service Desk, as part of the launch of new SLA for Digital Services provision.

Digital Analytics Highlight Report (Moderate Assurance)

- 16 deliverables have been achieved in August 2023. There are currently 10 deliverables for August 2023. In addition there is 1 delayed with plans to bring back on track during September.
- project kick off meeting for the movement of the Fraxinus and Data Warehouse infrastructure took place 22/6/23. The whole project is set to take 6-8 weeks. Issues have been raised during this work which are being worked on currently.
- Re write of Data Warehouse loads has commenced June 2023 which supports the delivery of the Digital Analytics plan
- Regular meetings take place between Digital Analytics and Digital Services to ensure alignment of workstreams.

Items for escalation

- We have experienced a significant delay in the delivery of the eOutcome Server move and we are seeking assurances from Digital Services that the prework will be completed and that this will not impact on the Database move and the extended deadline of the end of November 23.

Digital Care Delivery Highlight Report (Moderate Assurance)

- Meeting stepped down as not quorate.
- Digital Care Delivery Group TOR needs a full review on what is the quorate attendance and who needs to be there/what needs to be discussed.
- Clinical Safety - Clinical Risk Management Policy agreed at the clinical policy Group.
- Digital Champions - First course to be hosted by Bridgewater at Spencer House – date to be confirmed for October.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Digital Strategy Group would like to highlight the following items the attention of FSC, but for information only:

- Include the need for full highlight reporting regime for readiness.
- Comm's approach to policy and sop development
- Discussion with Paul Fitzsimmons about regular updates direct to all execs regarding Epcms.
- New format of strategic programmes update
- Antivirus roll out – cybersecurity.

4. RECOMMENDATIONS

The FSC is asked to note the contents of the report, including internally assessed assurance levels.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REF:	FSC/23/09/125				
SUBJECT:	Validation report				
DATE OF MEETING:	27 September 2023				
ACTION REQUIRED:	The Finance and Sustainability Committee is asked to note the RTT team validation report.				
AUTHOR(S):	Tom Coalbran, RTT Business Manager				
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer				
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.				
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**	
		√	√	√	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**	
				√	
	Further Information / Comments:				
EXECUTIVE SUMMARY:	This report will: • Provide an overview of the RTT Data Quality Validation Process • Provide an Overview of the RTT National Submissions processes • Provide an Overview of Audits and Actions • Provide an Overview of training and awareness strategy				
PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision	
RECOMMENDATION:	The Finance and Sustainability Committee is asked to note the RTT team validation report.				
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.			
	Agenda Ref.				
	Date of meeting				
	Summary of Outcome				
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.				
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full				
FOIA EXEMPTIONS APPLIED: (*if relevant*)	None				

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Validation report	AGENDA REF:	FSC/23/09/125

1. BACKGROUND/CONTEXT

The NHS constitution states that *"It is every patients constitutional right to receive their first definitive treatment within 18 weeks or 126 days of receipt of referral for routine procedures and 62 or 31 days for Cancer or Fast track referrals"*

All referrals into a consultant led service are applicable to a Referral to Treatment (RTT) waiting time, with some exceptions including maternity or emergency care. These referrals are governed by national rules and guidance.

RTT is split into two areas:

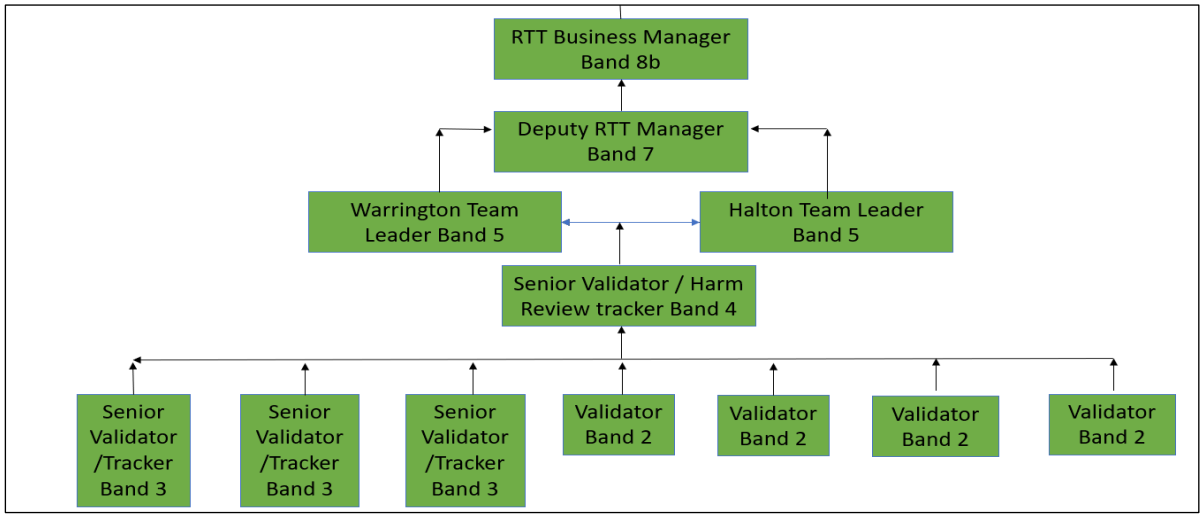
- Admitted - Patients listed or treated as an inpatient or daycase.
- Non-Admitted – Patients listed or treated in outpatients or where decision not to treat or a period of observation has been applied.

RTT is split into the following reportable areas:

- Part 1a – Clocks that have been stopped in an admitted setting.
- Part 1b – Clocks that are stopped not in a non-admitted setting.
- Part 2 - Incomplete, this is where a patient is on an open RTT clock awaiting treatment.

RTT team Structure:

The RTT team consists of 12 members of staff and has the below structure.



Validation Numbers:

The RTT Team validate on average 12,000 – 13,000 pathways a month, this an increase from 8,000 – 9,000 per month pre Covid, following investment into the team.

Local KPI's have a standard of 40 validations per day per each team member, throughput is monitored by the RTT business manager and deputy for assurance and quality purposes, audit is carried out twice monthly and any learning is shared back with the team members.

The RTT team also play a key part in National RTT Submissions of which there are currently three key submissions.

- RTT Weekly position.
- 78WW Weekly position.
- RTT Monthly position.

2. KEY ELEMENTS

2.0 Validation Processes:

There are two main reports utilised by the RTT team and the relevant services in line with national reporting requirements.

- Current RTT waiters – This shows the current RTT position as of the previous day. The amount of patients, the week band group and the current RTT percentage for that service and the Trust as a whole.

Table 1: RTT position as of 19/09/23

Record	WeekBa										% <18 Weeks (92%)	Shift from 18+ to <18 needed to hit 92%
SpecialtyAggregate	0 to 13	14 to 17	18 to 39	40 to 51	52 to 55	56 to 64	65 to 77	78 to 103	104+	Grand Total		
100 - GENERAL SURGERY	170	36	152	57	13	28	19	1		476	43.28%	232
101 - UROLOGY	907	205	587	163	38	73	87	13		2073	53.64%	796
110 - TRAUMA AND ORTHOPAEDICS	1278	308	1020	381	86	159	105	17		3354	47.29%	1500
120 - ENT	1000	308	1387	691	172	426	300	19		4303	30.40%	2651
130 - OPHTHALMOLOGY	1452	342	710	121	5	15	2			2647	67.77%	642
300 - GENERAL MEDICINE	23	2	6							31	80.65%	4
301 - GASTROENTEROLOGY	933	242	570	187	76	129	106	1		2244	52.36%	890
320 - CARDIOLOGY	919	164	540	236	50	90	4			2003	54.07%	760
340 - RESPIRATORY MEDICINE	695	177	701	264	69	128	37			2071	42.11%	1034
410 - RHEUMATOLOGY	170	75	51	2						298	82.21%	30
430 - GERIATRIC MEDICINE	3	1								4	100.00%	0
502 - GYNAECOLOGY	1420	433	1191	529	132	249	96	24		4074	45.48%	1896
Other	4356	1024	2948	780	207	400	157	19		9891	54.39%	3720
Grand Total	13326	3317	9863	3411	848	1697	913	94		33469	49.73%	14149

- Projected RTT Waiters – This shows the projected position for the end of the month. For example a patient at 14 weeks at the start of the month will show as 18 weeks at the end of the month. This enables the team and the services to see what week

band the patients will be on at the end of the month if they are still on an active pathway. This also shows the current RTT Position at month end.

Table 2: Projected RTT waiters;

Record	WeekBand											% <18 Weeks (92%)	Shift from 18+ to <18 needed to hit 92%
SpecialtyAggregate	0 to 13	14 to 17	18 to 39	40 to 51	52 to 55	56 to 64	65 to 77	78 to 103	Grand Total	Grand Total			
100 - GENERAL SURGERY	132	57	154	66	11	33	21	2	476	476		39.71%	249
101 - UROLOGY	791	214	661	178	38	88	86	17	2073	2073		48.48%	903
110 - TRAUMA AND ORTHOPAEDICS	1102	322	1119	391	102	164	130	24	3354	3354		42.46%	1662
120 - ENT	817	339	1438	705	189	423	368	24	4303	4303		26.86%	2803
130 - OPHTHALMOLOGY	1241	404	822	149	10	19	2		2647	2647		62.15%	791
300 - GENERAL MEDICINE	22	3	6						31	31		80.65%	4
301 - GASTROENTEROLOGY	799	242	673	189	67	132	141	1	2244	2244		46.39%	1024
320 - CARDIOLOGY	787	219	584	245	49	103	16		2003	2003		50.22%	837
340 - RESPIRATORY MEDICINE	602	177	738	286	67	140	61		2071	2071		37.61%	1127
410 - RHEUMATOLOGY	154	43	98	3					298	298		66.11%	78
430 - GERIATRIC MEDICINE	3		1						4	4		75.00%	1
502 - GYNAECOLOGY	1201	422	1321	564	138	273	120	35	4074	4074		39.84%	2126
Other	3730	1176	3279	828	207	418	224	29	9891	9891		49.60%	4194
Grand Total	11381	3618	10894	3604	878	1793	1169	132	33469	33469		44.81%	15793

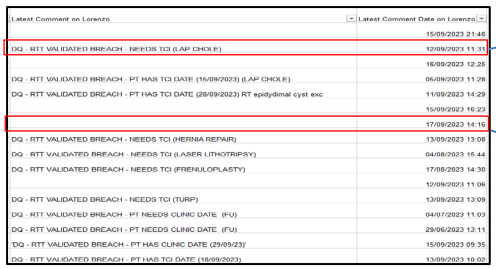
At the start of each month the RTT Current waiters projected report is utilised to start the validation process for the current month. This report displays the waiting time for all patients on the RTT waiting list at the end of that current month. This is utilised so that the RTT team and the relevant services are aware of the amount of patients that will breach 18 weeks or 65 and 78 weeks.

This enables the RTT team and the services have awareness of the patients that need to be actioned prior to month end, especially when dealing with National mandates such as 78 or 65 week wait patients. Both of these reports have patient level detail and by clicking on any of the numerical fields will take the user into the relevant patient level detail.

On both reports there is a section that captures the RTT DQ comments and if the patient has had a previous validation. If the patient has not yet been validated or has had activity since the previous validation then this will show as a blank comment on the report and will therefore require validating.

The RTT team use standardised comments, for example “DQ - RTT VALIDATED BREACH - PT NEEDS CLINIC DATE (FU)” to show where the patient is on their pathway to treatment.

This is demonstrated in the below screen shot. Were no comment is displayed (Blanks) then this indicates the patient requires validating, the report also displays the last time a comment was made or the last time the patients waiting list entry was updated and it captures the last person to validate the record or if not validated then the last member of staff that updated the pathway.



Latest Comment on Lorenzo	Latest Comment Date on Lorenzo
	15/09/2023 21:46
DQ - RTT VALIDATED BREACH - NEEDS TCI (LAP CHOLE)	12/09/2023 11:31
	16/09/2023 12:26
DQ - RTT VALIDATED BREACH - PT HAS TCI DATE (16/09/2023) (LAP CHOLE)	06/09/2023 11:28
DQ - RTT VALIDATED BREACH - PT HAS TCI DATE (28/09/2023) RT epidydimal cyst exc	11/09/2023 14:29
	15/09/2023 16:23
	17/09/2023 14:16
DQ - RTT VALIDATED BREACH - NEEDS TCI (HERNIA REPAIR)	13/09/2023 13:08
DQ - RTT VALIDATED BREACH - NEEDS TCI (LASER LITHOTRIPSY)	04/08/2023 16:44
DQ - RTT VALIDATED BREACH - NEEDS TCI (FRENULOPLASTY)	17/08/2023 14:30
	12/09/2023 11:06
DQ - RTT VALIDATED BREACH - NEEDS TCI (TURP)	13/09/2023 13:09
DQ - RTT VALIDATED BREACH - PT NEEDS CLINIC DATE (FU)	04/07/2023 11:03
DQ - RTT VALIDATED BREACH - PT NEEDS CLINIC DATE (FU)	29/06/2023 13:11
DQ - RTT VALIDATED BREACH - PT HAS CLINIC DATE (29/09/23)	15/09/2023 09:35
DQ - RTT VALIDATED BREACH - PT HAS TCI DATE (18/09/2023)	13/09/2023 10:02

This Patient has been validated on the 12/09/23 and requires a procedure (Lap Chole)

This Patient has either not been validated before or has had an attendance or an update to the waiting list since the last validation and requires validating

On average there are approximately 3,000 pathways at the start of the month that require validation. As the month progresses and patients attend appointments or admissions if the pathway has not been stopped then any RTT comments will be removed and the patient will require validating. On average this equates to a further 3,000 pathways.

Once this has been completed the next two phases of validation are carried out.

Validation process one:

First process reviews 'historical comments'. These are comments that have not been validated for over three months prior to the current month as no update or activity has occurred on the patients pathway since the last validation. Prior to the pandemic every patient that had breached 18 week wait were validated in month however, due to the waiting list growth this can now only be done for those over three months. To add some context to this the average waiting list size for Warrington & Halton prior to the pandemic was 19,500. As of the start of September this has grown to 38,289 including those patients that are on eRS (Choose & Book). The reason for this process is that some patients could have been discharged following tests where no activity has occurred other than a letter to inform the patient and GP that the patient does not require treatment. This also means that for reporting purposes all patients on an RTT pathway have been validated in the last three months.

As of the 2 August there were 4,569 patients that required re-validation between March and May. At beginning of September there were 3,977 that required validation between April and June. The average amount is around 4,000 per month that require revalidation.

Validation process two:

The Second process is the validation of all patients waiting between 14 – 17 weeks. In some services Validation is down to 10-12 weeks.

There are on average 3,500 patients that fall within this waiting period. The RTT team can generally validate around 1500 of these patients prior to month end. Emphasis is given to those patients that have already had activity. Those patients still not yet seen are not validated until they fall into the projected 18 week wait cohort the following month. This is down to determining that if the patient has not yet been seen then there is only a low requirement to validate as the patient has not yet been seen.

2.1 Data Quality Validation.

Data quality and ensuring that the Trust is managing patients in-line with the access policy is a key element of the RTT management team roles. Common errors identified include:

- Referral closure with RTT pathway remaining active.
- Did not attend (DNA) first appointment and the RTT clock not nullified.
- Discharge from a ward where the RTT clock has been left open – following admission.
- incorrect appliance of a period of observation without treatment being applied.

Table 3: Data quality report September 2023

Closed Referrals	All referrals closed but still on an open pathway	1580
Closed Referrals (eRS)	All eRS referrals closed but still on an open pathway	115
DNA OP Appointments	Number of pathways where the first OP appointment is marked as DNA but does not have a 33 code associated to it.	1256
3 or more OP Appointments	All pathways that have had 3 or more outpatient appointments on a ticking clock with no stops in between the appointments.	1109
Corrupt Pathways	All corrupt pathways where the episode/encounter had become detached	480
Duplicate Referrals	Same specialty/treatment function/team on different PPID's	689
Clock Restarts	Where a pathway has a clock stop and then a subsequent clock start	933
Deceased Patients	Number of patients deceased on a ticking clock	23

2.2 Submissions

RTT Weekly Submission

A weekly snapshot of the current RTT position is taken every Sunday which then requires validation prior to submission each Wednesday. The validation look at a sample of the total number validating:

- Any patients over 104 weeks – typically data quality errors
- All patients over 52 weeks on a non-admitted pathway

The position is then re-run by the Information Team and sent out generally Wednesday morning. The RTT team then asses the numbers on the report to ensure they look as accurate as possible given the time constraints.

Once in agreement the RTT team then email COO/Deputy COO to confirm they are happy for the submission to be approved. Once approval is given the Information team then submit the RTT weekly position.

a. RTT Audits

Data quality and compliance Audits are completed twice a month, this review:

- RTT Clocks stopped via staff outside of the RTT team, completed on all patients over 52 weeks, with a average DQ rate of 4%
- RTT Clocks stopped by the RTT team, spot checks on 10 patients by a senior RTT analysist, feedback and learning opportunities are shared, with a average DQ rate of 3%.

b. RTT training

Current process:

- All new starters that have a smart card and Lorenzo access complete a basic training module for RTT
- Adhoc training offered at the monthly audit meetings to capture clinical and non clinical staff who have exposure to RTT
- Adhoc training offered to ward clerks and outpatient staff

Proposed process:

- All staff that manage RTT pathways to have annual refresher training
- Audit meetings attended annually to provide a refresher to the clinical team

c. Digital systems used to support data quality assurance

There are two Digital applications that have been commissioned by NHSe to support the validation process:

- LUNA
- RADIR

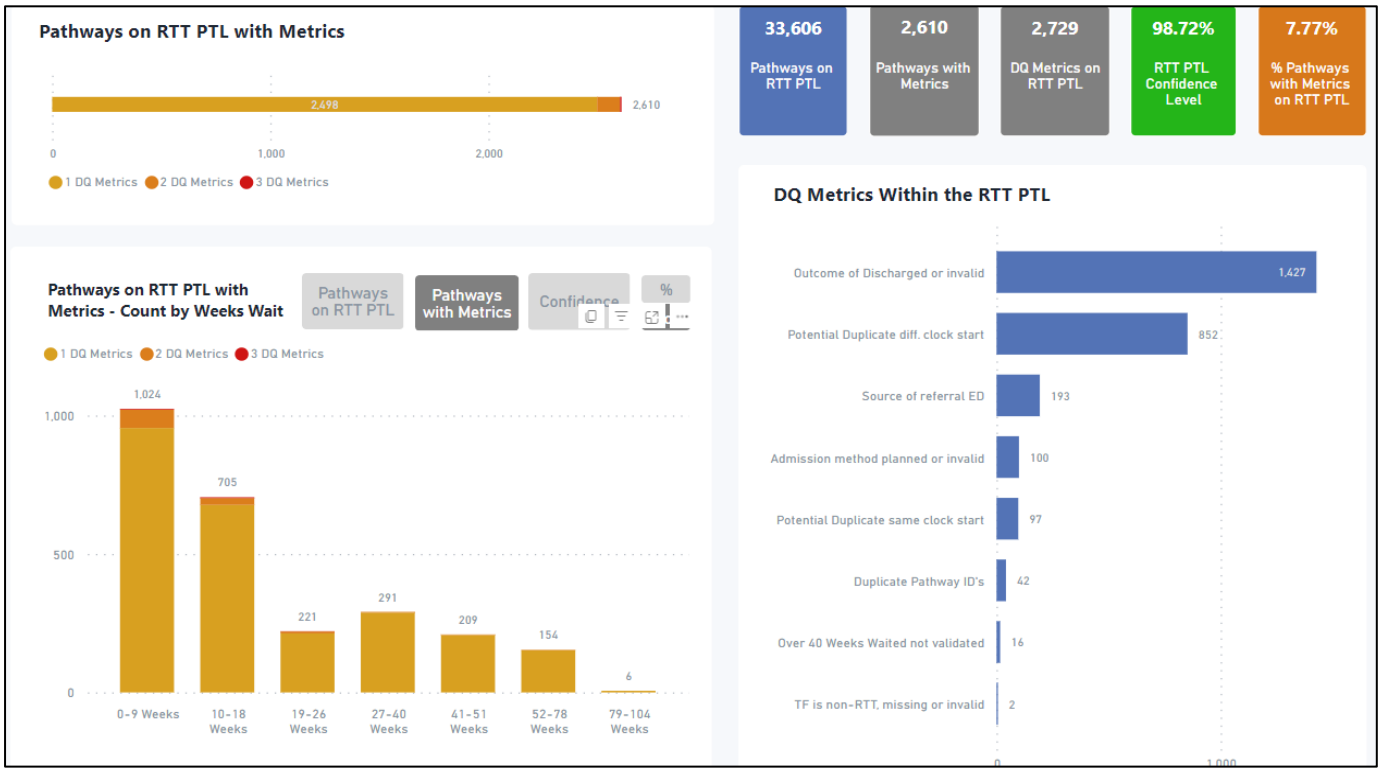
LUNA - National Data Quality Solution, Luna is utilised nationally to indicate performance for all submitting providers.

It contains the following information:

- Total RTT waiting List size.
- DQ metrics
- Confidence of submitted RTT PTL

The table below shows the Trust is at 98.72% accuracy on the submitted RTT position, however it should be noted that there are some DQ in the report for DQ reporting due to duplicate records being included, this has been raised with the National team.

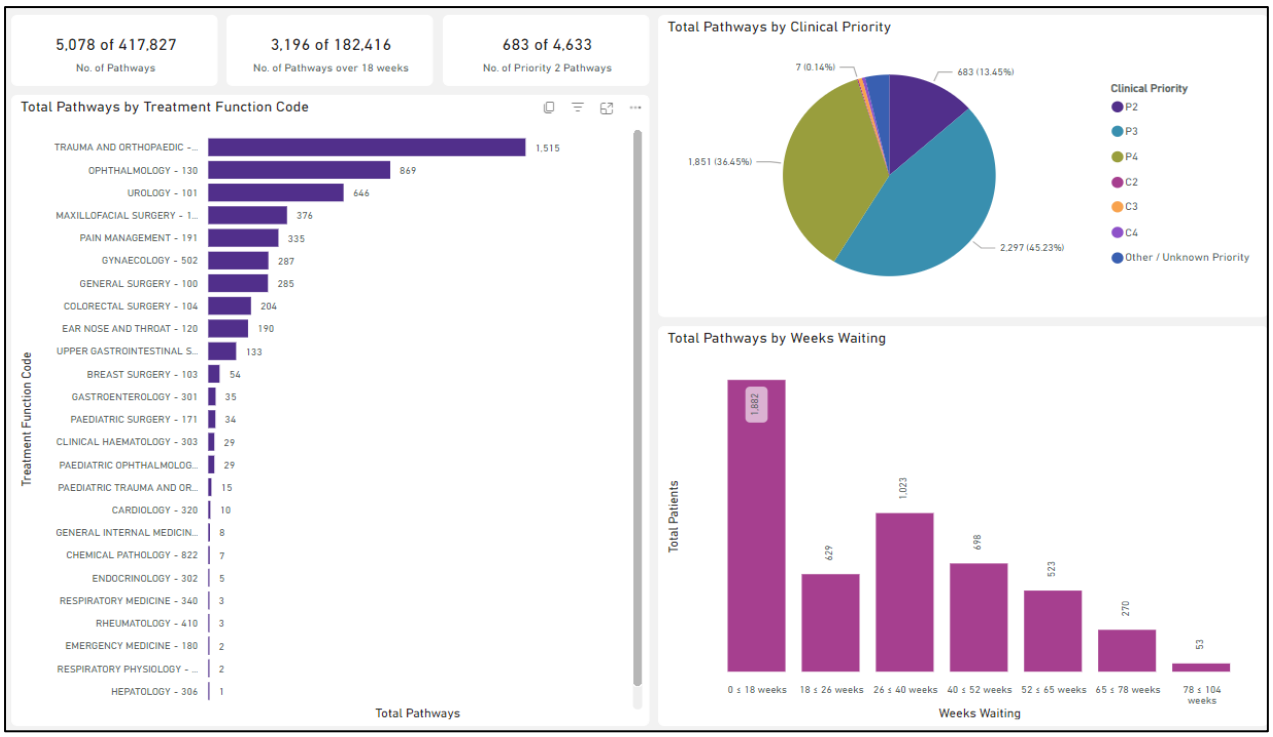
Table 4 displays the trust performance for Warrington and Halton from the LUNA application as of 19.09.23.



RADIR – This is also commissioned and utilised by NHSe and contains information around admitted and diagnostic waiting lists such as

- Waiting List by Specialty / Treatment function
- Priority codes assigned.
- Week band groups

Table 5 RADIR report for Warrington & Halton as of the 19/09/2023.



The pie chart is showing that of the 5078 patients that are on a inpatient or day case elective waiting list 95.27% have been given a priority code in line with national guidance. However, local data indicates 97%.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The RTT validation assurance report details the work programme and validation process that is undertaken with the Trust to support Elective recovery and ensuring that RTT standards and the access policy is correctly applied across the Trust.

RTT validation report will be monitored through the Performance review Group (PRG) on a monthly basis, with a weekly RTT meeting providing a weekly learning environment for the operational teams.

4. MEASUREMENTS/EVALUATIONS

Reduction in Data quality errors, compliance with the Access policy standards through regular audit.

5. TRAJECTORIES/OBJECTIVES AGREED

Following covid and no moving back into elective recovery the following actions are being introduced.

- Annual refresher training for all individuals in pre-identified roles

- Monthly update on validation position and data quality summary to be presented to performance Review group monthly
- New escalation process agreed when actions are not completed in a timely manner by operational teams

6. MONITORING/REPORTING ROUTES

RTT validation report to come to Performance review Group on a monthly basis.

7. TIMELINES

A monthly assurance report will be reviewed at Performance review group on a monthly basis.

8. ASSURANCE COMMITTEE (IF RELEVANT)

Performance Review Group, held weekly.

9. RECOMMENDATIONS

The board are asked to note this report, noting the increase in validation rates against pre-covid levels and the continuing work to improve this.