Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD - 28 July 2021 UPDATE

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/101**	
SUBJECT:	**Quality Assurance Committee – Chair's Annual Report**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):		
NON-EXECUTIVE DIRECTOR SPONSOR:	Margaret Bamforth	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	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.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#1079** Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff. **#224** Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience. **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience,	

	delays in treating patients and increased admission to the surgical bed base. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report seeks to deliver assurance to the Quality Assurance Committee that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to apprve the approve the Quality Assurance Committee Chair's Annual Report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/21/07/178**		
	Date of meeting	6th July 2021		
	Summary of Outcome	Approved via Chair's actions		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Annual Report of the Quality Committee 2020-21	AGENDA REF:	BM/21/07/101

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Quality Assurance Committee Annual Report which covers the reporting period 1 April 2020-31 March 2021.

The Quality Assurance Committee (the Committee) is accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality, including strategy, quality improvement, delivery, clinical risk management and clinical governance, clinical audit and the regulatory standards relevant to quality and safety. This includes assurance around relevant Health and Safety matters.

The Quality Assurance Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational strategic risks are managed appropriately.

This report details the membership and role of the Committee and the work that it has undertaken during the reporting period.

During the reporting period, the Committee has been composed of two Non-Executive Directors with a quorum of 2 (including the Chair). Any Non-Executive Director is able to attend the Committee to cover any absence.

During the reporting period, there were 10 meetings. The Quality Committee attendance record is attached in **Appendix 1**.

Terms of Reference

The Committee's Terms of Reference were reviewed during Quarter 3 of 2020-21, and the Cycle of Business in Quarter 4 2020-21, to ensure there was a focus on integrated systems of quality and assurance and also in line with the roll out of the revised Trust meetings structure. The terms of reference are attached in **Appendix 2.** The Quality Assurance Committee continues to focus on assurance monitoring, with its reporting sub committees meeting to deliver the agenda. High level briefings are provided to the Quality Assurance Committee from the Executive Led Sub Committees for assurance purposes.

Frequency of Meetings and Summary of Activity

The frequency of the meetings changed from bi-monthly to monthly from August 2020 in response to the COVID-19 pandemic and subsequently the Committee met 10 times during the year. A summary of the activity covered at these meetings follows:

- **Strategy Development**

  The Committee has had regular updates in relation to the Strategic Quality Priorities for the Trust. In addition, updates of enabling quality strategies have been provided e.g. Mortality reports, Dementia Strategy, Patient Experience Strategy, Adult Palliative and End of Life Strategy, Risk

Management Strategy, Safeguarding Strategy, Learning Disability Strategy, Mental Health Strategy, Quality Strategy.

- **Risk Management**

The Quality Assurance Committee oversees the Trust's strategic risks, as the designated Board Committee responsible for risk. The Committee has liaised closely with the Audit Committee to ensure the Strategic Risk Register and Board Assurance Framework drives the internal audit plan and to provide the Audit Committee assurance regarding systems of internal control.

The Committee oversaw significant changes to the Board Assurance Framework as a result of the COVID-19 pandemic, with the number of strategic risks on the board assurance framework increasing significantly in year. In February 2021, there were 21 risks on the board assurance framework, which increased from 9 in March 2020. 12 of the 21 risks related specifically to the Covid-19 pandemic. Moreover, the 8 highest rated risks refer directly to COVID-19.

Risks are presented on a monthly basis and is presented at the following Committees:

- Risk Review Group
- Finance and Sustainability Committee
- Strategic People Committee
- Quality Assurance Committee
- Patient Safety and Clinical Effectiveness Sub Committee

along with any oversight Committees of Strategic/Corporate risks.

The Risk Review Group continued to meet to ensure that there was scrutiny of departmental, speciality and Clinical Business Unit risk registers, with appropriate escalation processes in place.

- **Quality Dashboard**

The Committee has overseen an ongoing review of quality Key Performance Indicators, which are monitored in the corporate Integrated Performance Dashboard. A report is received at each meeting of the Quality Dashboard to review performance and to determine assurance of mitigating actions as appropriate.

- **Assurance**

The Cycle of Business for the Committee has been reviewed, with focus on assurance monitoring. Reporting sub committees are constantly under review, ensuring ongoing scrutiny.

The Committee approved several amendments to Quality Indicators on the Trust's IPR

Key areas which have been monitored in year are COVID-19, Maternity Services, the Ockenden Review, Complaints, Serious Incidents, Falls Prevention, Infection Prevention, IT, Safeguarding, VTE, Health & Safety, DNACPR, Medicines Management and Phase 3 Recovery.

As part of the Trust's response to the Ockenden review and the Local Maternity System requirements, serious incidents are reported to the Committee and then onwards to the Trust Board

- **Investigations and Lessons Learned**

  The Committee receives a regular update, to assure itself that investigations from Serious Incidents are being undertaken as per statutory and regulatory requirements. This also includes monitoring Duty of Candour for which the Trust has maintained 100% compliance.

  The Committee receives regular updates on how the Lessons Learned Framework is being implemented, including having receipt and scrutiny of a Lessons Learned Audit, whereby actions and recommendations from Serious Incidents and Complaints are audited for assurance of completion. Further assurance regarding this process is supported by the Executive led weekly meeting of harm.

  The Complaints Quality Assurance Group, which is chaired by the Trust Chairman, monitors the quality of the complaints responses in the Trust and also how we are implementing learning and change as a result of patient and public feedback.

- **Quality Academy**

  The Quality Academy has received additional investment in the form of the following: Associate Director of Quality, Two QI specialists, Project Manager and Head of Research.

  The Quality Academy are working alongside AQUA regarding additional training opportunities and collaboratives have now restarted as part of recovery with improvements being noted in both the reduction of pressure ulcers and falls. The QI team are also working on a number of microsystems and training opportunities for staff across all disciplines to embed a true culture of improvement and safety Trust wide. This will support the requirements of CQC well led.

  The Halton Clinical Research Unit opened this year and the first COVID-19 Covid trial (Valneva) has taken place with the full recruitment target achieved. Relationships have been established with Liverpool University Foundation Trust and the Clinical Research Network to create a Partnership Board and grow research at WHH.

- **Deep Dives**

  Several Deep Dives have taken place as part of the assurance process. These include, Medicines Management, Urology, DNACPR, Care Homes, Infection Control, Radiology, Trust-wide Digital and Maternity Digital, Ophthalmology, ENT, Safeguarding, Cyber Security.

  Hot topics received included, Emergency Services Framework, Infection Prevention and Control, COVID-19 Clinical Harm Reviews, COVID-19 Diabetes Service, assurance of adequate oxygen supply during the COVID-19 pandemic, COVID-19 Nosocomial transmission.

- **Regulatory and Statutory monitoring**

  The Committee continued to monitor the statutory and regulatory requirements relating to quality governance throughout the year. This included monitoring of the post Care Quality Commission Inspection Action plan (also via the Moving to Outstanding agenda) national audit activity, NICE guidance, national surveys, quality KPIs and complaints improvement.

  Furthermore, the Committee receives and monitors the Trust's CQC Moving to Outstanding Framework and action plan

The Quality Assurance Committee received, supported and approved a number of annual reports including, Health & Safety, Medicines Management & Controlled Drugs, Safeguarding, Risk Management, Complaints, Infection Prevention & Control, Clinical Audit, Quality Strategy.

- **Issues Carried Forward**

There are a number of issues which the Committee will carry forward into 2020-21.

- Implementation of the Quality Priorities for the year.
- Hot Topic programme to March 2022 including Safeguarding, DNACPR (Protect, Respect, Connect decisions about living and dying well during COVID-19, Antimicrobial Point Prevalence Audit
- Maternity Digital Improvement
- Monitoring of the requirements of the Ockenden Review

Summary

I as Chair of the Quality Assurance Committee encourage honest and open discussion, so that areas of success can be celebrated, and areas of improvement escalated and actioned. To ensure that the patient voice is heard, on a bi-monthly basis, meeting commences with a patient story.

This has been a challenging year and the Committee has had to adapt and adopt a flexible approach in order to maintain the necessary level of oversight needed during the pandemic. Committee members have responded to this challenge and provided the assurance required as well as managing the demands resulting from the pandemic. The Committee continues to develop, and this year has seen the introduction of hot topics, a more streamlined agenda to ensure discussion is focussed on the most important issues and a return to monthly meetings to ensure oversight during a period of fast-moving developments.

I would like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

Margaret Bamforth
Chair of Quality Assurance Committee & Maternity Safety Champion

QUALITY ASSURANCE COMMITTEE ATTENDANCE RECORD April 2020-March 2021

	May	July	Aug	Sept	Oct	Nov	Dec		Jan 2021	Feb 2021	March 2021	% inc Dep Attendance	% exc Dep Attendance
Margaret Bamforth Non-Executive Director, Board Maternity Safety Champion	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	100%	
Cliff Richards, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	100%	
Terry Atherton, Non-Executive Director	✓	✓	✓										
Kimberley Salmon-Jamieson, Chief Nurse + Deputy CEO/Mat Safety Champion	✓	✓	A/D	✓	✓	✓	✓		✓	✓	✓	90%	100%
Leyla Alani, Deputy Director Integrated Governance	✓	✓	✓	✓	✓	✓	✓		✓	✓	A/D	90%	100%
Michelle Cloney, Chief People Officer	✓	✓	✓	A/D	✓	✓	A/D		✓	✓	✓	80%	100%
Tracey Cooper, Associate CN Midwife/Midwifery Safety Champion (to 07/2020	✓	✓	✓									100%	
Alison Coackley, Consultant in Palliative Medicine/ Director of Medical Education (wef August 2020)			✓	✓		A	A		✓	A	A	30%	
Alex Crowe, Executive Medical Director	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	100%	
John Culshaw, Trust Secretary	✓	✓	A	✓	✓	✓	✓		✓	✓	✓	90%	90%
Chris Evans Chief Operating Officer (to 11.09.2020)	✓	✓	✓	A/D								75%	100%
Lucy Gardner Director of Strategy & Partnerships	ANR	A	✓	✓	A	✓	A		A	✓	✓	55%	
John Goodenough, Deputy Chief Nurse	A/D	✓	✓	✓	A	✓	✓		A	✓	✓	70%	80%
Debby Gould, Interim HoM/ Midwifery Safety Champion (wef 08/2020)			✓	✓	✓	✓	✓		✓	✓	✓	100%	
Mark Halliwell, Associate Medical Director Clinical Effectiveness	ANR	A	A		A				A			0	
Eshita Hasan, Governance Lead Obs + Safety Champion Lead (to Jan 2020)	ANR											-	
Eshita Hasan, Associate Medical Director Patient Safety (wef March 2020)		✓	✓	A	✓	✓	✓		✓	A	✓	77%	77%
Katie Alldred, Governance Lead Obs + Safety Champion Lead (wef March 2020)	ANR	✓	A	✓								22%	
Phill James, Chief Information Officer (to February 2021)	ANR	✓	✓		✓	A/D	✓		✓	✓		75%	87%
Diane Matthew Chief Pharmacist	ANR	✓	✓	✓	✓	✓	✓				✓	77%	
Daniel Moore, Acting Chief Operating Officer (wef 10/2020) COO wef 01/2021					✓	✓	A		A	✓	A/D	50%	66%
Alison Kennah , Deputy Chief Nurse Patient Safety + Clinical Education	✓	✓	✓	✓	✓	✓	✓		A	✓	✓	90%	
Carol Millington Head of Therapies (to December 2020)	ANR	A	A	A	A							0	
Michelle Smith, Interim Lead AHP/Head of Therapies (from Jan 2021)										✓		33%	
Lesley McKay Associate Director Infection Prevention and Control	✓	✓	✓	✓	✓	A	✓		A	✓	✓	80%	
Andrea McGee, Chief Finance Officer + Deputy CEO	ANR	A/D	✓	A/D	✓	✓	A/D		✓	✓	✓	66%	100%
Anne Robinson Associate Medical Director Patient Safety (Acting Dep MD 10/19) (Deputy MD wef 07/2020)	✓	✓	✓	✓	✓	✓	✓		A	✓	A	80%	
In attendance													
Julie Burke Secretary to Trust Board(Minutes)	✓	✓	✓		✓	✓	✓		✓	✓	✓	90%	
Anne Robinson, Public Governor (observing)	✓	✓	✓		✓	✓	✓		✓	✓	✓	90%	
Dan Moore, Director of Operations + Performance		✓	✓										
Val Doyle, Associate Director Planned Care				X/D									
Marie Garnett, Head of Contracting, Performance + Commercial Development		X/D											
Angela Parfitt, Associate Director Governance (Compliance) observing					✓						X/D		
Matthew Gardner, Deputy Chief Information Officer						X/D							
Dan Birtwistle Deputy Head Contracts & Performance							X/D						
Deb Smith, Deputy Chief People Officer				X/D			X/D						
Deborah Carter, Project Director Women and Children's Services										✓			
Hilary Stennings											X/D		

A/D Apologies - Deputy Attending	X/D attending as Deputy	A – Apologies	ANR – attendance not required

TERMS OF REFERENCE

QUALITY ASSURANCE COMMITTEE

1. PURPOSE

The purpose of the Quality Assurance Committee (the Committee) is to be accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality, including strategy, improvement, delivery, clinical risk management and governance, clinical audit and the regulatory standards relevant to quality and safety.
The Quality Assurance Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational risks are managed appropriately in line with professional and regulatory standards.

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly

3. QUORUM

Quorum shall be seven members, of which at least two should be Non-Executive Directors.

4. MEMBERSHIP

The Committee shall be composed of two Non-Executive Directors, one of whom shall be appointed by the Board to be Chair of the Committee

Core Members

- Chief Nurse & Deputy CEO
- Executive Medical Director
- Chief Operating Officer
- Deputy Director Governance
- Chief Finance Officer & Deputy CEO
- Deputy Chief Nurse
- Director of Strategy
- Chief People Officer
- Chief Information Officer
- Trust Secretary
- Chief Pharmacist
- Director Medical Education
- Associate Medical Director – Patient Safety
- Associate Medical Director – Clinical Effectiveness
- Interim Associate Medical Director – Innovation and Improvement
- Assistant Chief Nurse – Patient Safety & Clinical Education
- Assistant Chief Nurse– Clinical Effectiveness
- Associate Chief Nurse/Associate DIPC
- Head of Midwifery/Midwifery Safety Champion Lead + Governance Lead
- AHP Lead

Attendees

- Obstetrics/Obstetrics Safety Champion Lead + Governance Lead

Observers

- **Public Governor**

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

5. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of people external to the Trust, with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.
- The Chair of the Committee will provide a written key issues report to the Board bi-monthly following each meeting providing assurance of the quality governance arrangements in place within the Trust and provide an annual report to be presented to the Board meeting on its work and performance in the preceding year.

The sub committees listed below are required to submit high level briefing papers to the Committee:

- Patient Safety & Clinical Effectiveness Sub-Committee
- Patient Experience Sub-Committee
- Health, Safety & Risk Sub-Committee
- Information Governance and Corporate Records Sub Committee
- Safeguarding Sub Committee
- Risk Review Group
- Complaints Quality Assurance Group
- Research and Development Sub Committee
- Infection Prevention and Control Sub Committee
- End of Life Steering Group
- Equality Diversity & Inclusion Sub Committee

7. DUTIES & RESPONSIBILITIES

The Committee will undertake the following duties:

- Oversee the development and implementation of the Trust's strategies aligned to integrated governance and quality, including the overarching Quality Strategy, Risk Management Strategy, Clinical Effectiveness Strategy, Patient Experience Strategy, Quality Improvement Strategy, with a clear focus on upholding the tenants of quality and integrated governance and avoiding harm, ensuring that all strategies and performance indicators are consistent with the Trust's Mission, Vision and strategic objectives;
- Be the Trust Board of Directors delegated Committee responsible for risk management, ensuring that there is scrutiny and oversight of the strategic risk register and Board Assurance Framework, prior to approval at the Board of Directors and that there is appropriate liaison with the Audit Committee, to ensure internal audit resources within the Trust are aligned appropriately to risk;
- Overseeing 'Deep Dive Reviews' of risks to quality identified by the Board or the Committee, particularly "Serious Incidents Requiring Investigation" and how well any recommended actions have been implemented;
- The Committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board;
- Review the quality dashboard and information presented to the Committee, with regard to ensuring assurance is received on all quality and safety of patient care matters, which fulfils the Trust's strategic goals regarding quality and assurance, as well as statutory, regulatory and contractual requirements;
- Ensure there is a process in place regarding assessing and monitoring the impact on quality from Trust transformation and efficiency plans;
- To consider all appropriate matters of clinical and non-clinical, quality governance including patient care, patient experience and patient and staff safety, via a planned integrated quality governance assurance system, giving assurance either directly to the Committee or indirectly via its reporting Sub Committees, and all risks are appropriately escalated;
- Ensure there is an appropriate investigations framework within the Trust i.e. ensure all incidents and complaints are appropriately investigated, ensure that the Trust's Mortality Review process aligns to the Royal College of Physicians Standard Judgment Review process, and that people have the skills and expertise to undertake these investigations;
- Ensure there is an appropriate policy development and review framework within the Trust, and that staff education strategy and organisational development is aligned to policy development within the Trust;
- Ensure there is an action planning framework in place within the Trust, so that actions from investigations, risk assessments and internal and external reviews are implemented, monitored appropriately and escalated when off track;
- Ensure that there is a learning framework in place within the Trust, so that aggregate learning from incidents, Serious Incidents, complaints, claims, audit and assessments are communicated appropriately and changes in practice are facilitated;
- Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery;
- Ensure all external accreditations are monitored within the Trust, so that the Board of Directors has assurance that the Trust is meeting external quality requirements, and where there is variance or risk, actions are put in place appropriately;
- Obtain assurance of the Trust's on-going compliance with the Care Quality Commission registration through appropriate systems of control.

- Ensure that the Trust has effective communication channels in place for ward to Board monitoring and that the Clinical Business Unit, directorate, speciality, ward and department governance and quality assurance structures are robust;
- Monitor the process for the production of the Trust's year end quality (Quality Accounts) and risk management (Annual Governance Statement) reports before they are presented to the Trust Audit Committee and Board for formal approval;
- Ensure all reporting Sub Committees have effective reporting structures in place and that planned assurance reports are scrutinised through a business and assurance cycle;
- To inform the Board where it has significant concerns about:
  - Standards of care in the Trust
  - Or where it considers any service (or part of) to be unsafe

8. ATTENDANCE

A record of attendance will be kept; attendance of 75% per year is expected
Members unable to attend must send a deputy who is able to make decisions on their behalf.
Other Executive Directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Officers who are unable to attend a meeting of the Committee may appoint a deputy who will attend. It is the responsibility of the core member to inform the Chair of the Committee if they are unable to attend and who will attend as their deputy.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee the Agenda and Papers will be sent out 5 working days before the date of the meeting. No Papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established

Papers to this Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Tuesday preceding the Quality and Assurance Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Divisional leads/service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed
5. Presentations must be sent to the Administrator ahead of the meeting
6. No tabled papers will be accepted unless in an emergency and with permission of the Committee Chair.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Committee.
The Cycle of Business will be reviewed by the Committee every 12 months.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Quality Assurance Committee
Version:	V4.1
Implementation Date:	November 2020
Review Date:	January 2021
Approved by:	Quality Assurance Committee
Approval Date:	QAC 03.11.2020 Board 25.11.2020

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
V3 6 December 2016	5 - Membership	Revised to include Non-Executive Directors to be amended to read **two** Core Attendees – to read **Core Members** Delete Divisional Operational Directors from the Core Membership **ADD Transformation Director** **ADD - Co-Opted Members from the Workforce Sub Group.** The Quality Committee to receive minutes from the WSG and appropriate colleagues to be invited to the Quality Committee where assurance is required for specific matters in relation to staffing, quality and safety. Quorum – change from 10 **to maximum of 7, to include 1 Executive Director, 1 Non-Executive Director and 1 representative from each Division.**	QAC 6.12.2016
	10 – Administrative Arrangements	The Committee will be supported by the Secretary to the Trust Board.	QAC 7.2.17
V3 10 January 2017	5 - Membership	Membership further reviewed to include Head of Midwifery and Associate Director Infection Control + Prevention.	QAC 7.2.17
V3 7 February 2017	5 – Membership	Delete Director of IM&T	QAC 7.2.17
V3 02 January 2018	4 – Membership	Delete Chief Pharmacist, Chiefs of Service, Surgery, Women's & Children and Acute Care Services, Associate	QAC 09.01.2018

		Directors of Nursing, Associate Director of Infection Control.	
V3 02 January 2018	2 – Frequency of Meetings	Meetings to move from monthly to bi-monthly	QAC 09.01.2018
V3 02 January 2018	6 – Reporting	Removal of Infection Control Committee, medicines management, Inclusion of Risk Review Group, Complaints Quality Assurance Group, Research and Development Sub Committee and Safeguarding Committee,	QAC 09.01.2018
V3 04 May 2018	4 – Membership	Add Audit and Governance Lead for Women's Health	QAC 03.08.2018
V3 08.01.2019	4 – Membership	**Add** CEO DoF + Commercial Development Chief Pharmacist AHP Lead **Replace Deputy HRD with** Director of HR + OD **Replace Deputy DoIM&T with** Chief Information Officer Change in titles of Director of Strategy, Associate Medical Directors and Associate Chief Nurses **Move** Audit and Governance Lead for Women's Health to attendee section	QAC 08.01.2019 + Trust Board 29.05.2019
V3 08.01.2019	6 – Reporting	**Add** Infection Prevention + Control SC End of Life Steering Group Divisional Governance Medicines Governance	QAC 08.01.2019 Trust Board 29.05.2019
V3 08.01.2019	10– Review/Effectiveness	**Add** Cycle of business reviewed annually	QAC 08.01.2019 Trust Board 29.05.2019
V4 07.01.2020	4 – Membership	**Add** Director of Medical Education Observer section – Public Governor **Remove** CEO **Amend** Assistant Chief Nurses to Associate Chief Nurses Medical Director Strategy to Interim Associate Medical Director Innovation and Improvement Obstetrics/ Obstetrics Safety Champion Lead add + Governance Lead	QAC 07.01.2020 Board 29.01.2020
V4 07.01.2020	6 – Reporting	**Remove** Divisional Governance Medicines Governance	QAC 07.01.2020 Board 29.01.2020
V4.1 03.11.2020	6 – Reporting	**Add**	QAC 03.11.2020 Board 25.11.2020

		Equality Diversity & Inclusion + change in titles CFO, Chief Nurse and CPO	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
07.01.2020	**V3 – replaced with Version 4**	QAC 07.01.2020 Board 29.01.2020

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/102**	
SUBJECT:	**Nursing and Midwifery Strategy (2021-2024)**	
DATE OF MEETING:	28 July 2021	
AUTHOR(S):	John Goodenough, Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**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.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1079** Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff. **#224** Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience. **#1372** FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	

	#145 Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Nursing and Midwifery Strategy for 2021-2024 outlines how WHH nurses and midwives will deliver outstanding patient care and patient experience underpinned by the latest practice, education, research and innovation. There has been wide involvement of nursing and midwifery staff at all levels and the following strategic objectives and drivers to deliver the Strategy have been identified: 1. Brilliant Basics, getting the basics right every time 2. Year on year improvements in patient care 3. Empowering all nurses and midwives to drive service improvement and quality 4. Valuing and developing our workforce 5. Developing our leaders

PURPOSE: ***(please select as appropriate)***	Information *	Approval *	To note	Decision
RECOMMENDATION:	The Board of Directors are asked to receive and approve the revised and updated Nursing and Midwifery Strategy (2021-2024)			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/21/07/180(a)
	Date of meeting	Approved via Chairs action 6 July 2021
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Moving Forward to Outstanding with YOU

Our Nursing & Midwifery Strategy

2021-2024

We are WHH & We are PROUD to make a difference

"Massive goals don't require massive action.
They require consistent action."
J. Mike Field

Message from the Chief Nurse and Deputy Chief Executive

I am passionate about ensuring that every patient is provided with the standard of care that we would want for our loved ones. As nurses and midwives we are in a very privileged position of caring and supporting patients and their families at some of the most vulnerable times in their lives. We make a huge contribution to ensuring safe and effective care to our patients and their families.

The COVID-19 pandemic has challenged and changed the NHS in far more ways than perhaps we imagined one year ago. There are many experiences that we would rather leave behind although there is much that we have learned about ourselves, our Trust and our communities that we should and must take into the future.

This strategy has been developed in close consultation with you, through a number of engagement events, including an initial consultation meeting with nurse leaders and a survey to discuss key priorities with individual nurses and teams. Through the feedback that we have received we have identified areas that you are proud of and also some key challenges that you face now and anticipate for the future.

We are very proud to launch our refreshed Nursing and Midwifery Strategy 2021-2024. The nursing and midwifery staff at Warrington and Halton Hospitals have continued to go 'above and beyond' to provide the best possible care to patients and families with continuing compassion and kindness.

Thank you for your ongoing support and commitment to providing outstanding care to our patients and their families and I look forward to working with you to deliver the 2021-2024 Nursing and Midwifery Strategy.

I am very proud of you all and what we have achieved together and now we move forward to the next step to move to "outstanding".

Kimberley Salmon-Jamieson
Chief Nurse and Deputy Chief Executive

Introduction

Introduction

The Nursing and Midwifery Strategy for 2021–2024 outlines how Warrington and Halton Teaching Hospitals nurses and midwives will deliver outstanding patient care and patient experience underpinned by the latest best practice, education, research and innovation.

This Strategy has been created with recognition and alignment of National Plans and Strategies; The People Plan, the National Nursing Strategy, the 10 year Forward View and Integration and Innovation; working together to improve health and social care for all.

Integrating care: next steps to building strong and effective integrated care systems across England.

There has been wide involvement of nursing and midwifery staff at all levels to identify five key overarching objectives and drivers to deliver the aims identified within this Strategy.

The five objectives are:

- Brilliant Basics
- Year on year improvements in patient care
- Empowering all nurses and midwives to drive service improvement and quality
- Valuing and developing our workforce
- Developing our leaders

Delivery of outstanding care which is kind, respectful and compassionate every time

Objective one

Objective one

Brilliant Basics, getting the basics right every time

- Deliver care which meets the individual needs of all patients, providing nutritious and appropriate food and drink and ensuring pain is managed effectively, always considering inclusivity and personalisation
- Implement the Learning Disability & Autism and Mental Health Strategies to reduce health inequalities for patients
- Ensure effective communication takes place with regard to discharge planning starting on admission involving patients and their families to ensure timely discharge when the patient is medically optimised
- Ensure effective communication at shift handover, board rounds and ward rounds to ensure seamless patient care
- Timely administration of medicines will be an 'always event'
- Nursing and midwifery documentation will be standardised across
- The Trust harnessing digital solutions where possible contributing to the new in-patient digital record
- Ensure infection prevention measures are implemented and strictly adhered to ensuring the highest standards of cleanliness through our "time to shine" campaign learning from our experiences of the COVID-19 pandemic

High quality patient care

Objective two

Objective two

Year on year improvements in patient care

- Continue to provide safe, effective, high quality patient care and further embed a culture of continuous improvement, focusing on reducing harm and delivery of improvements in all quality indicators
- Continue to deliver improvement initiatives that support all clinical quality external accreditation such as the NHS Litigation Authority, the Care Quality Commission(CQC) and our plans to move to "outstanding"
- Measure what we do and track variation so we can use quality improvement to improve such as pressure ulcer damage and falls
- Support staff to understand data and be data driven in all improvement work
- Encourage patients to raise any questions or concerns so as they may be resolved in a timely manner either by speaking directly to staff or via our 'Tell us Today' service
- We commit to communicating with each other in an accessible, friendly and respectful manner

University of Chester

NHS Health Education England

Care Quality Commission

aqua Shape Change Inspire Quality Transform Care

NHS Litigation Authority

Empowering all nurses and midwives

Objective three

Objective three

Empowering all nurses and midwives to drive service improvement and quality

- Create a culture which promotes quality improvement and co-creation with our patients and families voice the centre of everything we do
- Embrace an ethos which celebrates developing new ways of working to enhance the experience for our patients, their families, carers and staff
- Embrace the utilisation of digital solutions to enhance and streamline systems and processes
- Integrate education, innovation and research into the care that we provide
- Regularly review nursing and midwifery policies, guidelines and procedures to make sure they are based on the best current evidence.
- Support staff to publish and present at conferences
- Promote careers in research to strengthen the focus on evidence based care
- Share learning across different clinical areas and specialities ensuring accessibility of the Quality Improvement Team for all staff

Rewarding roles through training and education and excellent learning environments

Objective four

Objective four

Valuing and developing our workforce

- Develop a "communication" and "lessons learned" framework
- Promote a clear work/life balance by providing flexibility in the workforce
- Ensure rewarding roles through training and education
- Reduce the reliance on temporary staffing
- Listen to what our staff say about what would help them to be more productive and efficient
- Provide induction, preceptorship and an excellent learning environment increasing collaborative learning in practice (CLIP)
- Encourage open and transparent communication at all times through Chief Nurse and Senior Nurse 'keeping in touch sessions' for all staff
- Support our staff to be open and raise concerns where necessary
- Demonstrate commitment to our staff by making sure senior nurses and midwives and consistently present in clinical areas
- Recognise the contribution of specialist nurses and midwives to patient care and outcomes
- Develop a highly visible nurse and midwife specialist workforce who motivate and inspire
- Harness Advanced Nurse Specialists' and Specialist Nurses' expertise to skill up staff and pioneer innovations and excellence in practice

Providing outstanding care as an outstanding leader

Objective five

Objective five

Developing our leaders

- Speak as a collective voice through our Communication framework
- Role model behaviours and standards required to deliver an outstanding service and outstanding leadership
- Embrace a 'just culture' to promote trust, honesty and teamwork
- Develop and support matrons and ward managers to deliver outstanding ward management and excellence in clinical practice
- Develop mentors and ensure a mentor or coach is available for all senior leaders or those that request one to enhance the reputation of the Trust's nursing and midwifery workforce
- Support staff to speak up when things require improvement and be bold when they have good ideas
- Create equal opportunity, being inclusive for staff to develop their leadership potential
- We will define leaders' roles and responsibilities for improving the care and experience of our patients delivering improvements
- We will increase the availability and support staff to take forward customer care training
- We will increase the quality of complaint responses

Thank you to the following contributors and partners for supporting the development of the Nursing and Midwifery Strategy 2021- 2024

WHH Patient Experience Committee
Allied Health Professionals
Staff Nurses
Midwives
Health Care Assistants
Ward Managers
Sisters and Charge Nurses
Specialist Nurses
Associate Chief Nurses
Deputy Chief Nurses
Assistant Practitioners
Nursing Associates
Advanced Clinical Practitioners
Consultant Nurses

University of Chester

aqua
Shape Change Inspire Quality Transform Care

NHS Warrington Clinical Commissioning Group

NHS England

NHS Health Education England

For more information or any queries see contact details below:

John Goodenough

Deputy Chief Nurse

jgoodenough@nhs.net

SCAN ME

www.whh.nhs.uk

@WHHNHS

@WHHNHS

WarringtonAndHaltonHospitalsNhsFoundationTrust

We are WHH & We are PROUD to make a difference

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/103**	
SUBJECT:	**Safeguarding Children and Safeguarding Adults Annual Report 2020 / 2021**	
DATE OF MEETING:	28 July 2021	
AUTHOR(S):	John Goodenough, Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	**X**
	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.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#145** Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	Safeguarding is a Care Quality Commission (CQC) standard and a duty at the centre of the Trusts daily business. The scope of safeguarding is wide reaching and incorporates all categories of abuse. This is the third joint Annual Report regarding adult and children's safeguarding within Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH). The Safeguarding of Children, Young People and Vulnerable Adults' in the NHS, Accountability and Assurance Framework (updated 2019) sets out the safeguarding roles, duties and responsibilities of all NHS organisations and is integral to the safeguarding agenda making clear that safeguarding is everyone's business and responsibility. This report provides assurance that the Trust is meeting its obligations to safeguard adults and children and is meeting the statutory and legal obligations to keep patients, service users and staff safe from harm and abuse.	

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note	Decision
	X		X	
RECOMMENDATION:	The Board of Directors are asked to receive and note the contents of the Safeguarding Children and Safeguarding Adults Annual Report 2020 / 2021.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/21/07/196
	Date of meeting	Approved via Chairs action 6 July 2021
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Safeguarding Children and Safeguarding Adults Annual Report 2020 - 2021

Report written by:

John Goodenough, Deputy Chief Nurse and Head of Safeguarding

Contributions from:

Wendy Turner, Lead Named Nurse Safeguarding Adults

Katie Clarke, Lead Named Nurse Safeguarding Children

1. Introduction

Safeguarding is a Care Quality Commission (CQC) standard and a duty at the centre of our daily business. The scope of safeguarding is wide reaching and incorporates all categories of abuse. This is the third joint Annual Report regarding adult and children's safeguarding within Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH).

This report gives assurance to WHH Trust Board, the Local Safeguarding Adults Board (LSAB) the Safeguarding Children Partnerships and Warrington Clinical Commissioning Group (CCG) that the Trust is meeting its obligations to safeguard adults and children and is meeting the statutory and legal obligations to keep patients, service users and staff safe from harm and abuse.

The Safeguarding of Children, Young People and Vulnerable Adults' in the NHS, Accountability and Assurance Framework (updated 2019) sets out the safeguarding roles, duties and responsibilities of all NHS organisations and is integral to the safeguarding agenda making clear that safeguarding is everyone's business and responsibility.

Aiming to be proactive in fulfilling its safeguarding function, effective safeguarding requires robust recruitment and screening processes for staff. By working collaboratively, with Safeguarding Boards and Safeguarding Partnerships, guidelines are developed to support the national and local safeguarding agenda. Assurance of adult and children's safeguarding activity and practice are reported via the Safeguarding Committee to the Trust Quality Assurance Committee (QAC), a subcommittee of the Trust Board.

The 2019/2020 annual report reflected on the year that had passed and set out aims and objectives to be delivered in 2020/2021. However, the publication coincided with the COVID-19 g pandemic and nationally the NHS rapidly reviewed the needs and requirements of its service delivery, Safeguarding was no exception. Nationally people were told to stay at home and community services were forced to alter how they delivered their support. At that time the full impact of the pandemic was not known; preparations and contingencies were put into place to increase and strengthen provisions. This was in readiness for the expected surge in safeguarding activity that would arise from the effect of national lockdowns as victims were at home with their abusers and people had significantly reduced, or no access to their normal support networks. Although the full impact was not known, it was clear that the main areas of focus would be Mental Health, Domestic Abuse and Self-Neglect. The Executive Safeguarding Lead at WHH quickly ensured a review of the Safeguarding Team establishment took place, which resulted in increasing the team by two whole time equivalent (WTE) band 7 specialist nurses, with a later addition of two band 7 WTE (temporary) dedicated training posts.

1.1 Executive Summary

The main activities of the Safeguarding Team at WHH can be found detailed below. Further information relating to these activities are expanded on in greater detail throughout the content of this report.

- Spotlight on safeguarding to promote the importance of safeguarding during the COVID-19 pandemic.
- As expected, activity continued to increase across all areas of safeguarding in line with the national picture post COVID-19 lockdowns.
- Safeguarding training remained a priority and has continued throughout the year. Delivery of training via virtual platforms such as Microsoft Team's has enabled this.
- Multi-agency case reviews continue to be supported in line with National Safeguarding Policy.
- WHH have supported with an increased number of fabricated Induced Illness cases as per the previous year.
- Audit has led to improved safeguarding processes to support staff in their practice.
- Amended policies, documents and pathways have improved staff safeguarding practice.
- Assurance is provided via monthly and quarterly reporting to Safeguarding Committee, Quality Assurance Committee, Safeguarding Partnerships and Safeguarding Adult Board, Clinical Commissioning Group (CCG) and NHS England.
- WHH have continued to lead the ICON programme across the Cheshire footprint.
- Safeguarding, Mental Health (MH) and Learning Disability (LD) Strategies and associated workplans continue to be monitored.
- The National LD Improvements Standards benchmarking audit workstreams continue to be monitored via the newly formed LD steering group.

1.2 Reflection of 2020 / 2021 Focus

It is too early to understand the full effects of the COVID-19 pandemic on the safety of children, young people and adults as the far-reaching effects of the virus are unknown. Data provided by the National Society for the Prevention of Cruelty to Children (NSPCC), How Safe are our Children Report 2020, describes a worrying picture. Many of the risk factors associated with abuse and neglect have been exacerbated throughout the COVID-19 pandemic, while the support services that would traditionally identify and respond to these concerns have been unable to see many of the children and families they work with face-to-face.

Lockdown prevented families and friends from meeting and care homes and hospitals closed to visitors. Normal service provision changed causing people to struggle with access to their usual support, people living alone became increasingly isolated. There are increasing concerns about the child protection system's ability to cope with a potential influx of newly identified concerns and therefore a proactive response is required in recognising any trends and/or themes ensuring timely appropriate escalation. In addition to the previously highlighted areas of concerns slavery and trafficking have continued to rise.

2. Update on Objectives Set for 2020 - 2021

The Trust's objectives for 2020-2021 were to deliver its safeguarding duties effectively based on the delivery of seven key priority outcomes that were aligned to the shared priorities detailed below (Figure 1). The 2019-2021 Safeguarding Strategy demonstrates how each of these priorities will be addressed. The associated Safeguarding Strategy work plan is reviewed and updated on a monthly basis with progress reported via the Trust Safeguarding Committee into the Trust Quality Assurance Committee. Each objective is explored further within the report with supporting evidence embedded throughout. All priorities are on target for completion in 2021.

Figure 1

No.	Priorities	Target Date	Current position
1	Domestic Abuse 1. To raise awareness to enable staff to identify domestic abuse and what their responsibilities are. 2. To ensure information and learning about coercive and controlling behaviour, that was acquired during a Domestic Homicide Review (DHR) that commenced after a lady was murdered in 2018, is shared via training and supervisory discussion. To support our Occupational Health and HR departments where domestic abuse victims/perpetrator involved Trust staff.	Feb 2021 Feb 2021	Completed
2	Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS) / Liberty Protection Safeguards (LPS) 1. To continue to train staff regarding their MCA and DoLS responsibilities in order to enable good practice. 2. To plan and monitor training regarding the new LPS process. 3. To work towards roll out of LPS.	April 2022 – The implementation date was amended as a result of the COVID-19 pandemic	Awaiting government guidance for the code of practice and regulations that will determine the LPS process, the documentation to be used and the required training package. Recruitment of the staff for the posts cannot commence without the direction of the documents above.
3	Child Sexual Exploitation (CSE) 1. To raise awareness through masterclass training. 2. To help staff to understand all elements of CSE including the criminal aspects of this abuse. 3. To support staff in recognising and reporting this abuse HSAB priorities and actions to be added then circulate for comment before final sign off.	Feb 2021	Completed
4	Neglect		Completed

	1. This element of safeguarding includes neglect of adults at risk and children, it also includes self-neglect. 2. To raise awareness of neglect amongst Trust staff and to provide education to enable them to recognise and report neglect of all types. 3. To raise awareness of the self-neglect assessment tool. 4. To raise awareness of processes that support child neglect.	Feb 2021	
5	Learning Disabilities 1. To promote flagging of inpatients and outpatients by staff creating alerts in Lorenzo where required. 2. To continue to support the learning disability improvements programme. 3. Upon the appointment of the new Safeguarding Adults staff member, to further support the learning disability agenda across the agenda.	Feb 2021	Completed
6	Early Help 1. To raise awareness across the organisation of staff responsibility to offer early help to families in need in paediatric and adult settings. 2. To ensure that staff in inpatient and outpatient areas are aware of support for families.	Feb 2021	Completed
7	Modern Slavery/Trafficking 1. To provide training to raise awareness of modern slavery and human trafficking issues in relation to children and adults at risk. 2. To raise awareness of county lines via training. 3. To support staff in recognising and reporting modern slavery and trafficking. 4. To work with our procurement teams to gain assurance that our business is conducted with businesses that observe the modern slavery act 2015.	Feb 2021	Completed

3. Safeguarding Activity

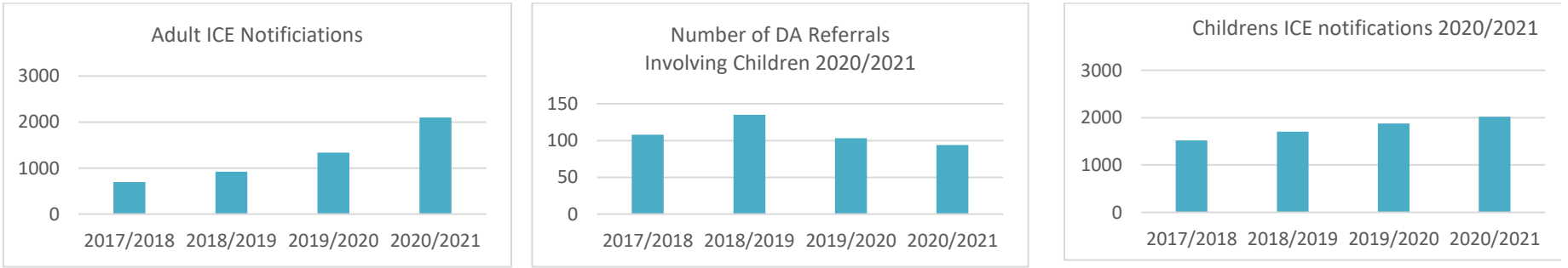
Comparisons of the data collected pre and post the COVID-19 pandemic has shown some unusual activity. An unexpected effect of the lockdown was a reduction of hospital attendances, the ripple effect of reduced hospital attendance on safeguarding activity was noted. The activity below demonstrates how people began to access services as national lockdowns came and went. As people started to access services again, it was recognised that the presentation had become far more complex than previously noted. The Safeguarding Teams continue to receive safeguarding concerns and information via several routes.

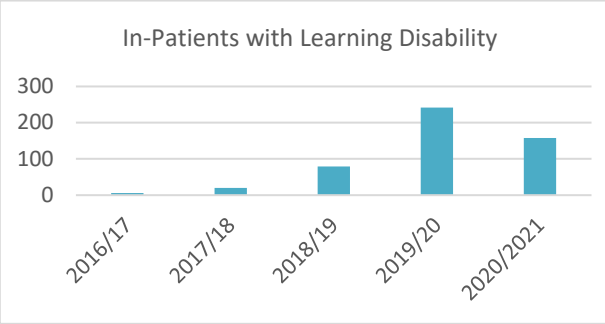
Please see figures 2 and 3 for a breakdown of the referral activity:

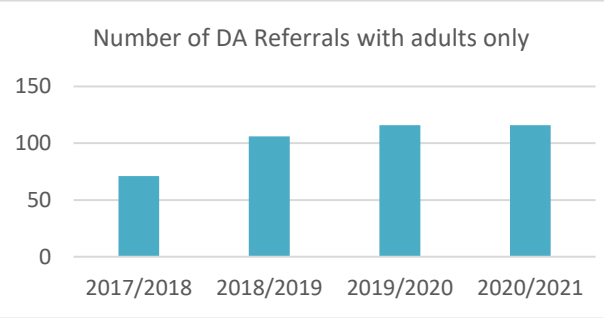
Figure 2

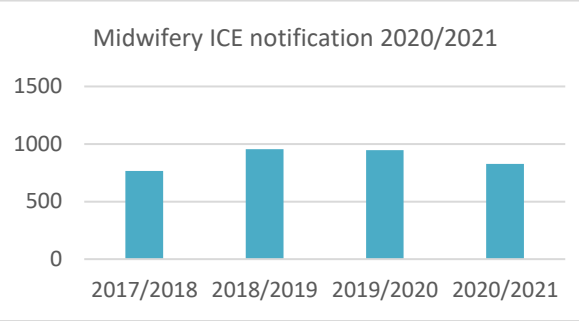
ICE Notifications	Adult	Children's	Maternity	DA (Children in the Family)	DA Adult Only Cases	LD In-Patients	In-Patient and Outpatient Flagged LD Patients	Prevent	DoLS
2016/2017	343	1502	795	126	18	6	0	0	225
2017/2018	696	1520	765	108	71	20	178	0	629
2018/2019	922	1706	955	135	106	79	175	4 cases	511
2019/2020	1336	1876	846	103	116	242	1433	0	525
2020/2021	2100	2021	827	94	116	158	831	1	480
% change 19/20 to 20/21	**↑57%**	**↑7%**	**↓ 2%**	**↓ 6%**	**Static**	**↓ 34.7%**	**↓ 42%**	**↑100%**	**↓8.6%**

Figure 3









4. Safeguarding Training

4.1 Training recruitment

Continuous Professional Development (CPD) funding has been utilised to recruit two full time trainers who will have a specific focus upon:

- Learning Disability (LD) and Autism.
- Domestic Abuse.

A vacancy remains for a Liberty Protection Safeguards/Mental Capacity Act/ Mental Health Act (LPS/MCA/MHA) trainer.
The trainers commenced their posts in December 2020 quickly implementing robust training programmes which are now being delivered Trust wide.

4.2 Training Compliance

Delivery of training has continued throughout the COVID-19 pandemic. As expected, training compliance did reduce, however plans are in place across all Clinical Business Units (CBUs) to address this and increase compliance by the end of the 2021/22 financial year, progress is being monitored via the internal Safeguarding Committee.

The following data as detailed in figure 4 provides an update on the training compliance from April 2020 to March 2021. Since April 2021, the number of virtual and face to face training available sessions have increased thus creating greater accessibility for staff to attend.

Figure 4

Training – 1st April 2020 – 31st March 2021	Number of people to be trained	Number of people trained	Compliance
DoLS	2715	2382	87.73%
MCA	2759	2551	92.46%
WRAP	1825	1663	91.12%
Prevent Basic Awareness	4322	3951	91.42%
Safeguarding Children Level 1	4319	3847	89.7%
Safeguarding Children Level 2	2669	2138	81%
Safeguarding Children Level 3	545	413	76%
LD level one (this data is indicative of the training commenced in February 2021)	1351	161	11.92%
LD level two (this data is indicative of the training commenced in February 2021)	3063	227	7.41%
Autism level one (this data is indicative of the training commenced in February 2021)	1347	161	11.95%
Autism level two (this data is indicative of the training commenced in February 2021)	3063	204	6.66%
Domestic Abuse Level 1 (this data is indicative of the training commenced in February 2021)	1574	135	8.58%
Domestic Abuse Level 2 (this data is indicative of the training commenced in February 2021)	2828	121	4.28%
Domestic Abuse Level 3 (this data is indicative of the training commenced in February 2021)	3008	71	2.36%
Adult safeguarding level one	Please see detail below*		73.68%
Adult safeguarding level two	Please see detail below*		64.10%
*Work is currently underway to address an anomaly in the recording of level 1 and 2 adult safeguarding training. Due to an issue in how training had been recorded the figures were only partly reported. The figures above are an interim picture and indicative of the work that is happening to better understand the compliance levels regarding adult safeguarding level 1 and 2 training data.			

Safeguarding training compliance is an important indicator of the ability of staff to act on safeguarding concerns. In order to fulfil these responsibilities all professionals and their teams should have access to and engage in training commensurate to their role and level of responsibility. The safeguarding training programmes are reviewed in real time following learning from case reviews and hospital incidents along with National guidance (Intercollegiate Documents).

4.3 Additional training delivered internally focussed on specific topics include:

- Child sexual exploitation.
- The impact of domestic abuse on children.
- Impact of neglect on children.
- Learning from serious case reviews.
- Physical harm.
- Child criminal exploitation.
- Voice of the child.
- Modern slavery and trafficking.
- Liberty protection safeguards.
- Suicide prevention.
- Carer stress.
- Self-neglect.

5. Learning and improving

5.1 Safeguarding Reviews

5.1.1 Safeguarding Children Serious Case Review (SCR)

When a child dies, or is seriously harmed, as a result of abuse or neglect, a case review is conducted to identify ways that local professionals and organisations can improve the way they work together to safeguard children. As reported in the previous annual report, WHH have been involved with two multi-agency case reviews. Although the published findings of both reviews are still awaited it is noted that there were no actions requiring an immediate response however it is expected that there will be elements of learning which can be applied to the acute Trust.

5.1.2 Safeguarding Adult Reviews (SAR) / Domestic Homicide Reviews (DHR)

The Local Authority has a duty to investigate when an adult at risk comes to harm as a result of abuse or neglect. The investigation is conducted under section 42 of the Care Act. A Serious Adult Review is conducted in cases that meet section 44 of the Care Act, this happens where multi-agency involvement has contributed to the patients harm or death. Where death is the result of domestic abuse a Domestic Homicide Review is undertaken. Figure 5 provides an update of the Safeguarding Adult Reviews with WHH involvement.

Figure 5

SAR	Brief description	Action required	Progress of action
SAR G detailed in 2018/19 report	An elderly man who was caring for his wife attempted to kill her. Following intense review, it was discovered his wife was a perpetrator of domestic abuse	Learning from a carer crisis, (the domestic abuse element was found a year after the review was completed)	The actions assigned to WHH regarding supporting staff to recognise carer crisis has been completed, the Safeguarding Team promote awareness of carer crisis in training and during ward discussions. In addition, during November 2020 to January 2021, the LA have conducted multi agency carer crisis audits of several cases. The audits results were shared, and further actions taken to raise awareness of this. The subsequent learning has been incorporated into WHH training packages.
SAR F Warrington detailed in 2018/19 report	This SAR was regarding a young lady who took her own life whilst in the care of a local private Mental Health provider, she had been placed out of area and had attended our emergency department on several occasions	The likely actions for the Trust are focused on communication between partner	Following the completion of this review work is underway to ensure the learning from this will be aligned to agencies. Subsequent actions will be monitored at Warrington SAB Serious Adult Review and Learning Group and at Safeguarding Committee. A further task and finish group

		agencies and out of area partners	(of which the lead nurse adult safeguarding is a member) has been set up to review how communication can be improved between agencies.
DHR Warrington	This case was regarding a lady with Autism who had a daughter and who was violently killed by her partner, the domestic abuse had gone un-noticed by all agencies involved in the patients care. Her husband was observed to be an attentive caring person who was supportive towards his family and was seen in a positive light by our Trust in his attendance to support clinic appointments for his wife and daughter. There were no suspicions of domestic abuse. The Trust had a number of contacts with the victim, the last being an extremely difficult cancer fast track situation in which the victim attempted to self-harm and threatened her husband. It transpired that the victim was self-harming at home when her daughter was present. Her husband admitted killing her during his trial sometime later.	All agencies involved were responsible for their own actions via a master action plan. This was monitored via Safeguarding Committee. Actions for the Trust centred on record keeping. It was also identified that staff required training regarding recognising coercive and controlling behaviour.	All actions from this DHR are now completed and closed.
SAR H Warrington	This SAR was regarding a young lady who passed away following an incident whilst she was in the care of a local mental health provider.	The likely actions for the Trust are centred around communication between partner agencies and out of area partners	Following the completion of this review work is under-way to ensure the learning from this will be aligned to agencies. Subsequent actions will be monitored at Warrington SAB Serious Adult Review and Learning Group and at Safeguarding Committee. A further task and finish group (of which the lead nurse adult safeguarding is a member) has been set up to review how communication can be improved between agencies.

5.2 Positive Feedback

It is important to reflect and share the learning from recognised good practice. Some examples of good practice recognised this year are detailed below:

- An external agency expressed thanks to the Safeguarding Team for the quick planning and delivery of a safeguarding birth plan involving a highly complex case.
- "Supervision session was extremely useful and helped me feel supported. I never knew how beneficial and important supervision was. Thank you, Safeguarding Team" Paediatric Staff Nurse.
- Thanks, received by the Safeguarding Adult Team from:
    - A Consultant for supervision, he found this very useful.
    - Emergency dept. for supervisory and targeted training sessions.
    - Local Authority for support with audits and multi-agency training.
    - NHSE/I National LD lead for the work the Trust is doing to improve LD care.
- "Thank you to the Safeguarding Adult Team for the support shown to ITU during the difficult months at the height of the pandemic" from the Lead Nurse.
- NHS England Safeguarding Lead relayed positive feedback following the Spotlight on Safeguarding event.

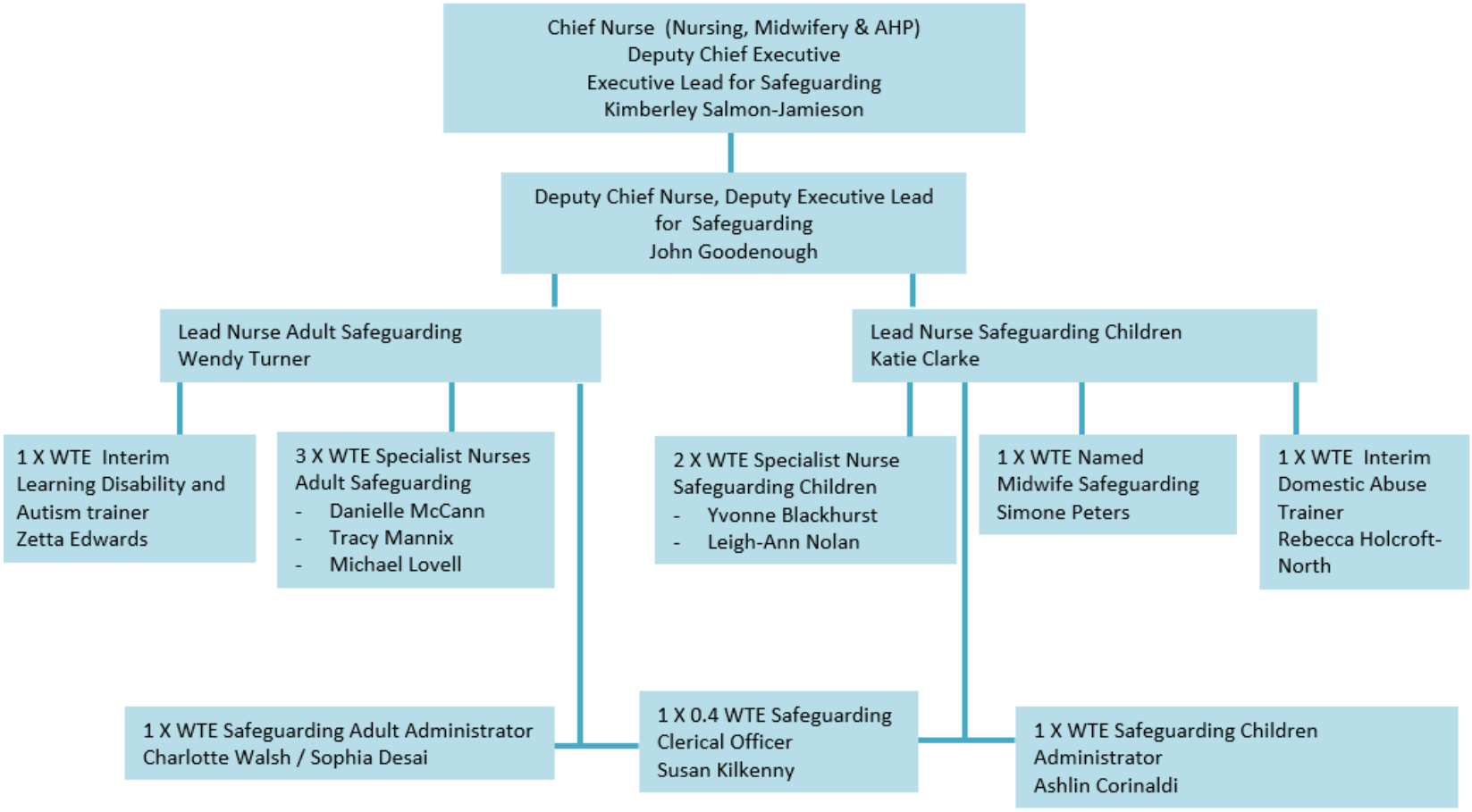
5.3. Internal and Multi-Agency note audits

Multi-Agency notes audits have continued throughout the COVID-19 pandemic on a virtual platform. The focus for the audits included early help, carer crisis and parental mental health. Whilst no immediate actions were identified, learning from the audits are shared and incorporated into the internal training presentations.

6. Safeguarding Team

Figure 6 provides an organogram of the current Safeguarding Team establishment, there is currently a vacancy for the LPS/MCA/Mental Health trainer.

Figure 6



7. Inspections

During the COVID-19 pandemic the Office for Standards in Education, Children's Services and Skills (OFSTED) and Care Quality Commission (CQC) paused the inspection process. There are no outstanding actions from previous inspections to report.

8. Safeguarding Strategy

The Safeguarding Strategy continues to support the direction in which the safeguarding agenda requires focus. The current Safeguarding Strategy (2019-2021) is under review and consideration based upon the newly developing evidence following the impact of the COVID-19 pandemic. The associated work plan will continue to be monitored via Safeguarding Committee.

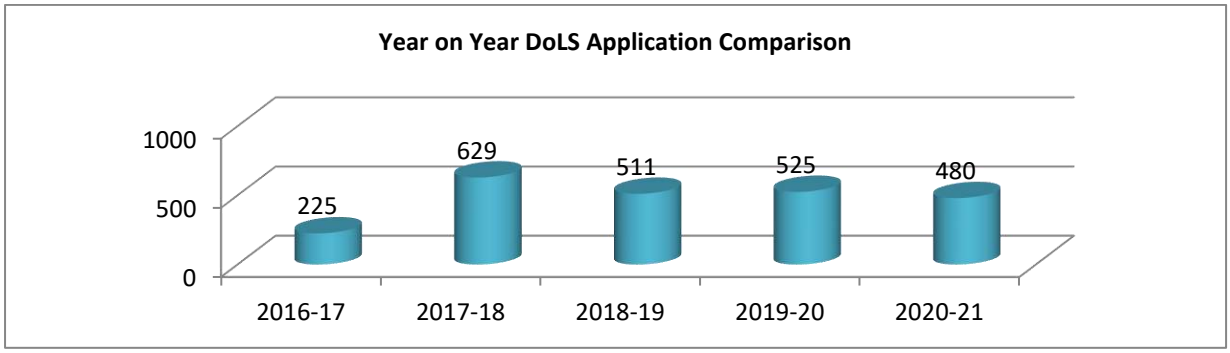
9. Mental Capacity Act (MCA) /Deprivation of Liberty Safeguards (DoLS)

9.1 Mental Capacity Act (MCA)

It is evident from the training compliance detailed earlier in the report that staff are aware of their statutory obligations regarding the Mental Capacity Act. Day to day contact with wards and departments has demonstrated increased knowledge of the MCA and best interest processes.

There has been four Court of Protection Cases during 2020/2021 which equates to a 100% increase on the previous year. In addition to this 480 DoLS applications have been made. The activity associated with this support is significant as each application is recorded and monitored via the DoLS Safeguarding data base with a welfare checks conducted to support the ward with the patients care and DoLS process. Each application is notified to the CQC in line with statutory guidance. The following graph (figure 7) demonstrates the above detail relating to the number of DoLS applied for with comparison to previous years.

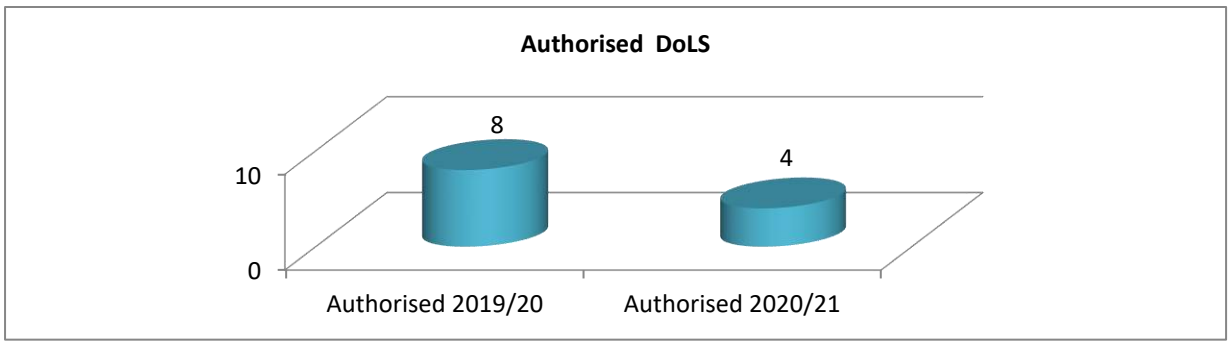
Figure 7



The Local Authority (LA) is the responsible body for authorisation of DoLS applications. During the COVID-19 pandemic a change in how the LA discharged its duties took place following emergency government guidance which meant that LA staff were unable to enter the hospital. Both Warrington and Halton LA's continue to operate with a significant back log of applications, this intensified during the COVID-19

pandemic. This is a national issue and one of the driving factors in the review of the DoLS act which has resulted in the new Liberty Protection Safeguards (LPS). Of the 480 applications described above, 4 were authorised, there were 8 authorisations the previous year, see figure 8.

Figure 8



DoLS applications are electronically completed by wards and emailed to the relevant Local Authority (LA) and the WHH Safeguarding Team. All standard DoLS documents are emailed back from the LA via the Safeguarding Team. Upon receipt of the document the Safeguarding Adult Team discuss the content with the ward letting them know that the conditions and restrictions set out in the document need to be embedded in the patients care plan. Due to the current resources and emergency pandemic guidance being in place the LA continue to risk assess those they receive using a National tool, only applying a standard in the most urgent of cases. However, this is not without challenge as there are patients who are assessed as being amber or green who are not reviewed for a standard DoLS prior to their discharge the pandemic has exacerbated this situation.

Although the responsibility for this is carried by the Local Authority, Trust teams are encouraged to be in contact with the Local Authority to monitor their patients' needs and requirements, communicating changes that may raise the patients risk rating. The number of patients awaiting the review of the Local Authority has increased significantly, this matter has been discussed with the Trust Solicitors ensuring the best possible outcome for our patients.

9.2 Liberty Protection Safeguards (LPS)

Following a period of review, the law underpinning MCA practice is to change. The final parliamentary stage of Liberty Protection Safeguards (LPS) was completed on 24th April 2019, following this completion Liberty Protection Safeguards received royal assent on 16th May 2019 and became Law. This new legislation repeals the Deprivation of Liberty Safeguards contained within the Mental Capacity Act (2005) [MCA].

The review of the current system of Deprivation of Liberty Safeguards (DoLS) happened because it was felt that the system needed to change and move away from the DoLS process. This change makes healthcare providers responsible bodies as well as the CCG; the Local Authority will also remain a responsible body. This will mean WHH will be responsible for authorising, monitoring and renewing their own DoLS, the law makers felt that by introducing a simpler process that also involves families would create faster access to assessments.

LPS establishes a process for authorising arrangements and enabling care and treatment which result in a Deprivation of Liberty, within the meaning of article 5 (1) of the European Convention on Human Rights

(ECHR), where a person lacks capacity to consent to the arrangements in place. The Government is currently working on a Code of Practice and regulations to support the use of this legislation. This was expected by the end of 2019 however this has been delayed to April 2022. Once in place the Code of Practice will lay out details of the process required and what roles should be in place to facilitate this new act of law.

WHH is represented at meetings with partners across Cheshire and Merseyside to review how the new law can be effectively implemented.

10. Female Genital Mutilation

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003 ("the 2003 Act"). It is a form of child abuse and violence against women. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons. The duty to mandatory report all FGM cases in under 18 years old came into effect in October 2015.

WHH continue to support identified survivors of FGM and consider the safeguarding for family members. The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is submitted on a quarterly basis. The dataset supports the Department of Health's FGM Prevention Programme by presenting a National picture of the prevalence of FGM in England.

Female Genital Mutilation - April 2019 to March 2020 Annual Report identified there were 6,590 individual women and girls who had an attendance where FGM was identified. These accounted for 11,895 total attendances reported at NHS trusts and GP practices where FGM was identified. Nationally the number of total attendances during 2019-20 has remained broadly stable, although the number of distinct individuals has reduced in the last quarter of the year. Within this annual report period, four survivors of FGM have been identified via WHH midwifery services. This has increased from two the previous year. The appropriate pathways were followed, and relevant agencies notified to ensure the safety of the unborn and any siblings were assessed.

11. Domestic Abuse

The UK's largest domestic abuse charity, Refuge, has reported a 700% increase in calls to its helpline in a single day, while a separate helpline for perpetrators of domestic abuse seeking help to change their behaviour received 25% more calls after the start of the COVID-19 lockdown. For many people, home is not a place of safety. It's more important than ever that help continues to be available to adults and children living with abuse.

In comparison to the previous year the number of referrals has reduced by 3 (See figure 9). During lockdown the number of people accessing services was reduced and therefore this would account for the very slight reduction in referrals. It should be noted that the number of referrals between March 2020 and July 2021 (1st National lockdown) were similar to the previous year and so whilst there was a reduction in footfall to the hospital, domestic abuse referrals remained the same. This would indicate that there had been an increase locally, however many victims were not accessing services to be identified and referred for support. Based on national data that is emerging, 2021/2022 referral numbers are expected to increase significantly.

Key statistics for WHH include:

- 213 domestic abuse cases identified.
- 16% victims were identified as men. This is a significant increase from the 10% identified the previous year.
- 53% of cases referred had children / unborns in the family.
- 46% cases were referred on to the appropriate MARAC (Multi -Agency Risk Assessment Conference).

In response to the recruitment of a domestic abuse trainer, the role of the hospital IDVA has been amended to provide a more focussed approach to supporting patients and staff victims ensuring clear safety plans are in place.

Figure 9a

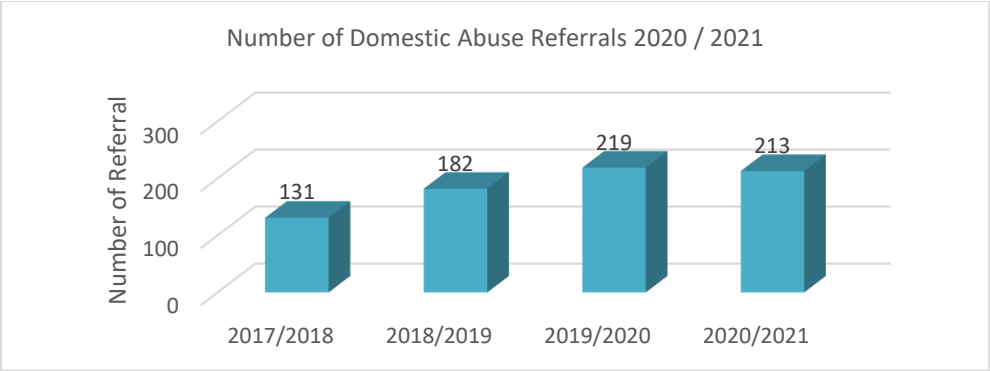
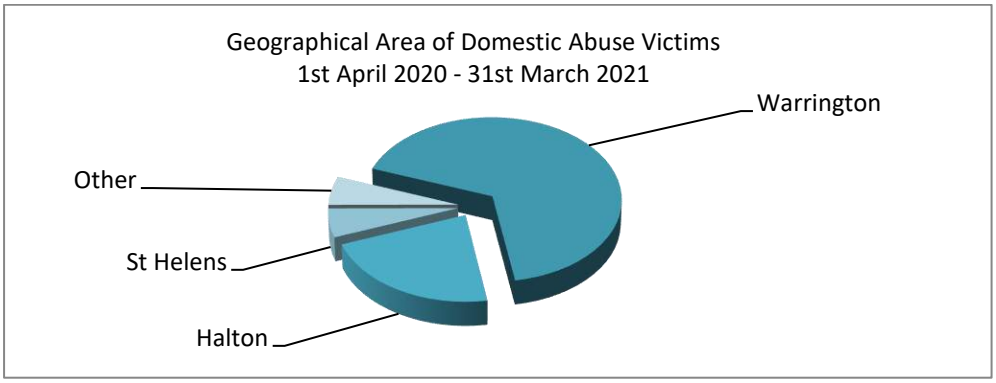


Figure 9b



12. Mental Health

12.1 Children's Mental Health

There are increasing calls to understand the impacts of National lockdown and school closures, on the mental health and wellbeing of children and young people during the COVID-19 pandemic. As lockdown measures begin to ease, it is important to understand what children and young people have been experiencing during the lockdown as well as how they can be best supported to resume to normal life over the coming months and years. For children and adolescents with mental health needs, such closures meant a lack of access to the resources they usually have through schools. In a survey by the mental health charity Young Minds, which included 2111 participants up to age 25 years with a mental illness history in the UK, 83% said the COVID-19 pandemic had made their conditions worse, 26% said they were unable to access

mental health support; peer support groups and face-to-face services have been cancelled, and support by phone or online can be challenging for some young people.

As lockdown restrictions were eased, it was recognised that the number of children and young people with complex mental ill health requiring hospital admissions was increasing. In collaboration with Warrington Clinical Commission Group (CCG), Warrington Local Authority and North West Boroughs the support available to young people was explored with it being recognised that therapeutic work at the earliest opportunity was a priority. Coordinated discharge planning was an additional priority which is to be explored further.

12.2 Adult Mental Health

The adverse effect on the mental health of people being locked down and asked to stay at home quickly became apparent. In the early lock downs of the COVID-19 pandemic mental health services, nationally, were instructed to implement a 24-hour crisis line so that people had access 24/7 to mental health support. This provided support at times of extreme stress, with a focus on suicide prevention.

Following the COVID-19 pandemic an increase in the number of patients requiring admission for physical issues associated to mental health issues has been noted with people requiring treatment for self-harm and overdose. Notably there were very few patient attendances from private partner agencies during the months of the COVID-19 pandemic. As restrictions have eased attendances have increased with some patients requiring prolonged periods of stay. Work has taken place since the last annual report to improve communication with private partners to prevent a delay in the sharing of information. This is important in improving patient care as lack of communication and its adverse effects has been cited in previous SAR reports as an area of focus. Work has also taken place to ensure a greater understanding of the restrictive practices sometimes required to support patient care in secure settings and how that care is transferred to patients when they are being cared for by WHH.

13. Mortality Review

The monthly Trust Mortality Review Group (MRG) has safeguarding representation to facilitate safeguarding oversight of the cases reviewed, with the Safeguarding Team providing further in-depth reviews where necessary. All patients who have passed away in the Trust who have a Learning Disability are also reviewed here using the Standard Judgement Review (SJR) process. All patients who have passed away whilst under a DoLS are also reviewed.

In order to link the Learning Disability Mortality Review (LeDeR) and SJR process, the SJR is shared with the monthly LeDeR review panel so that the patients care and treatment, in line with the national LeDeR process, can be reviewed. The panel is multi-agency and chaired by the CCG, WHH is represented at the panel, with any learning from the reviews shared with MRG and disseminated throughout WHH. To date the panel has not asked for any of the patients' cases to be further reviewed by MRG. Child death cases are presented quarterly.

14. Learning Disability (LD)

WHH participates in the annual National Improvement Standards LD audits and has submitted the third audit this year. In order to progress the extensive action plan associated to the audit and the wider LD agenda, an LD Steering Group has been formed. Progress of this work is also reported via the Warrington LD board of which WHH has representation.

The introduction of the inpatient and outpatient LD flagging system has supported the care of patients with an LD diagnosis and enabled reasonable adjustments to be considered ahead of appointments. The increased awareness of the needs of patients with an LD has created more enquiries and requests for assistance by staff from the Safeguarding Team. Clinicians are proactively enlisting the support of the Safeguarding Team in ensuring that planned admissions and appointments support the needs of patients with an LD diagnosis. Best interest processes are better understood and have become more frequent in the outpatient setting. The Safeguarding Team have supported several planned admissions and have been involved in supporting ward and department teams with complex patient care needs. The Safeguarding Team upload passports and care management plans into the Lorenzo record enabling staff to have information at hand as soon as their patient arrives on wards and departments. The LD Community Teams contact the Safeguarding Team when they know one of their patients are en route as an emergency enabling the safeguarding staff to contact the emergency department so that preparations can be made for the patients' arrival.

Improvement in care planning and accommodation of reasonable adjustments is evident, with continual review methods in place to ensure consistent improvements are made. The Learning Disability /Autism Practice Development Nurse offers expert advice and support to WHH staff regarding this area of their practice. Ward teams have welcomed the guidance supported by a tool provided to support with accommodating patients with an LD and in completing a welfare check on their behalf. Senior leads are prompted by twice daily emails alerting them of the location of patients in their areas. An LD training program began post March 2017 and was delivered by the safeguarding team, however following the appointment of the Learning Disability /Autism Practice Development Nurse training has improved and increased in frequency with level 1 and 2 LD and Autism training now in place with level 3 to follow in the summer. The Trust and the Safeguarding Team have worked closely with community partners in improving the care of patients with an LD and in supporting reasonable adjustments. Community partners have supported several planned admissions, complex discharges and vaccination access for patients with LD who needed extensive reasonable adjustments, they have been involved in supporting Ward and department teams with complex care needs.

15. Prevent

Responsibilities under the Home Office Prevent Strategy were placed on a statutory footing from July 2015 with the introduction of the Counter Terrorism and Security Act 2015. Following a change announced in 2019 Prevent training is no longer reported via the Home Office and prevent trainers are no longer required to register with the Home Office. Instead, prevent activity and compliance is reported quarterly via NHS digital.

In line with National guidance, WHH has a prevent lead who attends regional prevent meetings ensuring that important information and learning is shared via Safeguarding Committee. Following the increase in terror activity in 2017 the Home Office instructed all Trusts of a requirement to achieve 85% training compliance with 3 yearly updates. WHH are currently above the required training target.

A new arrangement across the Cheshire footprint has been implemented with partners from across Cheshire and Merseyside joining forces to share information and review radicalisation issues. The role of the Pan-Cheshire channel panel is under review with a focus on the policies, training and scrutiny processes. WHH is represented at the Pan-Cheshire Channel panel and relevant information for sharing is disseminated via Safeguarding Committee. WHH assurance data is reported on a quarterly basis in line with the statutory requirements.

16. Allegations against staff

All allegations of abuse of children by those who work with children must be taken seriously. Allegations against any person, who works with children, whether in a paid or unpaid capacity, cover a wide range of circumstances.

This procedure should be applied when there is such an allegation or concern that a person who works with children, has:

- Behaved in a way that has harmed a child or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

All allegations of abuse of adults by staff who are caring for patients using our services are taken seriously. Allegations against WHH staff, agency staff and those who come to our attention who work in other agencies are supported using WHH policy and the national PiPoT guidance.

There remains one open case requiring the support of the Local Authority Designated Officer (LADO).

17. Child Death

Working Together to Safeguard Children 2018 Chapter 5 sets the functions and processes of the Child Death Overview Panel (CDOP), which includes the collection and collation of data following the death of a child and subsequent recommendations following data analysis. This is an essential process for the CDOP, as the information gathered is used to safeguard and promote the welfare of children and for strategic planning purposes to support effective service delivery.

The Sudden Unexpected Death in Childhood (SUDIC) proforma & guidelines was updated in 2019. This guidance provides a framework for the investigation and care of families after an unexpected death of an infant or child. 2020/2021 data demonstrates an increase in the number of child deaths. All child deaths are reviewed by the Child Death overview Panel (CDOP). CDOP produce an annual report which providing information detailing themes, trends and lessons to be learned. Due to confidentially and ongoing investigations / meetings the causes of deaths cannot be documented within this annual report. Bereavement support is offered to the family and the staff involved in any child death incident. Following

relevant multi-agency meetings, feedback and learning is presented internally to the Mortality Review Group. Figure 10 demonstrates the number cases which have required WHH input.

Figure 10

	2017/2018	2018/2019	2019/2020	2020/2021
Number of deaths pronounced at WHH	5	15	3	8
Total number of child deaths requiring further information sharing / input from WHH	12	22	19	24

18. Child Protection – In-Patient

The hospital safeguarding children concerns form was introduced in 2002/3 to ensure compliance with the National standards and to give a measure of performance against the Laming recommendations. The 'Concerns form' is used in the Trust to highlight safeguarding children concerns. The number of concerns form commenced remains static at 400. As shown in the graph below (Figure 11) under 1s continue to be the most vulnerable group of patients with 25% of concerns forms commenced for this age group. Similar to the previous year's data the adolescents are highlighted as the second most vulnerable. This would correlate with the National picture that is emerging. The 2020's 'National Society for the Prevention of Cruelty to Children (NSPCC) How safe are our children' focussed on long-term trends in adolescents whilst also looking at the impact of the COVID-19 pandemic. Indicators show that adolescence is a time of heightened risk of some forms of harm and emerging evidence suggests the COVID-19 pandemic has exacerbated the risk. In response to this there has been increased training to focus on contextual safeguarding.

Figure 12 provides an overview of the categories of concern. In 2020/2021 the data collection criteria were reviewed and updated to ensure the mental health concerns were captured as a separate category. Several patients identify under more than one category. For example, children who cause harm to themselves could also be known to children's social care.

Figure 11

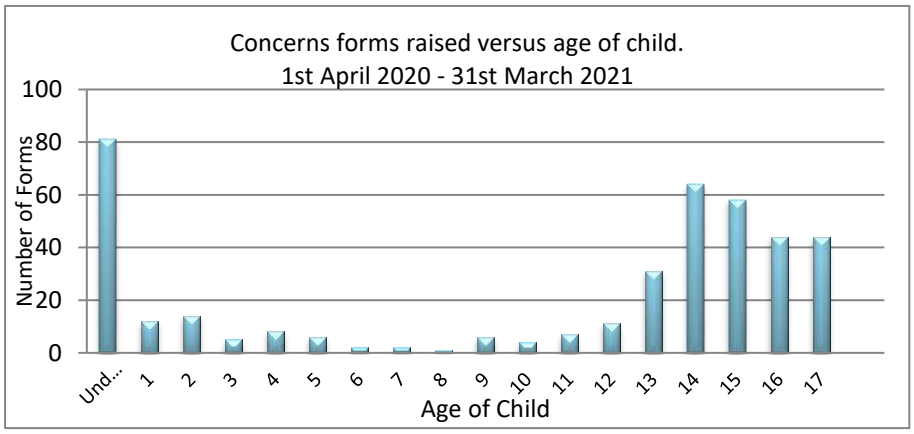
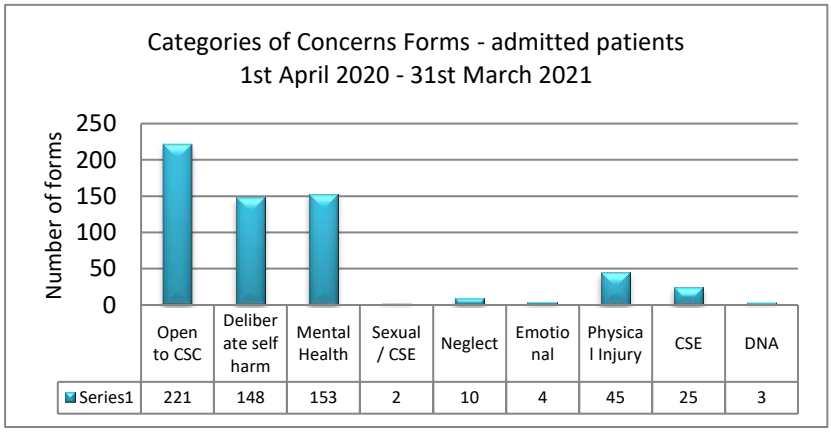


Figure 12



18.1 Child Protection Medicals

A child protection medical (CPM) assessment should always be considered when there is a suspicion of, or a disclosure of, child abuse and/or neglect involving injury, suspected sexual abuse or serious neglect. The need to consider a medical assessment in these cases arises from section 47 of the Children Act 1989 (and 2004) which places a statutory duty on the Local Authority to make enquiries to enable it to decide whether it should take action to safeguard and promote the welfare of a child. A total of 35 child protection medicals were completed during the reporting period which is a significant decrease from the previous year. This was expected for two reasons; due to the National lockdown and reduced visibility of children meaning medicals were not requested and due to the contract to complete all Halton child protection medicals concluding. It should be noted however that despite the contract for Halton medicals being with another service, 43% of the medicals completed at WHH were with children based in the Halton area.

Figure 13 provides the detail regarding the geographical areas of the children who attended for a child protection medical. Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014, (Brandon et al 2016) identified that “Infancy remains the period of highest risk for serious and fatal child maltreatment; there is a particular risk of fatality for both boys and girls during infancy” This is demonstrated within the activity seen in figure 14.

Figure 13

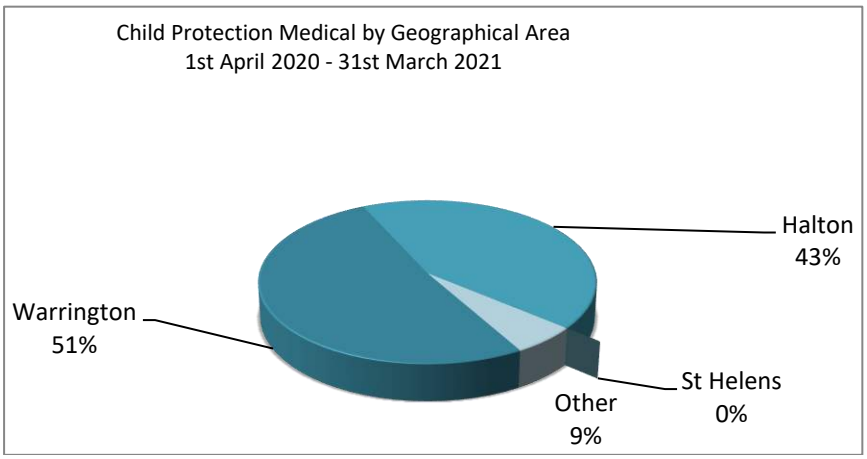
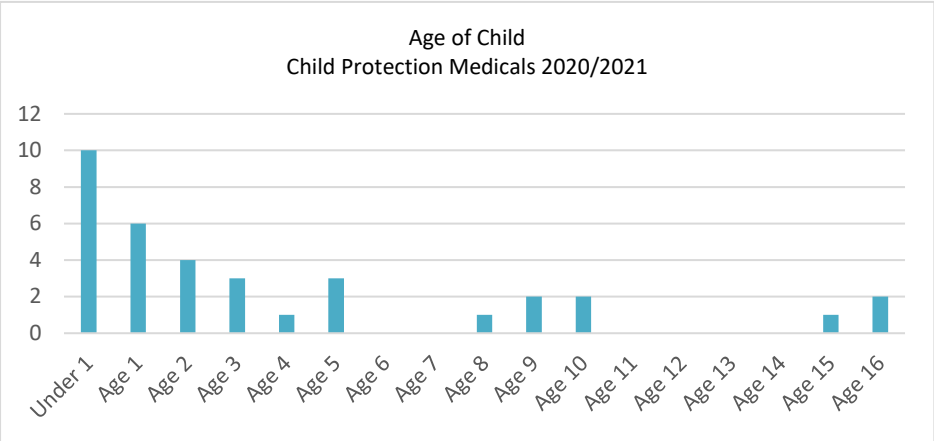


Figure 14



18.2 Peer Review

Peer review is the evaluation of work or performance by colleagues in the same field in order to maintain or enhance the quality of the work or performance in that field. The word peer is often defined as a person of equal standing. However, in the context of peer review, it is generally used in a broader sense to refer to people in the same profession who are of the same or higher ranking.

It is a core competency for all clinical staff working with children to undertake regularly documented reviews of practice, including peer review. It is a component of the Clinical Governance Framework and is expected by the judiciary, GMC and professional bodies. 89 cases were discussed as part of the peer review process with attendance from medical staff being consistent; this is an increase of 49 on last year's figures.

In 2018 Cheshire Police, Warrington and Halton Children's social care and Bridgewater NHS Trust were invited to join the peer review process. This has provided an opportunity to share learning and further develop and strengthen working relationships.

19. Safeguarding in Midwifery

Safeguarding within midwifery is constantly changing and becoming more complex. Research and experience indicate that very young babies are extremely vulnerable to abuse and that work carried out in the ante-natal period to assess risk and to plan intervention will help to minimise harm. For the second consecutive year there has been a slight decrease in the number of women with identified vulnerabilities who are being supporting through their pregnancy as detailed in figure 15. The Safeguarding Children Team provide a robust channel of communication with external partners and ensure that patient records and care plans are up to date in readiness for delivery of the baby. The data below in figure 16 provides detailed information regarding the number of special circumstance forms comments and from which geographical area the patients are from. 30% of women commenced on special circumstance forms live out of the area.

Figure 15

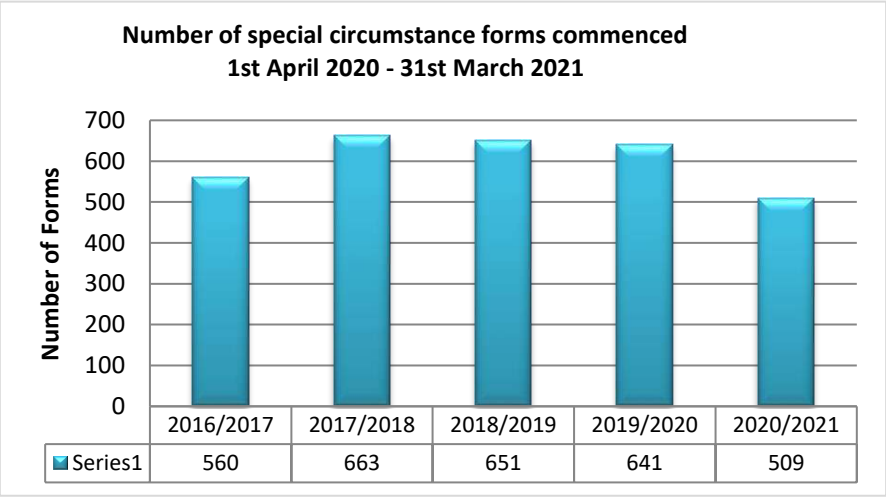


Figure 16

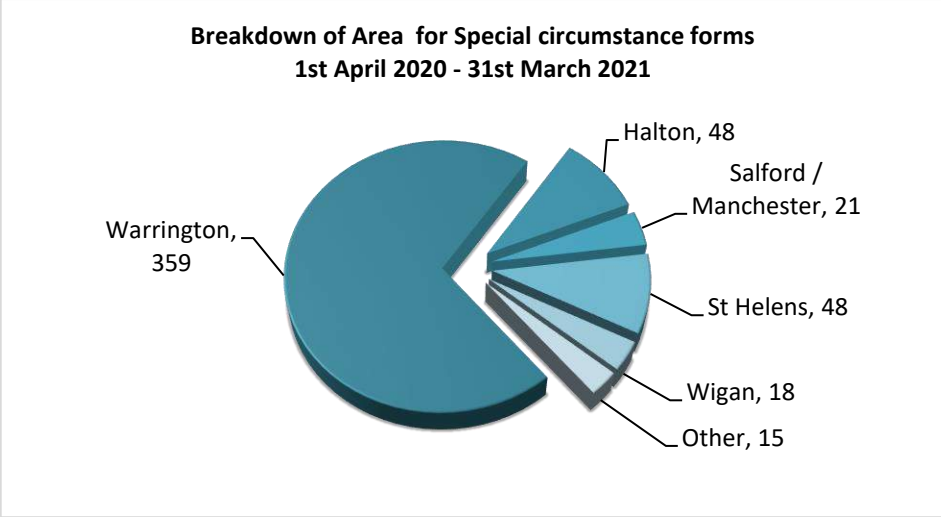
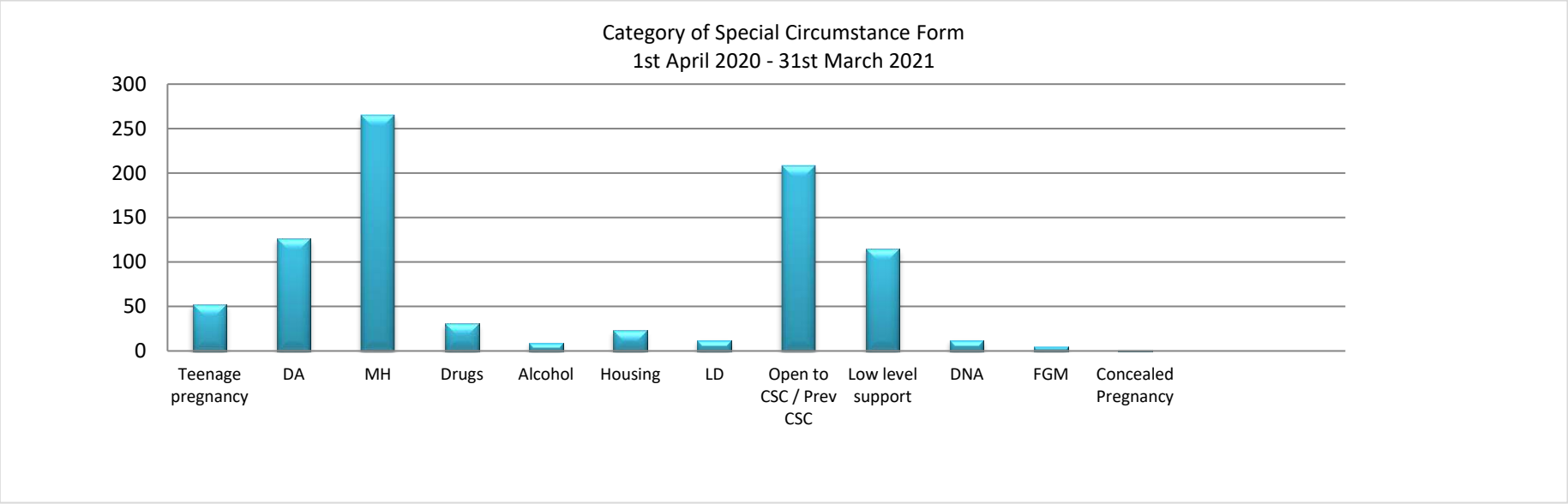


Figure 17 provides a detailed breakdown of the category of concerns raised. Consistent with the previous year's data mental health continues to be the most prevalent reason for concern (52%). The perinatal period, as defined in relation to mental illness, spans the time of conception to when the infant reaches the age of one. Perinatal mental illness is relatively common. The Royal College of Obstetricians and Gynaecologist conducted a survey which showed that 81% of women surveyed had experienced at least one perinatal mental health condition during or after their pregnancy. Low mood was experienced by over two-thirds of the women, anxiety by around half and depression by just over one-third. The severity of the condition will vary from individual to individual and may have some serious consequences if not identified and managed early and effectively. It is positive that so many women have been identified during the antenatal / postnatal period.

In 2019 the safeguarding documenting process within midwifery was reviewed and further developed. The new process is well now established and a reduction in DATIX incidents reported regarding missing safeguarding information has been noted.

Figure 17



20. Incident Reporting

20.1 Safeguarding Children Reported Incidents

DATIX incidents are responded to in a timely manner in collaboration with the appropriate Clinical Business Unit (CBU). 54 incidents were reported under the category of safeguarding children, this is a 10% increase on the previous year. Figure 18 provides an overview of the trends recognised and what actions have been taken to address the issues.

Figure 18

Concerns Raised	Actions taken to address
Information sharing with community services requires improvement.	Safeguarding Committee members asked to reiterate the importance of information sharing and ensure front line practitioners are confident in the processes required to be followed. WHH Safeguarding Team working closely with those departments above to establish what support is required to address the concerns raised. Recommendation for committee to consider: to consider the role of a Paediatric Liaison Nurse within WHH.
Missed opportunities within midwifery to identify and respond timely to early help and safeguarding concerns.	• Identified themes and trends have been escalated to senior midwifery team for review and consideration. • Safeguarding Team to provide virtual drop-in sessions / Facebook question and answer session to explore what the current difficulties are and ways in which midwives feel they need further support and guidance. Midwifery developed an action plan to address the concerns raised.
Early help referral process not fully utilised across WHH	• A condensed referral form has been developed with Warrington's Early Help Team. The pathway and guidance is provided within the referral form. • Identified person within the Warrington Early Help team has offered to provide further education and support. Sessions to be arranged. • Regular feedback to practitioners who refer cases to safeguarding providing education and support. • 7-minute briefing to be developed with the early help team and circulated trust wide. Number of early help referrals to be reported through safeguarding committee.
Timeliness of responding to identified safeguarding concerns requires improvement.	• Immediate action was taken in all cases to ensure the child, young person or adult at risk were safeguarded. Feedback provided to the practitioner and their manager highlighting expected practice.

20.2 Adult Safeguarding Reported Incidents

The Safeguarding Adult Team receives notifications for all incidents that have a safeguarding element to them. 90 incidents have been reviewed in the reporting year, this in an increase of 80%. The graph and table below provide an overview of themes and trends (Figure 19 and 20).

Figure 19

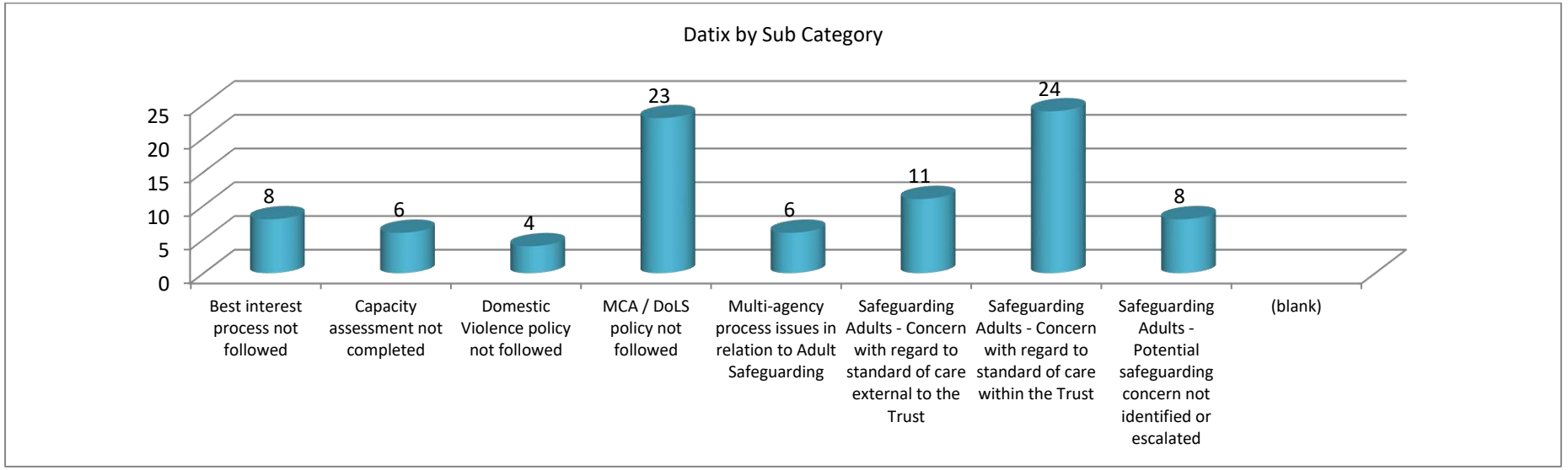


Figure 20

Main Issues / trends	Action taken from Safeguarding Adult Team
Domestic Abuse policy/hospital pathway not followed	4 of the 90 incidents reported were in this category, in all cases the patients were appropriately safeguarded, and the correct agencies were informed. Targeted training has been offered to support the staff involved
MCA/DoLS policy, capacity assessment not completed, best interest process not followed	In all 37 of the 90 incidents reported were in these three categories, in all cases the patients were appropriately safeguarded, and the correct process instigated regarding DoLS and MCA the relevant agencies were informed. Targeted training has been offered to support the staff involved and continued audit monitors this practice across the Trust. All MCA/DoLS activity is reported via Safeguarding Committee.
Potential safeguarding concern regarding the standard of care from another health provider	11 of the 90 incidents reported fall into this category. This category describes concerns raised about other health provider. If patients are admitted to us with skin damage or with concerns about any aspect of their care. In such cases the Safeguarding Adult Team and local authority work together to review the concern
Potential safeguarding concern regarding the standard of care from an area at the Trust	24 of the 90 incidents reported where in this category. This will include incidents regarding skin damage and complaints about care. Where required a 72-hr review is held, all concerns are reviewed by the Safeguarding Team and the CBU leads.

Multi-agency process issues in relation to adult safeguarding	6 of the 90 incidents reported where in this category. Where situations such as this arise, agencies will review the case and address any shortfall, lessons learnt are shared between all partners, WHH discusses at Safeguarding Committee. There has been one learning event January 2020 following such a case, however there were no actions for WHH.
Safeguarding adults potential safeguarding concern not identified or escalated	8 of the 90 incidents reported where in this category. Incidents have been raised following audit and incidental findings; these have been retrospectively reviewed. None of the incidents resulted in patient harm and awareness of near misses has been discussed at Safeguarding Committee.

21. Policy Development

Safeguarding and associated policies are key documents that helps staff understand what they need to know in order to keep patients safe. Policies are reviewed and updated as required and as new legislation dictates. During 2020/2021 the following policies have been reviewed and ratified:

- Surrogacy
- Chaperone
- Domestic Abuse – Supporting our staff

22. Achievements

Throughout the annual report there are areas of good work and positive achievements. In addition to those areas it is important to recognise additional work that has taken place.

22.1 Spotlight on Safeguarding – August 2020

In August 2020 the Safeguarding Team ran a programme of live learning sessions using MS Teams Live and the daily Hot Topic in the Trust wide Safety Huddle. The objective was to raise awareness among all staff of all elements of safeguarding, their own responsibilities and further learning for front line staff across all staff groups. The event was welcomed by partner agencies in Warrington and Halton boroughs and at National level with NHS England Safeguarding Team being involved.

In addition to resources being circulated, eleven teaching sessions were held live, which were recorded and uploaded to the Trust's YouTube channel. Externally, the MS Team Live events were shared with the following organisations (those shaded contacted WHH via twitter to ask for the programme) to share with their staff the event was also advertised via the WHH Twitter account: @WHHNHS

Warrington Borough Council	NHS Safeguarding	Morecambe Bay CCG	St Helens and Knowsley Hospitals NHS Foundation Trust	Sefton CVS
Halton Borough Council	NHS England and Improvement	Newcastle Gateshead CCG	Knowsley CCG	Rotherham NHS Foundation Trust
Warrington CCG	Newcastle Gateshead CCG	Garland Training	Greater Manchester West Mental Health NHS Foundation Trust	Midlands and Lancashire Commissioning Support Unit
Halton CCG	Cheshire Police	Penketh High School	Home Start Warrington	St Rocco's Hospice
North West Boroughs NHS Healthcare Trust	Bridgewater Community Healthcare Trust	Virgin Care	Lancashire and South Cumbria NHS Foundation Trust	Wirral Council

Training and supporting resources were delivered by WHH staff, Warrington Local Authority and the ICON Founder. Spotlight on safeguarding focused on key elements of safeguarding which included:

- Domestic Abuse and the impact of COIVD-19
- MCA/DoLS
- The impact of COVID-19 on Children
- ICON – Babies cry, you can cope
- Fabricated Induced Illness (F.I.I)
- Adult Mental Health
- Female Genital Mutilation – a multi-agency approach
- Child Exploitation and the impact of COVID-19
- Effect on people in lock down (carer breakdown)
- The impact of COVID-19 on Safeguarding
- Think Family

"Great effort from WHH – really appreciate it!"

Margaret Macklin, Head of Adult Safeguarding, Warrington Borough Council

"What a slick team you are! Many thanks for supporting me through that. You have all been brilliant."

Dr Suzanne Smith, ICON

"Thank you for inviting me to take part and for the support throughout the presentation. It has been a really good programme and one you should be proud of!"

Elaine Bentley, Head of Service for Early Help, Warrington Borough Council

22.2 ICON Week March 2021

Since the launch in 2019, the Pan-Cheshire ICON Partnership has gone from strength to strength ensuring that the ICON message is delivered routinely within midwifery and post-natal health care. ICON is well established across midwifery and health visiting services and so it was recognised that ICON needed to be reaching further with partner agencies. To support this increase in activity and to raise further awareness the Pan-Cheshire ICON Partnership held an ICON Week which proved to be a success.

The week which commenced 15th March 2021 involved daily lunch time webinars which focused on ICON and how as professionals we can embed this in our practice. Each day focused on a different element of the ICON message and was delivered by professionals across the Pan-Cheshire footprint. The resources and short video clips available via the ICON website were utilised and promoted throughout the webinars and received a positive response. 125 people accessed the live webinars and additional requests have been received in relation to accessing the recorded webinars. All presentations and resources are available to view via Warrington Hospital ICON websites https://WHH.nhs.uk/about-us/abusive-head-traumaicon-toolkit/resources/icon-week

Overall, the week was a success and the Pan-Cheshire ICON Partnership are already planning for a 2022 event.

22.3 Safeguarding Team Development

- Safeguarding Lead Nurses completed Bond Solons Clinical Leadership in Safeguarding training.
- 5 members of WHH staff trained by the NSPCC in Safeguarding Supervision.
- 2 members of WHH staff trained by Bond Salon in Safeguarding Supervision.
- Three members of WHH staff attended LPS conference.
- Two members WHH staff attended Safeguarding Resilience training.

22.4 Saville Training

WHH commissioned Ray Galloway, a former police officer who led the investigation into the Saville events, to present the learning from the investigation. In total 5 sessions were delivered to staff across the trust. The one-day safeguarding training course exposed the myths around Savile and reveals the vital lessons that can be learnt from how he operated, how he cultivated influence and how he was able to go undetected for over five decades. The training events were fully booked and received exceptional feedback.

23. Assurance Statement

Whilst this Annual Report provides many examples of the positive and inspiring progress made in 2020/2021, it is important to prepare for the challenges ahead. Partnership working will continue to raise awareness and find solutions to tackling emergent and persistent safeguarding issues for health such as self-neglect and child exploitation. Work to embed the Mental Capacity Act/Deprivation of Liberty Safeguards into practice will continue, as will promoting a culture of 'Making Safeguarding Personal' and 'Think Family'.

24. Key Objectives for 2021/2022

COVID-19 is having a detrimental impact on the safety and lives of both adults and children. As previously explored within the report this has raised concerns both Nationally and locally with safeguarding and domestic abuse increasing significantly for adults and children. In acknowledging the work that has already taken place the safeguarding of children, young people and adults with care and support needs from abuse and neglect remains a priority and work will continue to keep the systemic safety nets in place whilst implementing recovery plans.

Work will focus on the delivery of the seven key priority outcomes aligned to the current Safeguarding Strategy which is currently under review. The strategy will consider the impact that the COVID-19 pandemic has had on the safeguarding agenda ensuring that emerging safeguarding themes and trends are incorporated. Safeguarding findings from research is continually being reviewed and therefore the workplan aligned to the strategy is likely to be developed and updated throughout.

Safeguarding Children and Safeguarding Adults Annual Report 2020 - 2021

Report written by:

John Goodenough, Deputy Chief Nurse and Head of Safeguarding

Contributions from:

Wendy Turner, Lead Named Nurse Safeguarding Adults

Katie Clarke, Lead Named Nurse Safeguarding Children

1. Introduction

Safeguarding is a Care Quality Commission (CQC) standard and a duty at the centre of our daily business. The scope of safeguarding is wide reaching and incorporates all categories of abuse. This is the third joint Annual Report regarding adult and children's safeguarding within Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH).

This report gives assurance to WHH Trust Board, the Local Safeguarding Adults Board (LSAB) the Safeguarding Children Partnerships and Warrington Clinical Commissioning Group (CCG) that the Trust is meeting its obligations to safeguard adults and children and is meeting the statutory and legal obligations to keep patients, service users and staff safe from harm and abuse.

The Safeguarding of Children, Young People and Vulnerable Adults' in the NHS, Accountability and Assurance Framework (updated 2019) sets out the safeguarding roles, duties and responsibilities of all NHS organisations and is integral to the safeguarding agenda making clear that safeguarding is everyone's business and responsibility.

Aiming to be proactive in fulfilling its safeguarding function, effective safeguarding requires robust recruitment and screening processes for staff. By working collaboratively, with Safeguarding Boards and Safeguarding Partnerships, guidelines are developed to support the national and local safeguarding agenda. Assurance of adult and children's safeguarding activity and practice are reported via the Safeguarding Committee to the Trust Quality Assurance Committee (QAC), a subcommittee of the Trust Board.

The 2019/2020 annual report reflected on the year that had passed and set out aims and objectives to be delivered in 2020/2021. However, the publication coincided with the COVID-19 g pandemic and nationally the NHS rapidly reviewed the needs and requirements of its service delivery, Safeguarding was no exception. Nationally people were told to stay at home and community services were forced to alter how they delivered their support. At that time the full impact of the pandemic was not known; preparations and contingencies were put into place to increase and strengthen provisions. This was in readiness for the expected surge in safeguarding activity that would arise from the effect of national lockdowns as victims were at home with their abusers and people had significantly reduced, or no access to their normal support networks. Although the full impact was not known, it was clear that the main areas of focus would be Mental Health, Domestic Abuse and Self-Neglect. The Executive Safeguarding Lead at WHH quickly ensured a review of the Safeguarding Team establishment took place, which resulted in increasing the team by two whole time equivalent (WTE) band 7 specialist nurses, with a later addition of two band 7 WTE (temporary) dedicated training posts.

1.1 Executive Summary

The main activities of the Safeguarding Team at WHH can be found detailed below. Further information relating to these activities are expanded on in greater detail throughout the content of this report.

- Spotlight on safeguarding to promote the importance of safeguarding during the COVID-19 pandemic.
- As expected, activity continued to increase across all areas of safeguarding in line with the national picture post COVID-19 lockdowns.
- Safeguarding training remained a priority and has continued throughout the year. Delivery of training via virtual platforms such as Microsoft Team's has enabled this.
- Multi-agency case reviews continue to be supported in line with National Safeguarding Policy.
- WHH have supported with an increased number of fabricated Induced Illness cases as per the previous year.
- Audit has led to improved safeguarding processes to support staff in their practice.
- Amended policies, documents and pathways have improved staff safeguarding practice.
- Assurance is provided via monthly and quarterly reporting to Safeguarding Committee, Quality Assurance Committee, Safeguarding Partnerships and Safeguarding Adult Board, Clinical Commissioning Group (CCG) and NHS England.
- WHH have continued to lead the ICON programme across the Cheshire footprint.
- Safeguarding, Mental Health (MH) and Learning Disability (LD) Strategies and associated workplans continue to be monitored.
- The National LD Improvements Standards benchmarking audit workstreams continue to be monitored via the newly formed LD steering group.

1.2 Reflection of 2020 / 2021 Focus

It is too early to understand the full effects of the COVID-19 pandemic on the safety of children, young people and adults as the far-reaching effects of the virus are unknown. Data provided by the National Society for the Prevention of Cruelty to Children (NSPCC), How Safe are our Children Report 2020, describes a worrying picture. Many of the risk factors associated with abuse and neglect have been exacerbated throughout the COVID-19 pandemic, while the support services that would traditionally identify and respond to these concerns have been unable to see many of the children and families they work with face-to-face.

Lockdown prevented families and friends from meeting and care homes and hospitals closed to visitors. Normal service provision changed causing people to struggle with access to their usual support, people living alone became increasingly isolated. There are increasing concerns about the child protection system's ability to cope with a potential influx of newly identified concerns and therefore a proactive response is required in recognising any trends and/or themes ensuring timely appropriate escalation. In addition to the previously highlighted areas of concerns slavery and trafficking have continued to rise.

2. Update on Objectives Set for 2020 - 2021

The Trust's objectives for 2020-2021 were to deliver its safeguarding duties effectively based on the delivery of seven key priority outcomes that were aligned to the shared priorities detailed below (Figure 1). The 2019-2021 Safeguarding Strategy demonstrates how each of these priorities will be addressed. The associated Safeguarding Strategy work plan is reviewed and updated on a monthly basis with progress reported via the Trust Safeguarding Committee into the Trust Quality Assurance Committee. Each objective is explored further within the report with supporting evidence embedded throughout. All priorities are on target for completion in 2021.

Figure 1

No.	Priorities	Target Date	Current position
1	Domestic Abuse 1. To raise awareness to enable staff to identify domestic abuse and what their responsibilities are. 2. To ensure information and learning about coercive and controlling behaviour, that was acquired during a Domestic Homicide Review (DHR) that commenced after a lady was murdered in 2018, is shared via training and supervisory discussion. To support our Occupational Health and HR departments where domestic abuse victims/perpetrator involved Trust staff.	Feb 2021 Feb 2021	Completed
2	Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS) / Liberty Protection Safeguards (LPS) 1. To continue to train staff regarding their MCA and DoLS responsibilities in order to enable good practice. 2. To plan and monitor training regarding the new LPS process. 3. To work towards roll out of LPS.	April 2022 – The implementation date was amended as a result of the COVID-19 pandemic	Awaiting government guidance for the code of practice and regulations that will determine the LPS process, the documentation to be used and the required training package. Recruitment of the staff for the posts cannot commence without the direction of the documents above.
3	Child Sexual Exploitation (CSE) 1. To raise awareness through masterclass training. 2. To help staff to understand all elements of CSE including the criminal aspects of this abuse. 3. To support staff in recognising and reporting this abuse HSAB priorities and actions to be added then circulate for comment before final sign off.	Feb 2021	Completed
4	Neglect		Completed

	1. This element of safeguarding includes neglect of adults at risk and children, it also includes self-neglect. 2. To raise awareness of neglect amongst Trust staff and to provide education to enable them to recognise and report neglect of all types. 3. To raise awareness of the self-neglect assessment tool. 4. To raise awareness of processes that support child neglect.	Feb 2021	
5	Learning Disabilities 1. To promote flagging of inpatients and outpatients by staff creating alerts in Lorenzo where required. 2. To continue to support the learning disability improvements programme. 3. Upon the appointment of the new Safeguarding Adults staff member, to further support the learning disability agenda across the agenda.	Feb 2021	Completed
6	Early Help 1. To raise awareness across the organisation of staff responsibility to offer early help to families in need in paediatric and adult settings. 2. To ensure that staff in inpatient and outpatient areas are aware of support for families.	Feb 2021	Completed
7	Modern Slavery/Trafficking 1. To provide training to raise awareness of modern slavery and human trafficking issues in relation to children and adults at risk. 2. To raise awareness of county lines via training. 3. To support staff in recognising and reporting modern slavery and trafficking. 4. To work with our procurement teams to gain assurance that our business is conducted with businesses that observe the modern slavery act 2015.	Feb 2021	Completed

3. Safeguarding Activity

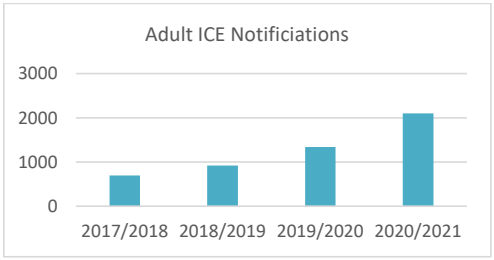
Comparisons of the data collected pre and post the COVID-19 pandemic has shown some unusual activity. An unexpected effect of the lockdown was a reduction of hospital attendances, the ripple effect of reduced hospital attendance on safeguarding activity was noted. The activity below demonstrates how people began to access services as national lockdowns came and went. As people started to access services again, it was recognised that the presentation had become far more complex than previously noted. The Safeguarding Teams continue to receive safeguarding concerns and information via several routes.

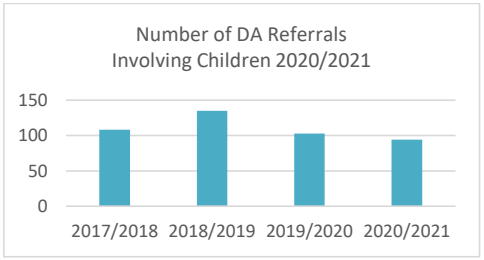
Please see figures 2 and 3 for a breakdown of the referral activity:

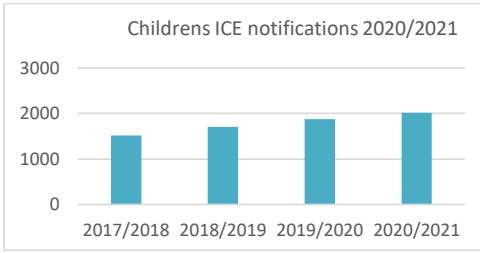
Figure 2

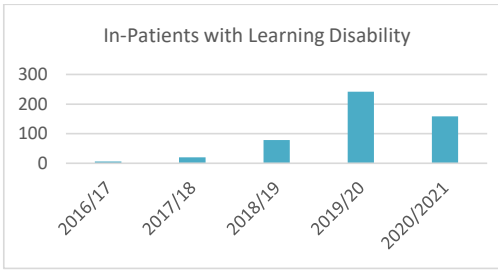
ICE Notifications	Adult	Children's	Maternity	DA (Children in the Family)	DA Adult Only Cases	LD In-Patients	In-Patient and Outpatient Flagged LD Patients	Prevent	DoLS
2016/2017	343	1502	795	126	18	6	0	0	225
2017/2018	696	1520	765	108	71	20	178	0	629
2018/2019	922	1706	955	135	106	79	175	4 cases	511
2019/2020	1336	1876	846	103	116	242	1433	0	525
2020/2021	2100	2021	827	94	116	158	831	1	480
% change 19/20 to 20/21	**↑57%**	**↑7%**	**↓ 2%**	**↓ 6%**	**Static**	**↓ 34.7%**	**↓ 42%**	**↑100%**	**↓8.6%**

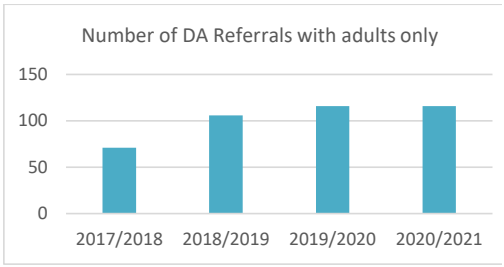
Figure 3

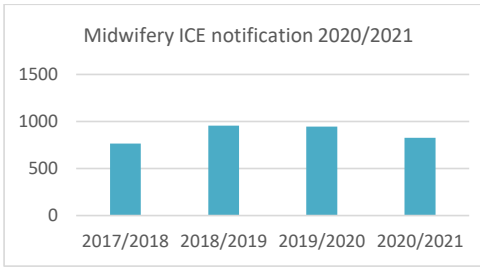












4. Safeguarding Training

4.1 Training recruitment

Continuous Professional Development (CPD) funding has been utilised to recruit two full time trainers who will have a specific focus upon:

- Learning Disability (LD) and Autism.
- Domestic Abuse.

A vacancy remains for a Liberty Protection Safeguards/Mental Capacity Act/ Mental Health Act (LPS/MCA/MHA) trainer.
The trainers commenced their posts in December 2020 quickly implementing robust training programmes which are now being delivered Trust wide.

4.2 Training Compliance

Delivery of training has continued throughout the COVID-19 pandemic. As expected, training compliance did reduce, however plans are in place across all Clinical Business Units (CBUs) to address this and increase compliance by the end of the 2021/22 financial year, progress is being monitored via the internal Safeguarding Committee.

The following data as detailed in figure 4 provides an update on the training compliance from April 2020 to March 2021. Since April 2021, the number of virtual and face to face training available sessions have increased thus creating greater accessibility for staff to attend.

Figure 4

Training – 1st April 2020 – 31st March 2021	Number of people to be trained	Number of people trained	Compliance
DoLS	2715	2382	87.73%
MCA	2759	2551	92.46%
WRAP	1825	1663	91.12%
Prevent Basic Awareness	4322	3951	91.42%
Safeguarding Children Level 1	4319	3847	89.7%
Safeguarding Children Level 2	2669	2138	81%
Safeguarding Children Level 3	545	413	76%
LD level one (this data is indicative of the training commenced in February 2021)	1351	161	11.92%
LD level two (this data is indicative of the training commenced in February 2021)	3063	227	7.41%
Autism level one (this data is indicative of the training commenced in February 2021)	1347	161	11.95%
Autism level two (this data is indicative of the training commenced in February 2021)	3063	204	6.66%
Domestic Abuse Level 1 (this data is indicative of the training commenced in February 2021)	1574	135	8.58%
Domestic Abuse Level 2 (this data is indicative of the training commenced in February 2021)	2828	121	4.28%
Domestic Abuse Level 3 (this data is indicative of the training commenced in February 2021)	3008	71	2.36%
Adult safeguarding level one	Please see detail below*		73.68%
Adult safeguarding level two	Please see detail below*		64.10%
*Work is currently underway to address an anomaly in the recording of level 1 and 2 adult safeguarding training. Due to an issue in how training had been recorded the figures were only partly reported. The figures above are an interim picture and indicative of the work that is happening to better understand the compliance levels regarding adult safeguarding level 1 and 2 training data.			

Commented [HA(AHTHNF1]: A key would be useful with regards to compliance targets etc.

Safeguarding training compliance is an important indicator of the ability of staff to act on safeguarding concerns. In order to fulfil these responsibilities all professionals and their teams should have access to and engage in training commensurate to their role and level of responsibility. The safeguarding training programmes are reviewed in real time following learning from case reviews and hospital incidents along with National guidance (Intercollegiate Documents).

4.3 Additional training delivered internally focussed on specific topics include:

- Child sexual exploitation.
- The impact of domestic abuse on children.
- Impact of neglect on children.
- Learning from serious case reviews.
- Physical harm.
- Child criminal exploitation.
- Voice of the child.
- Modern slavery and trafficking.
- Liberty protection safeguards.
- Suicide prevention.
- Carer stress.
- Self-neglect.

5. Learning and improving

5.1 Safeguarding Reviews

5.1.1 Safeguarding Children Serious Case Review (SCR)

When a child dies, or is seriously harmed, as a result of abuse or neglect, a case review is conducted to identify ways that local professionals and organisations can improve the way they work together to safeguard children. As reported in the previous annual report, WHH have been involved with two multi-agency case reviews. Although the published findings of both reviews are still awaited it is noted that there were no actions requiring an immediate response however it is expected that there will be elements of learning which can be applied to the acute Trust.

5.1.2 Safeguarding Adult Reviews (SAR) / Domestic Homicide Reviews (DHR)

The Local Authority has a duty to investigate when an adult at risk comes to harm as a result of abuse or neglect. The investigation is conducted under section 42 of the Care Act. A Serious Adult Review is conducted in cases that meet section 44 of the Care Act, this happens where multi-agency involvement has contributed to the patients harm or death. Where death is the result of domestic abuse a Domestic Homicide Review is undertaken. Figure 5 provides an update of the Safeguarding Adult Reviews with WHH involvement.

Figure 5

SAR	Brief description	Action required	Progress of action
SAR G detailed in 2018/19 report	An elderly man who was caring for his wife attempted to kill her. Following intense review, it was discovered his wife was a perpetrator of domestic abuse	Learning from a carer crisis, (the domestic abuse element was found a year after the review was completed)	The actions assigned to WHH regarding supporting staff to recognise carer crisis has been completed, the Safeguarding Team promote awareness of carer crisis in training and during ward discussions. In addition, during November 2020 to January 2021, the LA have conducted multi agency carer crisis audits of several cases. The audits results were shared, and further actions taken to raise awareness of this. The subsequent learning has been incorporated into WHH training packages.
SAR F Warrington detailed in 2018/19 report	This SAR was regarding a young lady who took her own life whilst in the care of a local private Mental Health provider, she had been placed out of area and had attended our emergency department on several occasions	The likely actions for the Trust are focused on communication between partner	Following the completion of this review work is underway to ensure the learning from this will be aligned to agencies. Subsequent actions will be monitored at Warrington SAB Serious Adult Review and Learning Group and at Safeguarding Committee. A further task and finish group

		agencies and out of area partners	(of which the lead nurse adult safeguarding is a member) has been set up to review how communication can be improved between agencies.
DHR Warrington	This case was regarding a lady with Autism who had a daughter and who was violently killed by her partner, the domestic abuse had gone un-noticed by all agencies involved in the patients care. Her husband was observed to be an attentive caring person who was supportive towards his family and was seen in a positive light by our Trust in his attendance to support clinic appointments for his wife and daughter. There were no suspicions of domestic abuse. The Trust had a number of contacts with the victim, the last being an extremely difficult cancer fast track situation in which the victim attempted to self-harm and threatened her husband. It transpired that the victim was self-harming at home when her daughter was present. Her husband admitted killing her during his trial sometime later.	All agencies involved were responsible for their own actions via a master action plan. This was monitored via Safeguarding Committee. Actions for the Trust centred on record keeping. It was also identified that staff required training regarding recognising coercive and controlling behaviour.	All actions from this DHR are now completed and closed.
SAR H Warrington	This SAR was regarding a young lady who passed away following an incident whilst she was in the care of a local mental health provider.	The likely actions for the Trust are centred around communication between partner agencies and out of area partners	Following the completion of this review work is under-way to ensure the learning from this will be aligned to agencies. Subsequent actions will be monitored at Warrington SAB Serious Adult Review and Learning Group and at Safeguarding Committee. A further task and finish group (of which the lead nurse adult safeguarding is a member) has been set up to review how communication can be improved between agencies.

5.2 Positive Feedback

It is important to reflect and share the learning from recognised good practice. Some examples of good practice recognised this year are detailed below:

- An external agency expressed thanks to the Safeguarding Team for the quick planning and delivery of a safeguarding birth plan involving a highly complex case.
- "Supervision session was extremely useful and helped me feel supported. I never knew how beneficial and important supervision was. Thank you, Safeguarding Team" Paediatric Staff Nurse.
- Thanks, received by the Safeguarding Adult Team from:
    - A Consultant for supervision, he found this very useful.
    - Emergency dept. for supervisory and targeted training sessions.
    - Local Authority for support with audits and multi-agency training.
    - NHSE/I National LD lead for the work the Trust is doing to improve LD care.
- "Thank you to the Safeguarding Adult Team for the support shown to ITU during the difficult months at the height of the pandemic" from the Lead Nurse.
- NHS England Safeguarding Lead relayed positive feedback following the Spotlight on Safeguarding event.

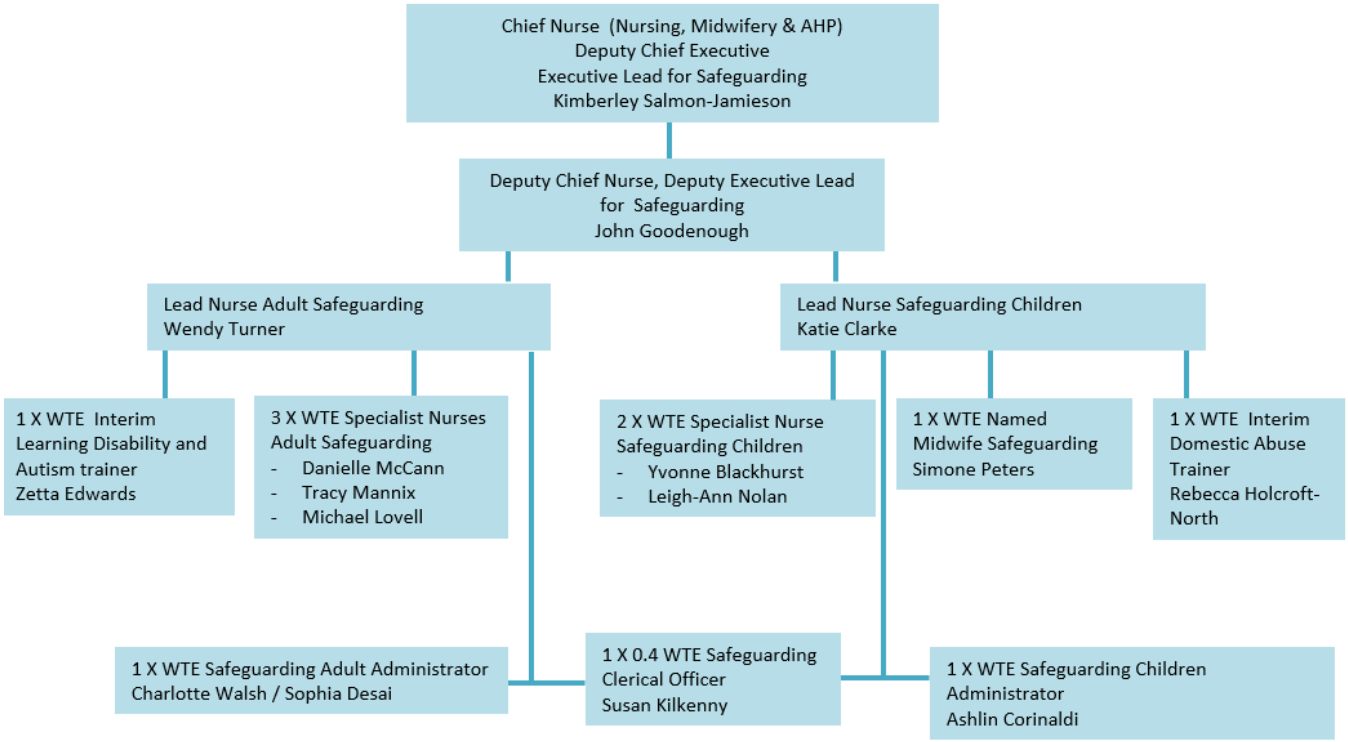
5.3. Internal and Multi-Agency note audits

Multi-Agency notes audits have continued throughout the COVID-19 pandemic on a virtual platform. The focus for the audits included early help, carer crisis and parental mental health. Whilst no immediate actions were identified, learning from the audits are shared and incorporated into the internal training presentations.

6. Safeguarding Team

Figure 6 provides an organogram of the current Safeguarding Team establishment, there is currently a vacancy for the LPS/MCA/Mental Health trainer.

Figure 6



7. Inspections

During the COVID-19 pandemic the Office for Standards in Education, Children's Services and Skills (OFSTED) and Care Quality Commission (CQC) paused the inspection process. There are no outstanding actions from previous inspections to report.

8. Safeguarding Strategy

The Safeguarding Strategy continues to support the direction in which the safeguarding agenda requires focus. The current Safeguarding Strategy (2019-2021) is under review and consideration based upon the newly developing evidence following the impact of the COVID-19 pandemic. The associated work plan will continue to be monitored via Safeguarding Committee.

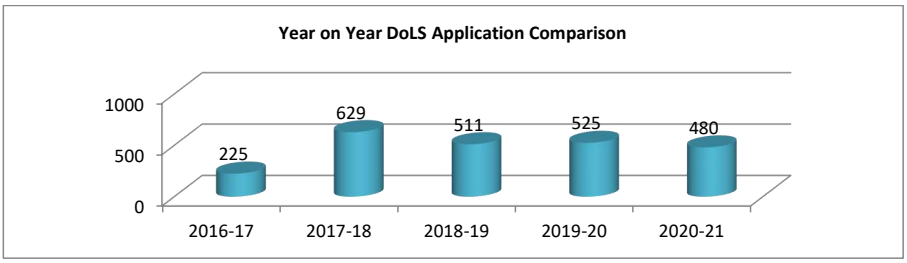
9. Mental Capacity Act (MCA) /Deprivation of Liberty Safeguards (DoLS)

9.1 Mental Capacity Act (MCA)

It is evident from the training compliance detailed earlier in the report that staff are aware of their statutory obligations regarding the Mental Capacity Act. Day to day contact with wards and departments has demonstrated increased knowledge of the MCA and best interest processes.

There has been four Court of Protection Cases during 2020/2021 which equates to a 100% increase on the previous year. In addition to this 480 DoLS applications have been made. The activity associated with this support is significant as each application is recorded and monitored via the DoLS Safeguarding data base with a welfare checks conducted to support the ward with the patients care and DoLS process. Each application is notified to the CQC in line with statutory guidance. The following graph (figure 7) demonstrates the above detail relating to the number of DoLS applied for with comparison to previous years.

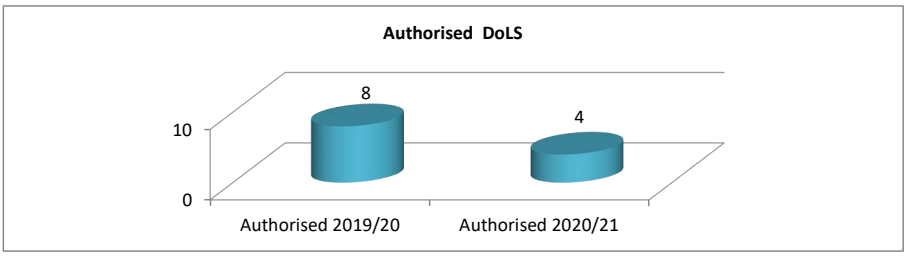
Figure 7



The Local Authority (LA) is the responsible body for authorisation of DoLS applications. During the COVID-19 pandemic a change in how the LA discharged its duties took place following emergency government guidance which meant that LA staff were unable to enter the hospital. Both Warrington and Halton LA's continue to operate with a significant back log of applications, this intensified during the COVID-19

pandemic. This is a national issue and one of the driving factors in the review of the DoLS act which has resulted in the new Liberty Protection Safeguards (LPS). Of the 480 applications described above, 4 were authorised, there were 8 authorisations the previous year, see figure 8.

Figure 8



DoLS applications are electronically completed by wards and emailed to the relevant Local Authority (LA) and the WHH Safeguarding Team. All standard DoLS documents are emailed back from the LA via the Safeguarding Team. Upon receipt of the document the Safeguarding Adult Team discuss the content with the ward letting them know that the conditions and restrictions set out in the document need to be embedded in the patients care plan. Due to the current resources and emergency pandemic guidance being in place the LA continue to risk assess those they receive using a National tool, only applying a standard in the most urgent of cases. However, this is not without challenge as there are patients who are assessed as being amber or green who are not reviewed for a standard DoLS prior to their discharge the pandemic has exacerbated this situation.

Although the responsibility for this is carried by the Local Authority, Trust teams are encouraged to be in contact with the Local Authority to monitor their patients' needs and requirements, communicating changes that may raise the patients risk rating. The number of patients awaiting the review of the Local Authority has increased significantly, this matter has been discussed with the Trust Solicitors ensuring the best possible outcome for our patients.

9.2 Liberty Protection Safeguards (LPS)

Following a period of review, the law underpinning MCA practice is to change. The final parliamentary stage of Liberty Protection Safeguards (LPS) was completed on 24th April 2019, following this completion Liberty Protection Safeguards received royal assent on 16th May 2019 and became Law. This new legislation repeals the Deprivation of Liberty Safeguards contained within the Mental Capacity Act (2005) [MCA].

The review of the current system of Deprivation of Liberty Safeguards (DoLS) happened because it was felt that the system needed to change and move away from the DoLS process. This change makes healthcare providers responsible bodies as well as the CCG; the Local Authority will also remain a responsible body. This will mean WHH will be responsible for authorising, monitoring and renewing their own DoLS, the law makers felt that by introducing a simpler process that also involves families would create faster access to assessments.

LPS establishes a process for authorising arrangements and enabling care and treatment which result in a Deprivation of Liberty, within the meaning of article 5 (1) of the European Convention on Human Rights

(ECHR), where a person lacks capacity to consent to the arrangements in place. The Government is currently working on a Code of Practice and regulations to support the use of this legislation. This was expected by the end of 2019 however this has been delayed to April 2022. Once in place the Code of Practice will lay out details of the process required and what roles should be in place to facilitate this new act of law.

WHH is represented at meetings with partners across Cheshire and Merseyside to review how the new law can be effectively implemented.

10. Female Genital Mutilation

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003 ("the 2003 Act"). It is a form of child abuse and violence against women. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons. The duty to mandatory report all FGM cases in under 18 years old came into effect in October 2015.

WHH continue to support identified survivors of FGM and consider the safeguarding for family members. The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is submitted on a quarterly basis. The dataset supports the Department of Health's FGM Prevention Programme by presenting a National picture of the prevalence of FGM in England.

Female Genital Mutilation - April 2019 to March 2020 Annual Report identified there were 6,590 individual women and girls who had an attendance where FGM was identified. These accounted for 11,895 total attendances reported at NHS trusts and GP practices where FGM was identified. Nationally the number of total attendances during 2019-20 has remained broadly stable, although the number of distinct individuals has reduced in the last quarter of the year. Within this annual report period, four survivors of FGM have been identified via WHH midwifery services. This has increased from two the previous year. The appropriate pathways were followed, and relevant agencies notified to ensure the safety of the unborn and any siblings were assessed.

11. Domestic Abuse

The UK's largest domestic abuse charity, Refuge, has reported a 700% increase in calls to its helpline in a single day, while a separate helpline for perpetrators of domestic abuse seeking help to change their behaviour received 25% more calls after the start of the COVID-19 lockdown. For many people, home is not a place of safety. It's more important than ever that help continues to be available to adults and children living with abuse.

In comparison to the previous year the number of referrals has reduced by 3 (See figure 9). During lockdown the number of people accessing services was reduced and therefore this would account for the very slight reduction in referrals. It should be noted that the number of referrals between March 2020 and July 2021 (1st National lockdown) were similar to the previous year and so whilst there was a reduction in footfall to the hospital, domestic abuse referrals remained the same. This would indicate that there had been an increase locally, however many victims were not accessing services to be identified and referred for support. Based on national data that is emerging, 2021/2022 referral numbers are expected to increase significantly.

Key statistics for WHH include:

- 213 domestic abuse cases identified.
- 16% victims were identified as men. This is a significant increase from the 10% identified the previous year.
- 53% of cases referred had children / unborns in the family.
- 46% cases were referred on to the appropriate MARAC (Multi -Agency Risk Assessment Conference).

In response to the recruitment of a domestic abuse trainer, the role of the hospital IDVA has been amended to provide a more focussed approach to supporting patients and staff victims ensuring clear safety plans are in place.

Figure 9a

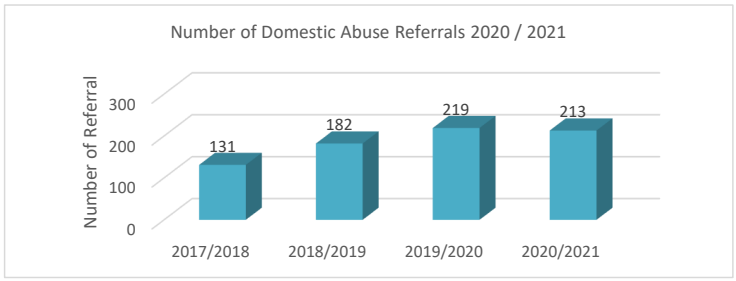
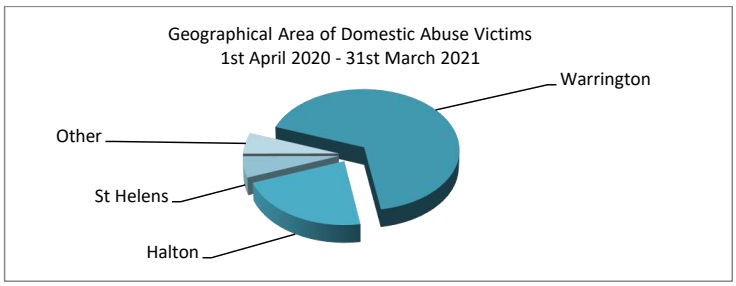


Figure 9b



12. Mental Health

12.1 Children's Mental Health

There are increasing calls to understand the impacts of National lockdown and school closures, on the mental health and wellbeing of children and young people during the COVID-19 pandemic. As lockdown measures begin to ease, it is important to understand what children and young people have been experiencing during the lockdown as well as how they can be best supported to resume to normal life over the coming months and years. For children and adolescents with mental health needs, such closures meant a lack of access to the resources they usually have through schools. In a survey by the mental health charity Young Minds, which included 2111 participants up to age 25 years with a mental illness history in the UK, 83% said the COVID-19 pandemic had made their conditions worse, 26% said they were unable to access

mental health support; peer support groups and face-to-face services have been cancelled, and support by phone or online can be challenging for some young people.

As lockdown restrictions were eased, it was recognised that the number of children and young people with complex mental ill health requiring hospital admissions was increasing. In collaboration with Warrington Clinical Commission Group (CCG), Warrington Local Authority and North West Boroughs the support available to young people was explored with it being recognised that therapeutic work at the earliest opportunity was a priority. Coordinated discharge planning was an additional priority which is to be explored further.

12.2 Adult Mental Health

The adverse effect on the mental health of people being locked down and asked to stay at home quickly became apparent. In the early lock downs of the COVID-19 pandemic mental health services, nationally, were instructed to implement a 24-hour crisis line so that people had access 24/7 to mental health support. This provided support at times of extreme stress, with a focus on suicide prevention.

Following the COVID-19 pandemic an increase in the number of patients requiring admission for physical issues associated to mental health issues has been noted with people requiring treatment for self-harm and overdose. Notably there were very few patient attendances from private partner agencies during the months of the COVID-19 pandemic. As restrictions have eased attendances have increased with some patients requiring prolonged periods of stay. Work has taken place since the last annual report to improve communication with private partners to prevent a delay in the sharing of information. This is important in improving patient care as lack of communication and its adverse effects has been cited in previous SAR reports as an area of focus. Work has also taken place to ensure a greater understanding of the restrictive practices sometimes required to support patient care in secure settings and how that care is transferred to patients when they are being cared for by WHH.

13. Mortality Review

The monthly Trust Mortality Review Group (MRG) has safeguarding representation to facilitate safeguarding oversight of the cases reviewed, with the Safeguarding Team providing further in-depth reviews where necessary. All patients who have passed away in the Trust who have a Learning Disability are also reviewed here using the Standard Judgement Review (SJR) process. All patients who have passed away whilst under a DoLS are also reviewed.

In order to link the Learning Disability Mortality Review (LeDeR) and SJR process, the SJR is shared with the monthly LeDeR review panel so that the patients care and treatment, in line with the national LeDeR process, can be reviewed. The panel is multi-agency and chaired by the CCG, WHH is represented at the panel, with any learning from the reviews shared with MRG and disseminated throughout WHH. To date the panel has not asked for any of the patients' cases to be further reviewed by MRG. Child death cases are presented quarterly.

14. Learning Disability (LD)

WHH participates in the annual National Improvement Standards LD audits and has submitted the third audit this year. In order to progress the extensive action plan associated to the audit and the wider LD agenda, an LD Steering Group has been formed. Progress of this work is also reported via the Warrington LD board of which WHH has representation.

The introduction of the inpatient and outpatient LD flagging system has supported the care of patients with an LD diagnosis and enabled reasonable adjustments to be considered ahead of appointments. The increased awareness of the needs of patients with an LD has created more enquiries and requests for assistance by staff from the Safeguarding Team. Clinicians are proactively enlisting the support of the Safeguarding Team in ensuring that planned admissions and appointments support the needs of patients with an LD diagnosis. Best interest processes are better understood and have become more frequent in the outpatient setting. The Safeguarding Team have supported several planned admissions and have been involved in supporting ward and department teams with complex patient care needs. The Safeguarding Team upload passports and care management plans into the Lorenzo record enabling staff to have information at hand as soon as their patient arrives on wards and departments. The LD Community Teams contact the Safeguarding Team when they know one of their patients are en route as an emergency enabling the safeguarding staff to contact the emergency department so that preparations can be made for the patients' arrival.

Improvement in care planning and accommodation of reasonable adjustments is evident, with continual review methods in place to ensure consistent improvements are made. The Learning Disability /Autism Practice Development Nurse offers expert advice and support to WHH staff regarding this area of their practice. Ward teams have welcomed the guidance supported by a tool provided to support with accommodating patients with an LD and in completing a welfare check on their behalf. Senior leads are prompted by twice daily emails alerting them of the location of patients in their areas. An LD training program began post March 2017 and was delivered by the safeguarding team, however following the appointment of the Learning Disability /Autism Practice Development Nurse training has improved and increased in frequency with level 1 and 2 LD and Autism training now in place with level 3 to follow in the summer. The Trust and the Safeguarding Team have worked closely with community partners in improving the care of patients with an LD and in supporting reasonable adjustments. Community partners have supported several planned admissions, complex discharges and vaccination access for patients with LD who needed extensive reasonable adjustments, they have been involved in supporting Ward and department teams with complex care needs.

15. Prevent

Responsibilities under the Home Office Prevent Strategy were placed on a statutory footing from July 2015 with the introduction of the Counter Terrorism and Security Act 2015. Following a change announced in 2019 Prevent training is no longer reported via the Home Office and prevent trainers are no longer required to register with the Home Office. Instead, prevent activity and compliance is reported quarterly via NHS digital.

In line with National guidance, WHH has a prevent lead who attends regional prevent meetings ensuring that important information and learning is shared via Safeguarding Committee. Following the increase in terror activity in 2017 the Home Office instructed all Trusts of a requirement to achieve 85% training compliance with 3 yearly updates. WHH are currently above the required training target.

A new arrangement across the Cheshire footprint has been implemented with partners from across Cheshire and Merseyside joining forces to share information and review radicalisation issues. The role of the Pan-Cheshire channel panel is under review with a focus on the policies, training and scrutiny processes. WHH is represented at the Pan-Cheshire Channel panel and relevant information for sharing is disseminated via Safeguarding Committee. WHH assurance data is reported on a quarterly basis in line with the statutory requirements.

16. Allegations against staff

All allegations of abuse of children by those who work with children must be taken seriously. Allegations against any person, who works with children, whether in a paid or unpaid capacity, cover a wide range of circumstances.

This procedure should be applied when there is such an allegation or concern that a person who works with children, has:

- Behaved in a way that has harmed a child or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

All allegations of abuse of adults by staff who are caring for patients using our services are taken seriously. Allegations against WHH staff, agency staff and those who come to our attention who work in other agencies are supported using WHH policy and the national PiPoT guidance.

There remains one open case requiring the support of the Local Authority Designated Officer (LADO).

17. Child Death

Working Together to Safeguard Children 2018 Chapter 5 sets the functions and processes of the Child Death Overview Panel (CDOP), which includes the collection and collation of data following the death of a child and subsequent recommendations following data analysis. This is an essential process for the CDOP, as the information gathered is used to safeguard and promote the welfare of children and for strategic planning purposes to support effective service delivery.

The Sudden Unexpected Death in Childhood (SUDIC) proforma & guidelines was updated in 2019. This guidance provides a framework for the investigation and care of families after an unexpected death of an infant or child. 2020/2021 data demonstrates an increase in the number of child deaths. All child deaths are reviewed by the Child Death overview Panel (CDOP). CDOP produce an annual report which providing information detailing themes, trends and lessons to be learned. Due to confidentially and ongoing investigations / meetings the causes of deaths cannot be documented within this annual report. Bereavement support is offered to the family and the staff involved in any child death incident. Following

relevant multi-agency meetings, feedback and learning is presented internally to the Mortality Review Group. Figure 10 demonstrates the number cases which have required WHH input.

Figure 10

	2017/2018	2018/2019	2019/2020	2020/2021
Number of deaths pronounced at WHH	5	15	3	8
Total number of child deaths requiring further information sharing / input from WHH	12	22	19	24

18. Child Protection – In-Patient

The hospital safeguarding children concerns form was introduced in 2002/3 to ensure compliance with the National standards and to give a measure of performance against the Laming recommendations. The 'Concerns form' is used in the Trust to highlight safeguarding children concerns. The number of concerns form commenced remains static at 400. As shown in the graph below (Figure 11) under 1s continue to be the most vulnerable group of patients with 25% of concerns forms commenced for this age group. Similar to the previous year's data the adolescents are highlighted as the second most vulnerable. This would correlate with the National picture that is emerging. The 2020's 'National Society for the Prevention of Cruelty to Children (NSPCC) How safe are our children' focussed on long-term trends in adolescents whilst also looking at the impact of the COVID-19 pandemic. Indicators show that adolescence is a time of heightened risk of some forms of harm and emerging evidence suggests the COVID-19 pandemic has exacerbated the risk. In response to this there has been increased training to focus on contextual safeguarding.

Figure 12 provides an overview of the categories of concern. In 2020/2021 the data collection criteria were reviewed and updated to ensure the mental health concerns were captured as a separate category. Several patients identify under more than one category. For example, children who cause harm to themselves could also be known to children's social care.

Figure 11

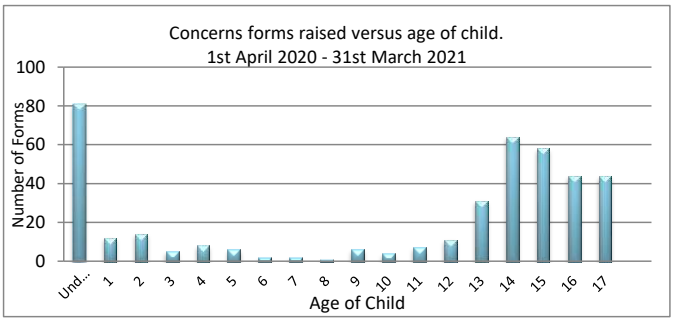
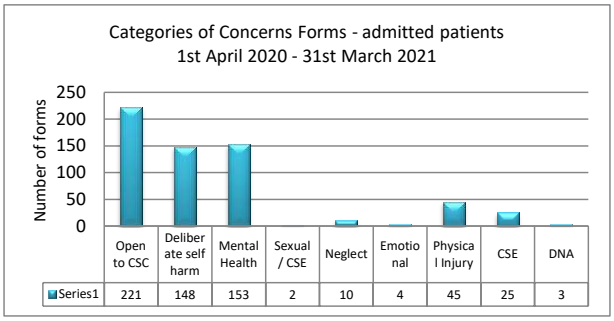


Figure 12



18.1 Child Protection Medicals

A child protection medical (CPM) assessment should always be considered when there is a suspicion of, or a disclosure of, child abuse and/or neglect involving injury, suspected sexual abuse or serious neglect. The need to consider a medical assessment in these cases arises from section 47 of the Children Act 1989 (and 2004) which places a statutory duty on the Local Authority to make enquiries to enable it to decide whether it should take action to safeguard and promote the welfare of a child. A total of 35 child protection medicals were completed during the reporting period which is a significant decrease from the previous year. This was expected for two reasons; due to the National lockdown and reduced visibility of children meaning medicals were not requested and due to the contract to complete all Halton child protection medicals concluding. It should be noted however that despite the contract for Halton medicals being with another service, 43% of the medicals completed at WHH were with children based in the Halton area.

Figure 13 provides the detail regarding the geographical areas of the children who attended for a child protection medical. Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014, (Brandon et al 2016) identified that “Infancy remains the period of highest risk for serious and fatal child maltreatment; there is a particular risk of fatality for both boys and girls during infancy” This is demonstrated within the activity seen in figure 14.

Figure 13

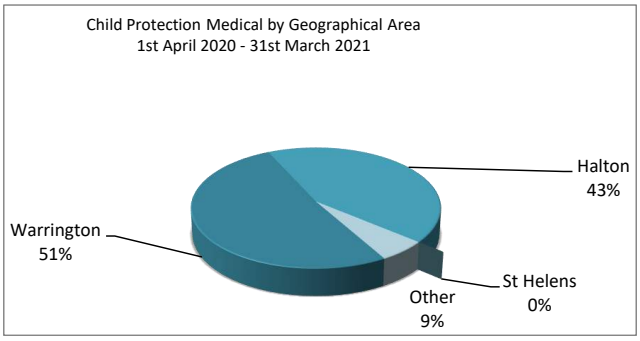
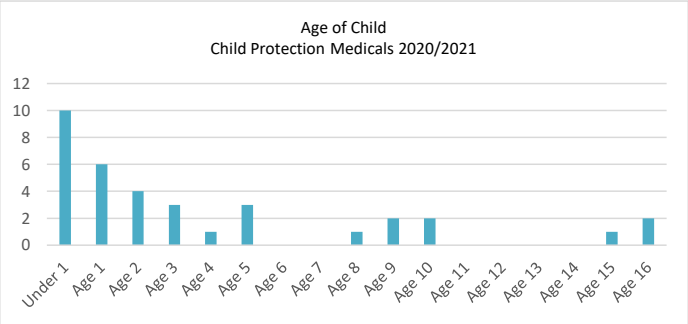


Figure 14



18.2 Peer Review

Peer review is the evaluation of work or performance by colleagues in the same field in order to maintain or enhance the quality of the work or performance in that field. The word peer is often defined as a person of equal standing. However, in the context of peer review, it is generally used in a broader sense to refer to people in the same profession who are of the same or higher ranking.

It is a core competency for all clinical staff working with children to undertake regularly documented reviews of practice, including peer review. It is a component of the Clinical Governance Framework and is expected by the judiciary, GMC and professional bodies. 89 cases were discussed as part of the peer review process with attendance from medical staff being consistent; this is an increase of 49 on last year's figures.

In 2018 Cheshire Police, Warrington and Halton Children's social care and Bridgewater NHS Trust were invited to join the peer review process. This has provided an opportunity to share learning and further develop and strengthen working relationships.

19. Safeguarding in Midwifery

Safeguarding within midwifery is constantly changing and becoming more complex. Research and experience indicate that very young babies are extremely vulnerable to abuse and that work carried out in the ante-natal period to assess risk and to plan intervention will help to minimise harm. For the second consecutive year there has been a slight decrease in the number of women with identified vulnerabilities who are being supporting through their pregnancy as detailed in figure 16. The Safeguarding Children Team provide a robust channel of communication with external partners and ensure that patient records and care plans are up to date in readiness for delivery of the baby. The data below in figure 17 provides detailed information regarding the number of special circumstance forms comments and from which geographical area the patients are from. 30% of women commenced on special circumstance forms live out of the area.

Figure 16

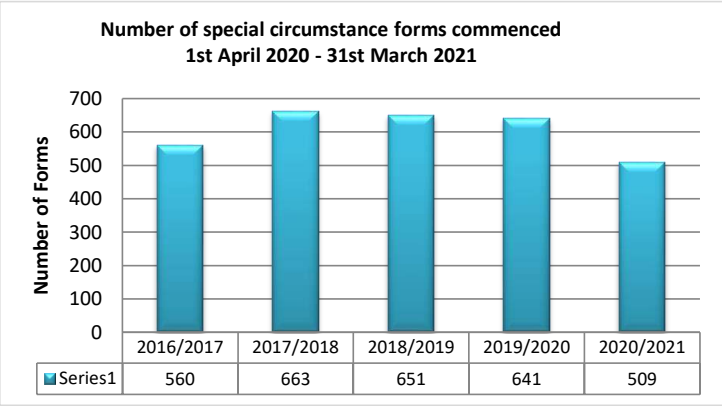


Figure 17

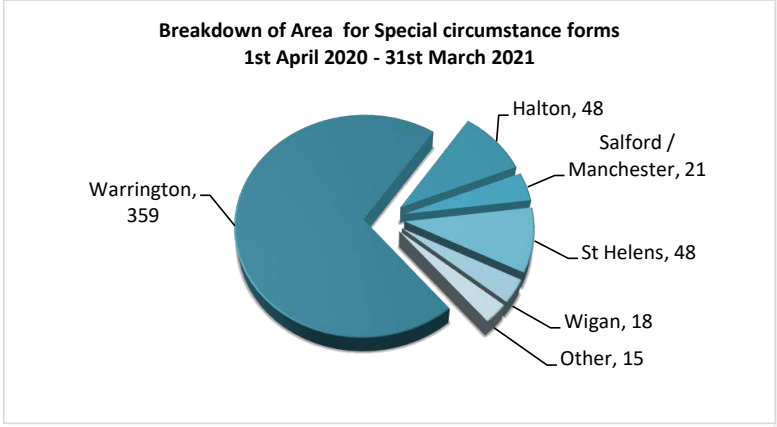
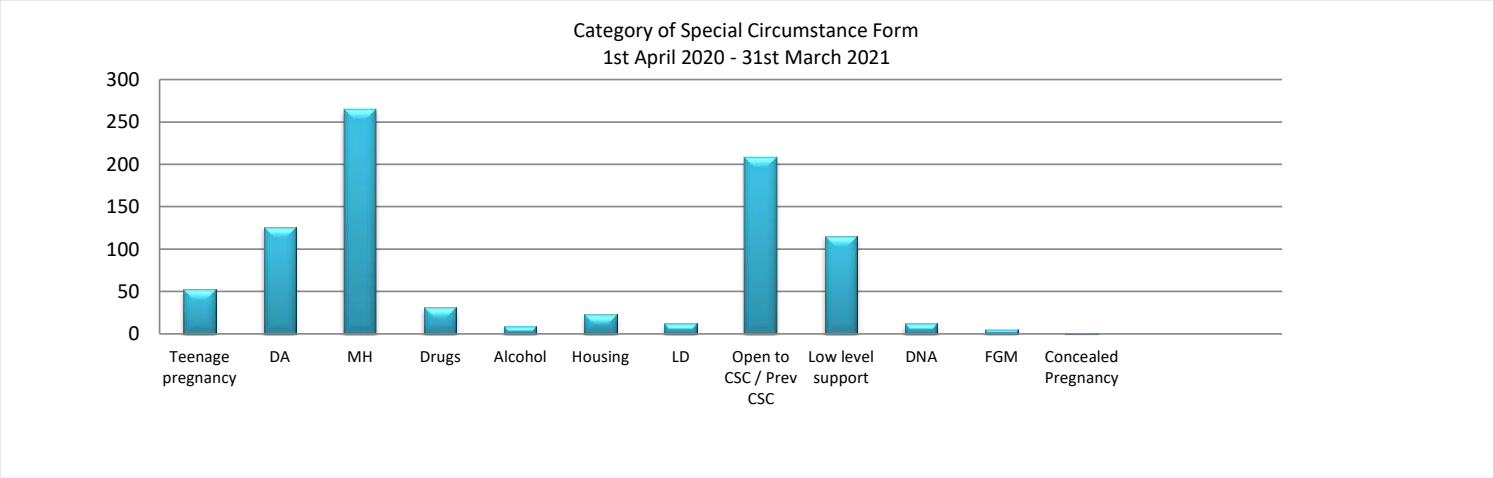


Figure 18 provides a detailed breakdown of the category of concerns raised. Consistent with the previous year's data mental health continues to be the most prevalent reason for concern (52%). The perinatal period, as defined in relation to mental illness, spans the time of conception to when the infant reaches the age of one. Perinatal mental illness is relatively common. The Royal College of Obstetricians and Gynaecologist conducted a survey which showed that 81% of women surveyed had experienced at least one perinatal mental health condition during or after their pregnancy. Low mood was experienced by over two-thirds of the women, anxiety by around half and depression by just over one-third. The severity of the condition will vary from individual to individual and may have some serious consequences if not identified and managed early and effectively. It is positive that so many women have been identified during the antenatal / postnatal period.

In 2019 the safeguarding documenting process within midwifery was reviewed and further developed. The new process is well now established and a reduction in DATIX incidents reported regarding missing safeguarding information has been noted.

Figure 17



20. Incident Reporting

20.1 Safeguarding Children Reported Incidents

DATIX incidents are responded to in a timely manner in collaboration with the appropriate Clinical Business Unit (CBU). 54 incidents were reported under the category of safeguarding children, this is a 10% increase on the previous year. Figure 18 provides an overview of the trends recognised and what actions have been taken to address the issues.

Figure 18

Concerns Raised	Actions taken to address
Information sharing with community services requires improvement.	Safeguarding Committee members asked to reiterate the importance of information sharing and ensure front line practitioners are confident in the processes required to be followed. WHH Safeguarding Team working closely with those departments above to establish what support is required to address the concerns raised. Recommendation for committee to consider: to consider the role of a Paediatric Liaison Nurse within WHH.
Missed opportunities within midwifery to identify and respond timely to early help and safeguarding concerns.	• Identified themes and trends have been escalated to senior midwifery team for review and consideration. • Safeguarding Team to provide virtual drop-in sessions / Facebook question and answer session to explore what the current difficulties are and ways in which midwives feel they need further support and guidance. Midwifery developed an action plan to address the concerns raised.
Early help referral process not fully utilised across WHH	• A condensed referral form has been developed with Warrington's Early Help Team. The pathway and guidance is provided within the referral form. • Identified person within the Warrington Early Help team has offered to provide further education and support. Sessions to be arranged. • Regular feedback to practitioners who refer cases to safeguarding providing education and support. • 7-minute briefing to be developed with the early help team and circulated trust wide. Number of early help referrals to be reported through safeguarding committee.
Timeliness of responding to identified safeguarding concerns requires improvement.	• Immediate action was taken in all cases to ensure the child, young person or adult at risk were safeguarded. Feedback provided to the practitioner and their manager highlighting expected practice.

20.2 Adult Safeguarding Reported Incidents

The Safeguarding Adult Team receives notifications for all incidents that have a safeguarding element to them. 90 incidents have been reviewed in the reporting year, this in an increase of 80%. The graph and table below provide an overview of themes and trends (Figure 19 and 20).

Figure 19

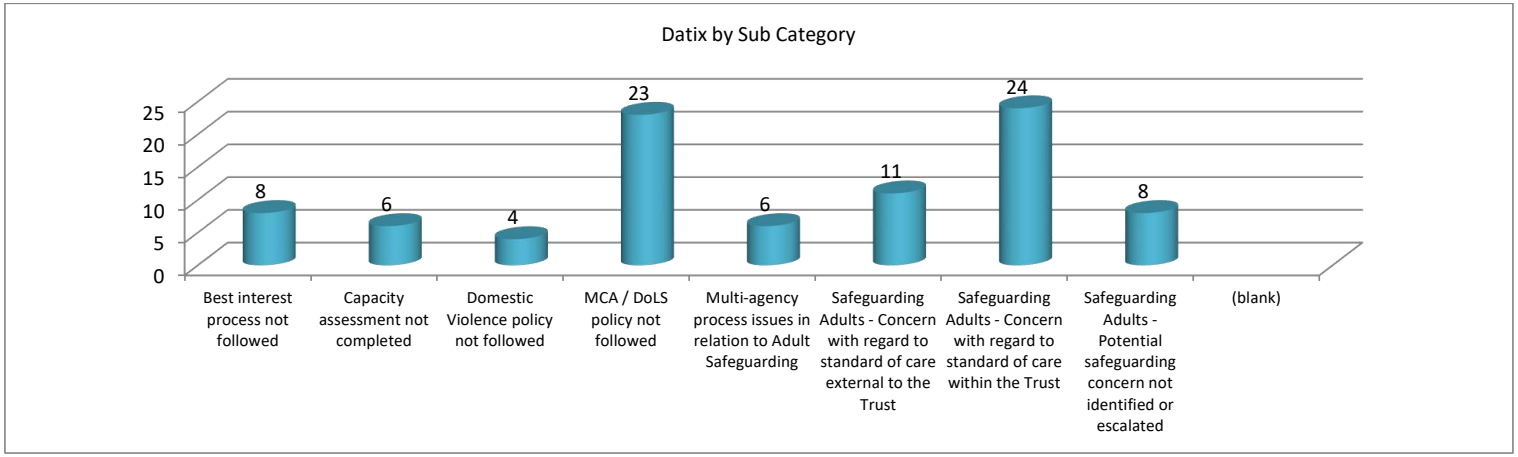


Figure 20

Main Issues / trends	Action taken from Safeguarding Adult Team
Domestic Abuse policy/hospital pathway not followed	4 of the 90 incidents reported were in this category, in all cases the patients were appropriately safeguarded, and the correct agencies were informed. Targeted training has been offered to support the staff involved
MCA/DoLS policy, capacity assessment not completed, best interest process not followed	In all 37 of the 90 incidents reported were in these three categories, in all cases the patients were appropriately safeguarded, and the correct process instigated regarding DoLS and MCA the relevant agencies were informed. Targeted training has been offered to support the staff involved and continued audit monitors this practice across the Trust. All MCA/DoLS activity is reported via Safeguarding Committee.
Potential safeguarding concern regarding the standard of care from another health provider	11 of the 90 incidents reported fall into this category. This category describes concerns raised about other health provider. If patients are admitted to us with skin damage or with concerns about any aspect of their care. In such cases the Safeguarding Adult Team and local authority work together to review the concern
Potential safeguarding concern regarding the standard of care from an area at the Trust	24 of the 90 incidents reported where in this category. This will include incidents regarding skin damage and complaints about care. Where required a 72-hr review is held, all concerns are reviewed by the Safeguarding Team and the CBU leads.

Multi-agency process issues in relation to adult safeguarding	6 of the 90 incidents reported where in this category. Where situations such as this arise, agencies will review the case and address any shortfall, lessons learnt are shared between all partners, WHH discusses at Safeguarding Committee. There has been one learning event January 2020 following such a case, however there were no actions for WHH.
Safeguarding adults potential safeguarding concern not identified or escalated	8 of the 90 incidents reported where in this category. Incidents have been raised following audit and incidental findings; these have been retrospectively reviewed. None of the incidents resulted in patient harm and awareness of near misses has been discussed at Safeguarding Committee.

21. Policy Development

Safeguarding and associated policies are key documents that helps staff understand what they need to know in order to keep patients safe. Policies are reviewed and updated as required and as new legislation dictates. During 2020/2021 the following policies have been reviewed and ratified:

- Surrogacy
- Chaperone
- Domestic Abuse – Supporting our staff

22. Achievements

Throughout the annual report there are areas of good work and positive achievements. In addition to those areas it is important to recognise additional work that has taken place.

22.1 Spotlight on Safeguarding – August 2020

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

In August 2020 the Safeguarding Team ran a programme of live learning sessions using MS Teams Live and the daily Hot Topic in the Trust wide Safety Huddle. The objective was to raise awareness among all staff of all elements of safeguarding, their own responsibilities and further learning for front line staff across all staff groups. The event was welcomed by partner agencies in Warrington and Halton boroughs and at National level with NHS England Safeguarding Team being involved.

In addition to resources being circulated, eleven teaching sessions were held live, which were recorded and uploaded to the Trust's YouTube channel. Externally, the MS Team Live events were shared with the following organisations (those shaded contacted WHH via twitter to ask for the programme) to share with their staff the event was also advertised via the WHH Twitter account: @WHHNHS

Warrington Borough Council	NHS Safeguarding	Morecambe Bay CCG	St Helens and Knowsley Hospitals NHS Foundation Trust	Sefton CVS
Halton Borough Council	NHS England and Improvement	Newcastle Gateshead CCG	Knowsley CCG	Rotherham NHS Foundation Trust
Warrington CCG	Newcastle Gateshead CCG	Garland Training	Greater Manchester West Mental Health NHS Foundation Trust	Midlands and Lancashire Commissioning Support Unit
Halton CCG	Cheshire Police	Penketh High School	Home Start Warrington	St Rocco's Hospice
North West Boroughs NHS Healthcare Trust	Bridgewater Community Healthcare Trust	Virgin Care	Lancashire and South Cumbria NHS Foundation Trust	Wirral Council

Training and supporting resources were delivered by WHH staff, Warrington Local Authority and the ICON Founder. Spotlight on safeguarding focused on key elements of safeguarding which included:

- Domestic Abuse and the impact of COIVD-19
- MCA/DoLS
- The impact of COVID-19 on Children
- ICON – Babies cry, you can cope
- Fabricated Induced Illness (F.I.I)
- Adult Mental Health
- Female Genital Mutilation – a multi-agency approach
- Child Exploitation and the impact of COVID-19
- Effect on people in lock down (carer breakdown)
- The impact of COVID-19 on Safeguarding
- Think Family

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

"Great effort from WHH – really appreciate it!"

Margaret Macklin, Head of Adult Safeguarding, Warrington Borough Council

"What a slick team you are! Many thanks for supporting me through that. You have all been brilliant."

Dr Suzanne Smith, ICON

"Thank you for inviting me to take part and for the support throughout the presentation. It has been a really good programme and one you should be proud of!"

Elaine Bentley, Head of Service for Early Help, Warrington Borough Council

22.2 ICON Week March 2021

Since the launch in 2019, the Pan-Cheshire ICON Partnership has gone from strength to strength ensuring that the ICON message is delivered routinely within midwifery and post-natal health care. ICON is well established across midwifery and health visiting services and so it was recognised that ICON needed to be reaching further with partner agencies. To support this increase in activity and to raise further awareness the Pan-Cheshire ICON Partnership held an ICON Week which proved to be a success.

The week which commenced 15th March 2021 involved daily lunch time webinars which focused on ICON and how as professionals we can embed this in our practice. Each day focused on a different element of the ICON message and was delivered by professionals across the Pan-Cheshire footprint. The resources and short video clips available via the ICON website were utilised and promoted throughout the webinars and received a positive response. 125 people accessed the live webinars and additional requests have been received in relation to accessing the recorded webinars. All presentations and resources are available to view via Warrington Hospital ICON websites https://WHH.nhs.uk/about-us/abusive-head-traumaicon-toolkit/resources/icon-week

Overall, the week was a success and the Pan-Cheshire ICON Partnership are already planning for a 2022 event.

22.3 Safeguarding Team Development

- Safeguarding Lead Nurses completed Bond Solons Clinical Leadership in Safeguarding training.
- 5 members of WHH staff trained by the NSPCC in Safeguarding Supervision.
- 2 members of WHH staff trained by Bond Salon in Safeguarding Supervision.
- Three members of WHH staff attended LPS conference.
- Two members WHH staff attended Safeguarding Resilience training.

22.4 Saville Training

WHH commissioned Ray Galloway, a former police officer who led the investigation into the Saville events, to present the learning from the investigation. In total 5 sessions were delivered to staff across the trust. The one-day safeguarding training course exposed the myths around Savile and reveals the vital lessons that can be learnt from how he operated, how he cultivated influence and how he was able to go undetected for over five decades. The training events were fully booked and received exceptional feedback.

23. Assurance Statement

Whilst this Annual Report provides many examples of the positive and inspiring progress made in 2020/2021, it is important to prepare for the challenges ahead. Partnership working will continue to raise awareness and find solutions to tackling emergent and persistent safeguarding issues for health such as self-neglect and child exploitation. Work to embed the Mental Capacity Act/Deprivation of Liberty Safeguards into practice will continue, as will promoting a culture of 'Making Safeguarding Personal' and 'Think Family'.

24. Key Objectives for 2021/2022

COVID-19 is having a detrimental impact on the safety and lives of both adults and children. As previously explored within the report this has raised concerns both Nationally and locally with safeguarding and domestic abuse increasing significantly for adults and children. In acknowledging the work that has already taken place the safeguarding of children, young people and adults with care and support needs from abuse and neglect remains a priority and work will continue to keep the systemic safety nets in place whilst implementing recovery plans.

Work will focus on the delivery of the seven key priority outcomes aligned to the current Safeguarding Strategy which is currently under review. The strategy will consider the impact that the COVID-19 pandemic has had on the safeguarding agenda ensuring that emerging safeguarding themes and trends are incorporated. Safeguarding findings from research is continually being reviewed and therefore the workplan aligned to the strategy is likely to be developed and updated throughout.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/104**			
SUBJECT:	**Terms of Reference:** - **Strategic People Committee (S)C)** - **Clinical Recovery Oversight Committee (CROC)**			
DATE OF MEETING:	28 July 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	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			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The proposed amended Terms of Reference for the Strategic People Committee and Clinical Recovery Oversight Committee is attached for consideration and approval.			
PURPOSE: ***(please select as appropriate)***	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the ToR for the above Committees.			
PREVIOUSLY CONSIDERED BY:	**Strategic People Committee**	Agenda Ref: SPC/21/07/40 Date of meeting: 21 July 2021 Summary of Outcome: **Approved**		
	Clinical Recovery Oversight Committee	Agenda Ref: CROC/21/05/40 Date of meeting: 25 May 2021 Summary of Outcome **Approved**		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	**SPC/21/07/40**
SUBJECT:	**Strategic People Committee Terms of Reference**
DATE OF MEETING:	22 July 2021
ACTION REQUIRED:	**Approval**
AUTHOR(S):	Carl Roberts, Deputy Chief People Officer
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People Officer
LINK TO STRATEGIC OBJECTIVE	SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future.
EXECUTIVE SUMMARY:	Amendments to the Strategic People Committee (SPC) ToR were approved November 2020 as it assumed responsibility for oversight of the Equality, Diversity and Inclusion Sub Committee from a People/Staff perspective, the Quality Assurance Committee (QAC) assuming oversight from a Patient and Service User perspective. Following approval by SPC of the establishment of a COVID-19 Workforce Recovery Steering Group (24 March 2021 SPC/21/03/24), further amendments are proposed for approval: <u>Amendment to Section 6 Reporting</u> • **ADD** – COVID-19 Workforce Recovery Steering Group • **AMEND** - Equality, Diversity and Inclusion Sub Committee to a Workforce Equality, Diversity and Inclusion Sub Committee (Staff Perspective Only) • Director of Strategy & Partnerships – title updated to reflect current roles. Proposed amendments to the ToR are detailed in the Revision Tracker.

PURPOSE: (please select as appropriate)	Information	**Approval √**	To note	Decision

RECOMMENDATION:	To approve the amended Terms of Reference for presentation to the Trust Board for formal ratification.	
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***	***Submit to Trust Board***	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

TERMS OF REFERENCE
STRATEGIC PEOPLE COMMITTEE

1. PURPOSE

The Strategic People Committee is accountable to the Trust Board and will maintain a strategic overview of the Trusts human resources and organisational development arrangements with a view to ensuring that these are designed to provide a positive working environment for colleagues, and that the Trust has in place at all levels the right people systems and processes to deliver, from a patient perspective, safe high quality care.

The Strategic People Committee will seek assurance on the:

- Trust's approach, plans and processes for the delivery of the People Strategy,
- Efficient and effective use of resources,
- CQC Well Led Domain specifically on culture, quality improvement and collaborative leadership development:
    - Key Lines of Enquiry (KLOE)1: Leadership, capacity, capability to deliver high quality sustainable care
    - Key Lines of Enquiry (KLOE)3: Culture of high quality sustainable care
    - Key Lines of Enquiry (KLOE)7: Are people who use services, public, staff and external partners engaged and involved to support high quality sustainable services.
    - Key Lines of Enquiry (KLOE)8: Robust systems and processes for learning, continuous improvement and innovation
- Controls and systems in place to support line managers to make effective decisions in the deployment of staff,
- Redesign of the workforce so that it remains fit for the future, and
- Plans to recruit and retain staff at all levels and how this is reducing the reliance on temporary workers, and

The Committee will oversee strategic actions to enable the trust to deliver the WHH Strategy and specifically the People Strategic Objectives. In addition the Committee will provide assurance to Trust Board that the Strategic People Objectives will support our quality outcomes of providing:

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

The Committee will provide assurance to the Trust Board on the management of risks related to our people.

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly.

3. MEMBERSHIP

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Chief People Officer
- Deputy Chief People Officer

- Chief Operating Officer
- Executive Medical Director
- Chief Nurse & Deputy Chief Executive
- Director of Strategy
- Chief Finance Officer & Deputy Chief Executive
- Director of Communications & Engagement

In attendance for specific agenda items scheduled in SPC annual workplan:

- Head of Staff Engagement & Wellbeing
- Head of HR
- Head of Workforce Systems and Intelligence

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Strategic People Committee may approve a matter in writing by receiving written approval from the quorate membership of the Committee, such written approval may be by email from the members Trust email account.

Other Directors including the Chief Executive or staff members may also be invited / expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

4. QUORUM

A quorum shall be two (2) members. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non Executives Directors not normally members of the Committee may attend in substitution and be counted in the quorum.

5. AUTHORITY

The Strategic People Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Strategic People Committee. The Strategic Committee may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee.

6. REPORTING

Governance

The Strategic People Committee will have the following reporting responsibilities:

A Chairs Key Issues Report will be formally recorded and circulated to the Trust Board of items discussed. The Chair of the Strategic People Committee shall draw to the attention of the Trust Board any issues that require disclosure to it, or require a decision or escalation.

The Strategic People Committee will report to the Trust Board annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Strategic People Committee by the Trust Board
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Board.
- To provide overview and scrutiny to the development of the People Strategy
- To ensure the People Strategy is designed, developed, delivered, managed and monitored appropriately
- To ensure that appropriate clinical advice and involvement in the People Strategy is provided
- To receive, agree and monitor progress on the People Strategy through receipt of exception reports and updates
- To ensure that the Trust attracts and retains our workforce using the principles of Model Employer to become the employer of choice.
- To ratify employment policies and procedures on behalf of the Trust
- To receive the annual National Staff Opinion Survey Results and to provide a set of recommendations for action by the Trust
- To receive, agree and monitor the staff engagement activity in the Trust and employee reward in order to be assured of the effectiveness of these activities on improved morale; increased Staff FFT results and improved patient experience.

Duties – advisory:

- Consider any relevant 'people' risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Strategic People Committee, as part of the reporting requirements,
- To ensure that the framework for Education Governance is supporting the management of risks associated with our people and the quality of care provided to our patients.

Duties – monitoring:

- To monitor the Trust's performance against national standards so far as they relate to employment.
- To monitor the effectiveness of the Trust's workforce performance reporting systems ensuring that the Trust Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the performance indicators relevant to the remit of the Strategic People Committee
- To report any areas of significant concern to the Trust Board as appropriate via the Chair Key Issues Report.
- To receive a report on Employee Relations Cases in respect of numbers, workforce demographics, emerging themes, lessons learned and in particular those cases where suspension/exclusion is involved

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented

Sub-Committees (Groups):

- Operational People Sub Committee
- Workforce Equality Diversity & Inclusion Sub Committee
- Workforce Recovery Steering Group

Each Sub-Committee will submit a Chair Key Issues Report detailing any items of escalation or items requiring decision or action rather than minutes.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

The Strategic People Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business (workplan) will be established

Papers to this Strategic People Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Wednesday preceding the Strategic People Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Members / HR & OD Service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed between meetings to enable members to respond.
5. Presentations must be sent to the Administrator ahead of the meeting
6. No tabled papers will be accepted unless in an emergency and with permission of the Chair of the Committee.

10. REVIEW / EFFECTIVENESS

The Strategic People Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Strategic People Committee.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	STRATEGIC PEOPLE COMMITTEE
Version:	V6.1
Implementation Date:	March 2020
Review Date:	March 2021
Approved by:	Draft v3 approved by TRUST BOARD (July 2018) Draft v4 – to be presented to September TRUST BOARD Draft v5 - to be presented to May 2019 Trust Board Draft V6 – approved by SPC 18 March 2020 to be presented to Trust Board 25 March 2020 and approved Draft V61.- approved by SPC 18.11.2020, Trust Board 25.11.2020
Approval Date:	19 September 2018 – SPC V4 approved 26 September 2018 – Trust Board V5 approved 20 March 2019 – SPC V6 approved 18 March 2020 at SPC and Trust Board 25 March 2020 V6.1- approved by SPC 18.11.2020, Trust Board 25.11.2020

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
May 2018	Draft TORs v1		Amendments – AW / MC
June 2018	Draft TORs v2		Amendments – AW / MC
July 2018	Draft TORs v3 – to include Appendix A: Governance Flow Chart - for use to proceed to seek approval		Amendments – AW / MC
July 2018	Appendix A – Amendment to Key – Explanation of Sub Committee / Groups to Assurance Committees		Amendments – AW / MC
September 2018	1. **Purpose** – clarification on Well Led KLOEs to be reported to SPC and further confirmation of role of SPC as an assurance committee 2. **Membership** – Written approval by quorate		Amendments agreed by members of the Strategic People Committee 19 September 2018 Approved Trust Board (September 2018)

	membership rather than full membership 3. **Duties & Responsibilities** – Section on Decision Making. Clarity on SPC role to assure actions taken to recruit and retain our workforce Section on Monitoring. Scope of Employee Relations Case Report clarified and to be included in workplan 4. **Subcommittees** – to include Triangulation Group		
20 March 2019	**Section 3 – Membership**	Updated attendee titles	
20 March 2019	**Section 7 – Duties + Responsibilities**	Triangulation Group removed	
18 March 2020	**Section 3 – Membership**	Updated attendee titles	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 10 – Administrative Arrangements**	Updated submission of papers timeframe	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 3 - Membership**	Removal of reference to Head of HR Strategic Projects	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 4 - Quorum**	To amend in line with other assurance committees	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 8 - Attendance**	To insert the term 'nominated' before deputy	V6 SPC 18.03.2020 Trust Board 25.03.2020
22 July 2020	**Section 3 – Membership**	Updated Executive Director titles, Deputy HRD&OD and attendee titles	V6.1 SPC 22 July 2020
18 November 2020	**Section 6 – Reporting**	**Add** Equality Diversity & Inclusion Sub Committee	V6.1 SPC 18.11.2020 Trust Board 25.11.2020
14 July 2021	**Section 6 – Reporting**	Added Workforce Recovery Steering Group – meeting monthly	For ratification to SPC in July 2021
14 July 2021	**Section 6 – Reporting**	Amended Equality Diversity & Inclusion Sub Committee to Workforce Equality Diversity & Inclusion Sub Committee	For ratification to SPC in July 2021

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
	Version 5 replaced with Version 6	SPC 18.03.2020 and Trust Board 25.03.2020

Warrington and Halton Teaching Hospitals NHS Foundation Trust

CLINICAL RECOVERY OVERSIGHT COMMITTEE

AGENDA REFERENCE:	**CROC/21/05/40**			
SUBJECT:	**Clinical Recovery Oversight Committee Revised Terms of Reference**			
DATE OF MEETING:	25th May 2021			
ACTION REQUIRED:				
AUTHOR(S):	Choose an item.			
EXECUTIVE DIRECTOR SPONSOR:	Choose an item.			
LINK TO STRATEGIC OBJECTIVE	All			
EXECUTIVE SUMMARY:	In order to reflect a change in the membership of the Committee, the proposed change to the Clinical Recovery Oversight Committee Terms of Reference is detailed as follows: **<u>Amendments to Section 4 – Membership</u>** Addition of Associate Director of Planned Care to the membership			
PURPOSE: (please select as appropriate)	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Committee is asked to approve the revised Terms of Reference			
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***	***Submit to Trust Board***			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

TERMS OF REFERENCE

CLINICAL RECOVERY OVERSIGHT COMMITTEE

1. PURPOSE

The COVID-19 pandemic of 2020/21 has significantly impacted NHS services in Warrington and Halton, putting pressure on all health and social care services.

The intended recovery of clinical services and a planned reduction of the treatment backlog has been complicated in Warrington and Halton by a second COVID-19 wave (October/ November 2020) and third COVID-19 wave commencing in December 2020. It is anticipated that these system wide pressures will remain throughout Q4 and beyond, with a requirement to support other regions in the North West (if necessary) in a response to the demands on acute and critical care services.

Due to this increased pressure on staffing, critical care and General and Acute beds, there is a significant risk that the ability to continue with the same elective surgical programme within Warrington and Halton Teaching Hospitals NHS Foundation Trust which has continued to date will be significantly reduced and the system in Warrington and Halton will have to enact a process of prioritisation for outpatients, diagnostics and surgery..

The purpose of the Clinical Recovery Oversight Committee is to be accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality and performance in relation to:

- Referral to Treatment (RTT)
- Patient Cancer Pathways
- Diagnostics including Endoscopy and Outpatients
- Progress of clinical harm reviews (CHR)

The Committee is a temporary Committee established during the COVID-19 pandemic and is accountable to the Board to ensure triangulation of matters detailed above under the purview of the Quality Assurance Committee and the Finance & Sustainability Committee; and ensuring that the organisational risks are managed appropriately in line with professional and regulatory standards.

2. FREQUENCY OF MEETINGS

Meetings shall be held fortnightly

3. QUORUM

Quorum shall be four members, of which at least two should be Non-Executive Director(s).

4. MEMBERSHIP

The Committee shall be composed of three Non-Executive Directors, one of whom shall be appointed by the Board to be Chair of the Committee

Core Members

- Non-Executive Chair of Finance & Sustainability Committee
- Non-Executive Chair of Quality Assurance Committee

- Non-Executive member of Quality Assurance Committee
- Chief Nurse & Deputy CEO
- Executive Medical Director
- Chief Operating Officer
- Deputy Director Governance
- Deputy Chief Finance Officer
- Associate Director of Planned Care

Attendees

- Other Directors including the Chief Executive or staff members may also be invited/expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting

Observers

- **Public Governor**

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

5. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of people external to the Trust, with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it or require executive action.
- The Chair of the Committee will provide a written Committee Assurance report to the Board bi-monthly following each meeting providing assurance of the quality governance arrangements in place within the Trust and provide an annual report to be presented to the Board meeting on its work and performance in the preceding year.

The following groups will report into the Committee:

- COVID-19 Tactical Group (designated sessions on Waiting List Oversight and Clinical Harm Reviews)

7. DUTIES & RESPONSIBILITIES

The Committee will provide oversight and assurance on all aspects of quality and performance in relation to:

- Referral to Treatment (RTT)
- Patient Cancer Pathways
- Diagnostics including Endoscopy and Outpatients
- Progress of clinical harm reviews (CHR)

8. ATTENDANCE

A record of attendance will be kept; attendance of 75% per year is expected
Executive members unable to attend must send a deputy who is able to make decisions on their behalf.
Other Executive Directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Officers who are unable to attend a meeting of the Group may appoint a deputy who will attend. It is the responsibility of the core member to inform the Chair of the Group if they are unable to attend and who will attend as their deputy.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Group the Agenda and Papers will be sent out 3 working days before the date of the meeting. No Papers will be tabled at the meeting without prior approval of the Chair. The Group will be supported by TBC

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Divisional leads/service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed
5. Presentations must be sent to the Administrator ahead of the meeting
6. No tabled papers will be accepted unless in an emergency and with permission of the Committee Chair.

10. REVIEW / EFFECTIVENESS

The Group will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 6 months by the Group.
The Cycle of Business will be reviewed by the Group every 6 months.

Recommendations

TERMS OF REFERENCE REVISION TRACKER

Name of Group:	Clinical Services Recovery Oversight Committee
Version:	1
Implementation Date:	TBC
Review Date:	12 months from approval
Approved by:	Finance & Sustainability Committee 24.03.2021 Trust Board 31.05.2021
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
25th May 2021	**4 - Membership**	Addition of Associate Director of Planned Care to the membership	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/105**	
SUBJECT:	**Finance and Sustainability Committee (FSC) Chair's Annual Report 2020-21**	
DATE OF MEETING:	28 July 2021	
AUTHOR(S):	Terry Atherton, Non-Executive Director, Chair of QAC	
EXECUTIVE DIRECTOR SPONSOR:	Choose an item.	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	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.**	✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability, #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision. #145 b. Failure to fund two new hospitals. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets. #241 Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report seeks to deliver assurance to the Trust Board that the Finance and Sustainability Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.	

PURPOSE: ***(please select as appropriate)***	Information	**Approval** ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review the document and ensure it meets its purpose.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance & Sustainability Committee		
	Agenda Ref.	FSC/21/06/100		
	Date of meeting	**23 June 2021**		
	Summary of Outcome	**Approved**		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/21/06/100**			
SUBJECT:	**Committee Chairs Annual Report 2020-21**			
DATE OF MEETING:	23 June 2021			
AUTHOR(S):				
NON-EXECUTIVE DIRECTOR SPONSOR:	Terry Atherton, Non-Executive Director, Committee Chair			
EXECUTIVE SUMMARY:	This report seeks to deliver assurance to the Finance and Sustainability Committee that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: (please select as appropriate)	Information	Approval ✓	To note	Decision
RECOMMENDATION:	**The Finance and Sustainability Committee is asked to review the document and ensure it meets its purpose.**			
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):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

SUBJECT	Annual Report of the Finance and Sustainability Committee 2020-21

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Finance and Sustainability Committee (F&SC) Annual Report which covers the reporting period 1 April 2020 to 31 March 2021.

The Committee is responsible on behalf of the Board for reviewing financial and operational planning, digital, performance and strategic and business development.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has primarily been composed of two Non-Executive Directors with a quorum of two (including the Chair). Any Non-Executive Director is able to attend the Committee to cover any absence. I have been the Chair of the Committee since February 2015.

The Finance and Sustainability Committee attendance record is attached in Appendix 1.

Regular attendees at the Committee meetings are the Chief Finance Officer & Deputy Chief Executive, Executive Medical Director, Chief Nurse & Deputy Chief Executive, Chief People Officer, Chief Operating Officer, Deputy Director of Finance & Commercial Development and Trust Secretary. Furthermore, a Trust Governor observes each meeting and provides feedback to the Council of Governors on how the meeting was Chaired, the extent of challenge and degree of assurance received.

Terms of Reference

The Committee's Terms of Reference were reviewed and approved by the Trust Board in November 2020 to ensure they continued to remain fit for purpose with amendments approved to:

- Section 4 – Duties and Responsibilities. The receipt of monthly Digital Services Reports to maintain oversight of digital investments in line with the Digital Strategy was added.
- Section 6 – Core attendees – The Chief Information Officer was added;
- Section 9 – Reporting Group – Digital Board was added.

Other amendments were made to reflect updated role titles.

Frequency of Meetings and Summary of Activity

In light of the COVID-19 pandemic, the meetings were held virtually via MS Teams and some agendas streamlined as appropriate. The Committee met virtually 12 times during the year. A summary of the activity covered at these meetings follows:

Reporting

In terms of reporting to the Finance and Sustainability Committee, the following key reports were submitted in 2020-21.

Pay Assurance

Including all pay spend, whilst maintaining a focus on temporary staffing. The report was refreshed July 2020 to provide the Committee with assurance and escalation regarding the processes in place to control all pay spend including:

- Establishment Control - Information on the establishment control process.
- Bank and Agency Rates - Information on bank and agency rates paid in comparison to Trust agreed rates, Cheshire and Mersey rates and NHS England and Improvement rates cap.
- Temporary Staffing Lead Times - Information on the lead time for temporary staffing requests. Appropriate lead times allow for 'gaps' in the workforce to be addressed in the most cost-effective way.
- 'Establishment' and 'Actual' - Information on the Full Time Equivalent workforce compared to establishment.
- Off Framework Workers - Information on any off-framework workers engaged in that month, reasons for engagement and plans to cease.
- Non-Clinical Agency Workers: Information on any non-clinical agency workers engaged in that month, reasons for engagement and plans to cease.
- WLI data
- Tier 1, 2, 3 spend breakdown from October 2020.
- International Nurse recruitment data included from March 2021

Pay Assurance Checklist – quarterly

The Pay Assurance Checklist details the position against a number of key areas of best practice aimed at reducing temporary staffing spend. Progress against the checklist is managed on a monthly basis at Premium Pay Spend Review Group and quarterly updates are submitted to the Committee. The Committee received regular updates relating to collaborative bank and medical bank arrangements across Cheshire and Mersey. As a result of the COVID-19 pandemic, reporting of this element was paused in May 2020.

Premium Pay Spend Review Group (PPSRG)

The Premium Pay Spend Group reviews all spend and puts in place controls and mitigations. As a result of the COVID-19 pandemic, the latest report was received in July 2020 which provided an update on the work streams in place through Premium Pay Spend Review Group.

Financial Resources Group

The Financial Resources Group (FRG) is responsible for monitoring and managing financial performance of all CBUs and Corporate divisions to ensure the provision of high quality healthcare within the resources available. An example agenda will review

- Financial Performance
- Productivity and Efficiency
- Patient Level Costing
- Service Line Reporting

As a result of the COVID-19 pandemic, meetings were paused between October 2020 – February 2021.

The Group's Terms of Reference were ratified by the Finance & Sustainability Committee in August 2020

Capital Planning Group
The Capital planning Group (CPG) monthly minutes are shared with the Committee. The group is responsible for monitoring and managing capital spend.

Risks

The Committee received updates on the key risks on the Strategic and Corporate Risk Registers affecting the Trust's Financial and Sustainability position at each meeting. The Committee monitors updates to existing risks, reviews and discusses proposals to add new risks, de-escalate risks and amend risk ratings or descriptions.

Examples of the risks and gaps in controls that emerged during the year include:

- COVID-19 related risks
- EU Exit Transition
- Recovery
- Capital planning
- Repayment of loans
- Provision of effective digital services

Strategic Risk Register – During the year, one new risk was added, the ratings of two risks amended and the titles of two risks amended.

Corporate Risk Register – During the year, three new risks were added and two risks were closed.

Finance

The Trust recorded a deficit of £11.3m and an adjusted deficit of £6.8m. This adjusted deficit is the value which NHSE/I monitors the Trust against and was achieved.

The response to COVID-19 impacted on Trust expenditure throughout the year with revenue expenditure of £32.6m. In addition, an element of income was impacted relating in the main to car parking and private patient income (£2.9m).

DHSC and NHSI converted all working capital loans to Public Dividend Capital (PDC) under the new cash and capital regime at the start of 2020/21, this equated to £57.8m.

The annual capital programme (including external funding) was £26.9m and the actual spend for the year was £25.7m, delivering an underspend of £1.2m.

PDC of £33.7m was provided in March 2021 to support the Trust in continuing to pay creditors promptly in line with guidance. The cash balance at the end of the year was £47.9m which was above plan due to additional income received in March for the annual leave accrual and for non NHS income and for an under spend on capital and delay in capital cash expenditure.

There were no failures in financial governance during the year. The Finance and Sustainability Committee reviewed and scrutinised the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. Furthermore, the Board reviewed the position and challenged forecast outturns and mitigations on regular basis.

Over the last 12 months the Trust has continued to have regular meetings with NHSE/I where the

financial position, forecast, COVID-19 expenditure and capital have been discussed, reviewed and challenged.

The Committee also:

- Reported COVID-19 revenue expenditure and loss of income for the year £35.5m (£2.6m March 2021).
- Reported Capital expenditure for 2020/21 £25.7m against a plan of £26.8m.
- Reported Cash balance at the end of the year £47.9m.
- The Better Payment Practice Code performance based on volume is 90% cumulative, March position reported the highest monthly performance at 96%.
- The value of creditors £7.3m; the value of debt £3.5m.
- The agency costs reported for 2020/21 £15.3m of which £9.0m relates to COVID-19. The expenditure is £6.6m above plan, therefore important that agency costs are monitored in 2021/22.
- Funding was received for the Flowers case of £0.6m.
- NHSE/I requested a CIP of 1.1% (£0.6m) in the second half of the year, £0.6m CIP has been delivered.

During the year the Committee received and reviewed the following:

- Dashboard setting out key finance and procurement metrics and performance
- Monthly, year to date and forecast financial performance
- Monthly, year to date and forecast capital expenditure.
- Monthly, year to date and forecast cash balances including short term cash flow.
- Control Total
- Monthly review of aged debt and aged creditors.
- Monthly, year to date and forecast of COVID-19 expenditure and income
- Updates on PPE issues
- Outcomes from Medical Stocktake review received April 2021.
- Enhanced pay controls
- Initial Operating Plan 2020-21, Draft and Final Operating Plan 2020-21
- Cheshire &Merseyside Financial Position
- Monthly and year to date performance against the Better Payment Practice Code.
- Risks and mitigating actions to financial position.
- Updates on, Service Line Reporting and Reference Costs.
- Local system financial performance information.
- NHSI Updates.
- Digital assurance reports

Virtual Approvals – delegated authority from Trust Board

Following approval by the Trust Board in January 2021, it was agreed that any changes to the capital plan could be delegated to the F&SC for the remainder of the financial year.

Extra Ordinary FSC 23 February 2021 – Changes to Capital Plan capital funding totalling £2.8m for COVID phase 2, and additional funding from the Critical Care Network of £0.1m and potential underspend of £0.3m on the current capital plan. A list of items was been created that comprised of a combination of brought forward schemes from 2021/22 capital requests, and items which would support elective recovery.

2 March 2021 – Additional Capital Approvals £72k shopping city scheme in 2020/21

- approve the 2021/22 shopping city commitment of £308k

11 March 2021 – Modular Build and enabling works at Halton site

- approve the circa £700k modular build in 2020/21
- approve the 2021/22 enabling costs of £258k
- Note no additional running costs as budget for B2 will be used – facilities and staff

Performance

Particular updates received included:

August 2020 Phase 3 Recovery Activity Update
September 2020 Phase 3 Performance / Activity / Submission update / Feedback / Recovery Prioritisation Revenue
January 2021 Review of Waiting Lists and Clinical Harm Review Report
January 2021 MLU Report

The Committee has reviewed and where appropriate challenged performance across all performance indicators including:

- Referral to treatment (18 week RTT)
- Cancer all standards.
- 4 hour standard.
- Diagnostic waiting time.
- Ambulance handover times.
- All NHSI Updates.

Despite the challenges of the COVID-19 Pandemic, the national target remained at 95% against the 4 hour standard. Due to the increasing volatile changes in demand, compliance with national IPC guidance, the need to segregate hot and cold flows in line with NHSE/I and RCEM guidance, the majority of acute Trusts have struggled to achieve this target in year. While the Trust performed well compared to peers it did not achieve the 95% national standard and closed marginally improved on 2019-20 with an all types performance of 85.86% (inc. Widnes Walk-in-Centre). The Committee continued to monitor and seek assurance relating to the actions that have supported performance, these have included investment and development of a new larger re-furbished Paediatric area, a bio quell pod installation to support segregated flows, the development and opening of a second Majors area, a re-located minors area into the MSK footprint and an ED plaza scheme to strengthen the Trusts Ambulatory care offer (due Q4 of 2021-22). Additionally, the Trust has opened additional bed capacity when necessary and worked with the local council to strengthen the reablement at home service to support discharges. All these developments have supported the increase of assessment capacity and reduction of direct admissions from our Emergency Department.

The Referral to Treatment (RTT) operational standard for England focused on the number of incomplete pathways less than 18 weeks. Whilst the Trust has a strong track record of consistently achieving this standard, the target of 92% over the Pandemic period has not been sustained in line with the impact nationally. The Committee regularly monitored the impact to compliance against the standard and the restoration and recovery plans, including assurance around the new waiting list and harm review processes. Most notably this included plans and trajectories to recover compliance, reduce the number of 52 week waiters, patients on a Cancer pathway and patients with a priority code of 2.

Digital

FSC assumed oversight and monitoring of Digital agenda from September 2020 receiving Digital Services Board updates and particular reports including:

- September 2020 Digital Services Stock Take – (wider IT strategy / maternity / future sustainability functionality of Lorenzo), and proposals for future reporting of Digital Services & Revised Terms of Reference.
- October 2020 - Deep Dive into Digital Risks on BAF.
- October 2020 - Digital Services Report and Digital Board minutes.
- November 2020 - Maternity EPR Business Case / Lorenzo Contract Extension Business Case
- January 2021 – received Digital Services Audit Plan
- January 2021 – Digital agenda direct reporting to Trust Board assumed.
- February 2021 - ePR Digital Services Deep Dive: ePR

Other issues considered / Reviewed during the year

- October 2020 – The Medical Establishment Review Interim report following a detailed review of the current workforce (Tier 1, 2 and 3) for each specialty and its associated spend has been undertaken. A Medical Workforce Steering Group was established across a number of workstreams led by the Deputy Medical Director for oversight and monitoring.

- October 2020 – The Committee effectiveness six month review to review and garner views of Committee members on the effectiveness of the Committee.

- January 2021 – The Committee requested an independent audit of the scheme and management of estates capital programme and specifically an audit of systems and processes of capital spend in relation to the MLU scheme,

- February 2021 - Local Clinical Excellence Awards – to approve funding for Clinical Excellence awards distribution amongst eligible consultants, as per national directive.

- March 2021 -MIAA Commissioned a review of MLU Capital Scheme and 18 additional beds and wider Capital Programme Review recommendations were received. It was agreed that Monthly progress reports and action plans would be received.

A review and refresh of the Performance Assurance Framework (PAF) and Integrated Performance Report (IPR) approved.

COVID-19 Monitoring
During 2019/20 the Committee received monthly updates on the COVID-19 expenditure, income and capital spend. Also supporting the revenue expenditure schemes over £500k to be approved at Board.

Issues Carried Forward

Each Finance and Sustainability Committee considers whether any business matters discussed should be escalated to the Board. The following were raised by the Finance and Sustainability Committee to the Board:

PACU Benefits Realisation
MRI additional spend
MIAA report on MLU and 18 beds
Lorenzo contract issues
COVID-19 expenditure and funding
Write off of loans
Receipt of additional cash to keep creditors low
Changes to block payments and contracts

The Committee will continue its work to ensure the overall financial governance system of internal controls and the assurance processes remain robust.

The Committee continued to receive and consider Sub Committee minutes, namely:

- Finance Resource Group
- Capital Planning Group
- Commissioner Contract Group
- Digital Services Board

Summary

The Committee encourages frank, open and regular dialogue between regular attendees to the meetings. I would like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

Terry Atherton
Chair of Finance and Sustainability Committee
June 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability Committee Attendance Record 2020-2021

	2020									2021			% attendance Excl, Deputy	% attendance Incl, Deputy
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March		
CORE MEMBERSHIP														
Terry Atherton, Chair, Non-Executive Director	√	√	√	√	√	√	√	√	√	√	√	√	100%	
Anita Wainwright, Non-Executive Director	√	√	√	√	√	√	√	√	√	√	√	√	100%	
IN ATTENDANCE														
Andrea McGee, Chief Finance Officer & Deputy CEO	√	√	√	√	√	√	√	√	√	√	√	√	100%	
Jane Hurst, Deputy Director of Finance & Comm D'vpment	√	√	√	√	√	√	√	√	√	√	A/D	√	91%	100%
Michelle Cloney, Chief People Officer	√	√	√	√	√	√	√	√	√	√	A/D	√	91%	100%
Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO	√	√	√	√	√	√	√	√	√	√	A/D	√	91%	100%
Chris Evans, Chief Operating Officer (to 08/2020)	√	√	√	√	√								100%	
Alex Crowe, Executive Medical Director	√	√	A/D	√	√	√	√	√	√	√	√	√	91%	100%
Dan Moore, Acting Chief Operating Officer (wef 09/2020) COO wef 01/21						√	√	√	√	√	√	√	100%	
John Culshaw, Trust Secretary	√	√	√	√	√	√	√	√	√	√	A	√	91%	
Julie Burke, Secretary to Trust Board	√	√	√	√	√	√	√	√	√	√	√	-		
Paul Bradshaw, Public Governor	√	√	√	√	√	√	√	√	√	√	√	√	100%	
NED / EXECUTIVE / DEPUTY ASKED TO ATTEND														
Ian Jones Non-Executive Director	√													
Margaret Bamforth Non-Executive Director		√		√										
Lucy Gardner, Director of Strategy (only when required)	ANR	ANR	ANR	ANR	ANR	ANR	ANR		ANR			ANR		
Anne Robinson, Deputy Medical Director			X/D		√		√		√					
Deb Smith, Deputy Chief People Officer				√		√					√			
Dan Moore, Director of Operations + Performance				√	√									
John Goodenough, Deputy Chief Nurse											√			
Lynn Simpson											X/D			

Key:
A = Apologies A/D = apologies with deputy attending X/D = Attendance as Deputy Xp = Part R = Left Trust ANR = Attendance Not Required

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/106**	
SUBJECT:	**Overview of final submission for Maternity Incentive Scheme (MIS)**	
DATE OF MEETING:	28th August 2021	
AUTHOR(S):	Deborah Carter, Project Director	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	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.	X x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1079** Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff. **#1372** FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's	

	challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The 10 safety actions for the year three MIS scheme were first published by NHSR on 23/12/19 As a result of the Covid-19 pandemic there were a number of changes to the technical guidance and reporting timeframes. The final revision of the scheme was published on 18/03/21. NHSR reporting deadline for the Board declaration of compliance with all 10 standards has been extended to 12 noon on Thursday 22nd July. A significant work programme has been undertaken in W&C CBU to ensure delivery of all 10 Safety Standards and provide the evidence to support self assessment. A preliminary report describing compliance against the March 21 revised standards was approved at the Quality Assurance Committee on 14/05/21. The final declaration was uploaded to the NHSR portal on the 19th July, signed by the Chief Executive on behalf of the Trust Board.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	Trust Board are asked to note the contents of the final MIS Safety Action report Women and Child Health CBU to develop the assurance reporting process and SOP to support future reporting of MIS progress			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC 21/02/120		
	Date of meeting	14/05/21		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Overview of final submission for Maternity Incentive Scheme (MIS)**	**AGENDA REF:**	**BM/21/07/106**

1. BACKGROUND/CONTEXT

The 10 safety actions for the year three MIS scheme were first published by NHSR on 23/12/19. As a result of the Covid-19 pandemic there were a number of changes to the technical guidance and reporting timeframes. The final revision of the scheme was published on 18/03/21. NHSR reporting deadline for the Board declaration of compliance with all 10 standards has been extended to 12 noon on Thursday 22nd July. A preliminary report describing compliance against the March 21 revised standards was approved at the Quality Assurance Committee on 14/05/21

2. RECOMMENDATIONS

Trust Board are asked to note the contents of the final MIS Safety Action report

Women and Child Health CBU to develop the assurance reporting process and SOP to support future reporting of MIS progress

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Maternity Incentive Scheme Year 3

Final Compliance Report

Trust Board Meeting

Debby Gould, Professional Midwifery Advisor (Head of Midwifery)
Deborah Carter Project Director

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Background

- The 10 safety actions for the year three MIS scheme were first published by NHSR on 23/12/19
- As a result of the Covid-19 pandemic there were a number of changes to the technical guidance and reporting timeframes.
- The final revision of the scheme was published on 18/03/21
- NHSR reporting deadline for the Board declaration of compliance with all 10 standards has been **extended to 12 noon on Thursday 22nd July**
- A preliminary report describing compliance against the March 21 revised standards was approved at the Quality Assurance Committee on 14/05/21

Trust Board Requirements

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- To note the required standards for each safety action alongside the final compliance status
- To note evidence of compliance has been provided for all 10 safety actions, has been reviewed by CBU Triumvirate and is available
- To complete the Trust Board declaration form stating the Board are satisfied that the evidence provided demonstrates achievement of the safety actions and meets the standards set out in the MIS technical guidance
- To note the content of the declaration was discussed with Commissioners on 21/05/21

The Trust Board declaration must be signed by the Trust Chief Executive to confirm

✓ The evidence of achievement of the 10 safety actions meets the required safety actions' sub-requirements

✓ The content of the Board declaration form has been discussed with the maternity service commissioner(s)

✓ There are no external maternity service reports that may provide conflicting information to the declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.)

Submission to the MIS portal was completed on the 20/07/20

Warrington and Halton Teaching Hospitals NHS Foundation Trust

The10 Maternity Safety Actions

- **Safety Action 1**: Use of the National Perinatal Mortality Review Tool
- **Safety Action 2**: Submitting data to the Maternity Services Data Set
- **Safety Action 3**: Transitional care services to support Avoiding Term Admissions Into Neonatal Units Programme
- **Safety Action 4**: Effective systems of clinical workforce planning
- **Safety Action 5**: Effective system of midwifery workforce planning
- **Safety Action 6**: Demonstrating compliance with Saving Babies Lives Care Bundle v2
- **Safety Action 7**: Gathering service user feedback and working with Maternity Voices Partnership to co produce local maternity services
- **Safety Action 8**: Multi professional maternity emergencies training
- **Safety Action 9**: Maternity Safety Champions
- **Safety Action 10**: Reporting of qualifying cases to HSIB and NHS Resolution Early Notification Scheme

Warrington and Halton Teaching Hospitals NHS Foundation Trust

NHSR Safety Action Summary

NHS Resolution

Section A : Maternity safety actions - Warrington and Halton Hospitals NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	8	0	0
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	2	0	0
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes	6	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	3	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	8	0	0
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	Yes	33	0	0
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes	5	0	0
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 20192	Yes	14	0	0
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes	17	0	0
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	Yes	4	0	0

132 of 417

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
1a	From 11/01/21, all perinatal deaths to be notified to MBRRACE-UK within 7 working days and the surveillance information completed within 4 months.	Q2, Q3, Q4 PMRT Reports 01/07/20-31/03/21 reported to QAC in Maternity Safety Champions reports PMRT Board Report confirms parents views have been included in the review. *Shadow validation by NHSR to cross reference data from MBRRACE-UK for standards a, b and c*	3 perinatal cases to reported to MBRRACE-Uk within timescale from 01/04/21 to 14/07/21	*Compliant*
1b	PMRT review of 95% of all deaths of babies, using the PMRT, from 20/12/19 -15/03/21 will have been started before 15/07/2021.		All cases have been reviewed within the timescale. Dec 2019 – 1 case reviewed 2020 - 17 cases reviewed 2021 - 3 cases for review	*Compliant*
1c	50% of all deaths of babies from 20/12/19 to15/03/21 will have had a PMRT at least a draft report generated.		18 cases have been reviewed 15 cases have completed reports 3 cases have draft report	*Compliant*
1d	For 95% of all deaths of babies from 20/12/19, parents will have been told that a review will take place, and their perspectives about the care sought.		PMRT Board Report confirms parents views have been included in the review. Evidence of completed reports available	*Compliant*
1e	Quarterly reports will have been submitted to the Trust Board from 01/10/ 2020 onwards	PMRT reviews are reported in the Maternity Safety Champion Reports to QAC **2020** - 07/01, 03/03, 07/07, 01/09, 06/10, 03/11 **2021** - 02/02, 05/21	Q1 -Apr-Jun 2020 Quarterly PMRT Report presented in the Maternity Safety Champion report to QAC, 04/08/2020 Q2, Q3, Q4 reports to be presented in May 2021 Maternity Safety Champions Report. Board and Non Executive Safety Champions are both members of QAC	*Compliant*

Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
2.1 2.2 2.4 - 2.13	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.	2.1, 2.2, 2.4 – 2.13 all complete. December 2020 MSDS Data Scorecard confirmed full compliance. Scorecard shared at Women's Health Governance Meeting 23/03/2020 and Maternity Safety Champions report to QAC March 2021. Items 1, 2, 4-13 were assessed by NHS Digital and email confirmation of compliance received from NHS Digital 03/03/21	External verification from NHS Digital received 03/03/21	*Compliant*
2.3	Trust Boards to confirm to that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 Amd 10/2018, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.	MSDS ISN nonconformity letter sent to NHS Digital Feb 2021explaining the limitations of the current maternity information systems ability to conform to the Digital Maternity Records standards and the impact on the MSDSv2 ISN. Digital Maternity Business cases approved 2020 Project Initiation Document monitored by Digital Maternity Project Board and reports progress to Digital Board	Plan in place to procure and deploy new maternity information system. First stages of plan to be initiated by end Q3 2021 Digital Project Manager in post.	*Compliant*

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units (ATAIN) Programme?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
3d	Commissioner returns for Healthcare Resource Groups 4/XA04 activity as per Neonatal Critical Care Minimum Data Set have been shared, on request, with the Operational Delivery Network and commissioner confirming approach to TC	No requests to share data have been received from ODN and/or commissioner	Routine submissions to ODN< MSDS and NNCCDS are made through BadgerNet	*Compliant*
3e	A review of term admissions to the neonatal unit and TC during the Covid-19 period (01/03/20 – 31/08/20) is required to identify the impact of: •closures or reduced capacity of TC •changes to parental access •staff redeployment •changes to postnatal visits leading to an increase in admissions	Audit review completed by 26/02/21. Summary of review included in the Women's and Child Health Governance Meeting May 21	Findings included in ATAIN Action Plan (3f)	*Compliant*
3f	An action plan to address findings from ATAIN reviews, including those from point in e above has been agreed with the maternity and neonatal safety champions and Board level champion.	ATAIN action plan in progress and presented at Women's Health Governance Meetings. Action plan presented monthly as part of Maternity Safety Champion QAC report **2020** - 03/03, 07/07, 04/08, 01/09, 06/10, 03/11, **2021** - 02/03		*Compliant*
3g	Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.			*Compliant*

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
4	**Anaesthetic Medical Workforce** An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation Standards 1.7.2.5, 1.7.2.1 and 1.7.2.6	Compliance with standard included in 06/21 QAC minutes	ACSA preliminary assessment visit completed 03/03/21 with supporting visit report provided for assurance.	*Compliant.*
	Neonatal Medical Workforce The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level	WHTH not compliant with BAPM Tier 2 medical staff training standards. Non compliance with standard reported to QAC 06/07/21 with supporting action plan to achieve compliance. Action plan submitted to the ODN June 21	Trust wide review of medical workforce underway. Findings from the review will inform business case to increase neonatal/paediatric medical workforce.	*Compliant*
	Neonatal Nursing Workforce The neonatal unit meets the BAPM national nursing standards. If this is not met, an action plan to address deficiencies is in place and agreed at board level	Neonatal staffing report included in WHTH Nursing and Midwifery Bi Annual Staffing Review. Presented to Workforce Committee Feb 2021	July 21, ODN informed staffing levels in accordance with BAPM therefore no action plan required.	*Compliant*

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
5a	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.	Birthrate Plus staffing review completed 2015 and 2018. Elements a-d covered in Midwifery Workforce Report included as part of Trust Bi Annual Nursing and Midwifery Staffing Review, presented to Workforce Committee Feb 2021 Action plan to be developed to support 100% compliance of supernumerary shift leader and plan to add Maternity Red Flags to e-roster	Birthrate Plus staffing review in progress to support recommendations from Ockenden report immediate and essential actions. Daily matron "sit rep" reports monitor staffing levels on a daily basis with reporting of midwifery red flags for immediate escalation of concerns with staffing, capacity or acuity concerns.	*Compliant*
5b	The midwifery coordinator in charge of labour ward must have supernumerary status; to ensure there is an oversight of all birth activity within the service			Compliant
5c	All women in active labour receive one-to-one midwifery care			*Compliant*
5d	Submit a 12 monthly midwifery staffing oversight report that covers staffing/safety issues to the Board.			*Complaint*

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Overall compliance

	Required Standard	Evidence	Comments	RAG
6.1	Do you have evidence of Trust Board level consideration of how the Trust is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019?	Midwifery Safety Champion Report, QAC 06/04/21 Midwifery Safety Champion Report, QAC 01/12/20 Midwifery Safety Champion Report, QAC 04/08/20 Progress and Compliance PPT presented to CCG and QAC March 21 and June 21		*Compliant*
6.2	Has each element of the SBLCBv2 been implemented?	Quarter 5 SBLCBv2 Survey Report returned to C&M LMS o behalf of NHSE Chief Nurse June 21. All elements demonstrate full compliance with the care bundle.		*Compliant*
6.3	The quarterly care bundle survey must be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements.	North West Coast LMS Quarter 1 Survey Return October 2019 North West Coast LMS Quarter 2 Survey Return June 2020 North West Coast LMS Quarter 3 Survey Return September 2020 North West Coast LMS Quarter 4 Survey Return January 2021 North West Coast LMS Quarter 5 Survey Return June 2021		*Compliant*

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Monitoring of Elements 1-3

	Required Standard	Evidence	Comments	RAG
SBL E1	Recording of carbon monoxide reading on Maternity Information System and inclusion in MSDS submission. Audit of percentage of Carbon Monoxide measurement at booking is recorded and percentage of CO measurement at 36 weeks is recorded.	Audit report completed 15/07/21	80% audit threshold achieved Action plan in place to achieve 95% threshold	*Compliant*
SBL E2	Percentage of pregnancies where a risk status for fetal growth restriction is recorded at booking. Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation In high risk pregnancies uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.	Audit report completed 15/07/21 SGA pathway and algorithm in place for USS routines in complex pregnancy Quarterly SGA Audit report received from Perinatal Institute and shared at Women's Health Governance Meeting Feb 2021	80% audit threshold achieved Action plan in place to achieve 95% threshold	*Compliant*
SBL E3	Audit of percentage of women who had received fetal movement leaflet/information by 28+0 weeks. Audit of percentage of women who attend with RFM who have a CTG.	Audit report completed 15/07/21	80% audit threshold achieved Action plan in place to achieve 95% threshold	*Compliant*

Safety action 6: continued Monitoring of Elements 4+5

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
SBL E4	Audit of percentage of staff training on intrapartum fetal monitoring Audit of percentage of staff who have completed mandatory annual competency assessment	K2 fetal monitoring training package in place QAC March 2021, commitment from Trust Board to facilitate local, in person MDT training when permitted. Training report presented at Women's Health Governance Meeting 14/05/21 Note : NHSR have removed 90% training threshold requirements for compliance	Fetal Surveillance Midwife supports staff training and monitors compliance Face to face training sessions recommenced July 2021 WHH maternity team trajectory to reach 90% of staff trained by July 2021 continues. Training compliance as of 14th July 2021 is : Consultant obstetricians 100% Other doctors 90% Midwives 90% NHSP 83%	*Compliant*
SBL E5	Audit percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.	Audit report completed 15/07/21 C&M LMS Regional Guideline for The Management of Preterm birth in place< 12/03/21	85% audit threshold achieved Action plan in place to achieve 95% threshold	*Compliant*

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
	Demonstrate a mechanism for gathering service user feedback, and that you work with service users through Maternity Voices Partnership (MVP) to coproduce local maternity services? Evidence requirements • MVP Terms of Reference •A minimum of one set of MVP meeting minutes demonstrating how feedback is obtained and the involvement of Trust in coproducing service developments based on feedback •Evidence of service developments resulting from coproduction with service users • Written confirmation from the service user chair that they are being remunerated for their work •Evidence that the MVP is prioritising women from Black, Asian, Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.	MVP Toolkit completed to cover all compliance elements. Completed toolkit approved by MVP Chair 07/07/21	Sarah Jackson, Paediatric Nurse Consultant appointed as MVP Co-Chair to provide more formalised support for the newly appointed MVP Chair. Co-Chair will also support the voice of neonatal families during MVP meetings	*Compliant*

Safety action 8: At least 90%* of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019 (*note 90% threshold removed by NHSR March 2021)

	Required Standard	Evidence	Comments	RAG
8a	Covid-19 specific e-learning training has been made available to the multi-professional team?	PROMPT e-learning package in place with scheduled online training sessions for MDT team. PDM training report presented at Women's Health Governance Meeting May and July 2021 confirming training achievements of individual MDT groups	Attendance at **PROMPT** training session as of 14th July 2021: Consultant obstetricians 100% Other doctors 100% Obstetric anaesthetists 100% Midwives 97.5% Critical Care Staff 100% MSWs 100%	*Compliant*
8b	Team involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019?	Separate training databases for neonatal and maternity workforces record details of staff training. Maternity workforce captured as part of PROMPT training Neonatal Teams have independent training sessions.	**NLS Training for Neonatal Teams** Neonatal Nurses Band 5 and above 87% Consultant and Speciality Paediatricians 94% ANNP 100% ST3-7 100% WHTH Peadiatric Service has been accredited as a national NLS training provider	*Compliant*
8c	There is a commitment by the Board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.	QAC March 2021, commitment from Trust Board to facilitate local, in person MDT training when permitted.	PROMPT face to face training session recommenced July 21	*Compliant*

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
a	A pathway has been developed to describe how frontline and Board safety champions share safety intelligence from floor to Board and through local LMS and Patient Safety Networks.	Pathway completed 28/02/2020	Posters of Maternity, Board and Non-Executive Safety Champions Displayed within Maternity and Neonatal Units.	*Compliant*
b	Board safety champions are undertaking sessions for staff to raise concerns, including those relating to Covid-19 service changes and can demonstrate that progress with actioning staff concerns.	Listening event dates scheduled for 2020 + 2021 Maternity Safety Champions Report to QAC 01/12/2020 06/04/2020 10/03/21	"You said we did" feedback shared with staff via Safety Champions Newsletter QI project to improve Maternity Triage in progress as a result of Safety Champion listening event.	Compliant
c	Board safety champions have reviewed continuity of carer action plan in the light of Covid-19, considering risks for Black, Asian, minority ethnic and vulnerable groups. Action plan describes a minimum 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups.	CoC action plan presented in Maternity Safety Champion Report to QAC **2020** - 07/01, 03/03, 07/07, 04/08, 01/09, 06/10, 03/11, 01/12 **2021** - 02/02, 03/03	WHH Trust Board have invested circa £500K recurrent in CoC. WHTH maternity Service has been nominated for HSJ Patient Safety Award for CoC project Progress of CoC is monitored by C&M LMS	*Compliant*

Safety action 9 continued

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
d	Frontline and Board safety champion and MatNeoSIP Networks has reviewed local outcomes in relation to: Maternal and neonatal morbidity and mortality rates including women who delayed or did not access healthcare in the light of Covid-19, following recommendations made by UKOSS, MBRRACE –UK and NHSE Chief Nurse.	WHTH participated in NWC SCN review of maternal and neonatal morbidity in June 2020 Review of maternal and neonatal morbidity cases completed 30/11/2020 CoC Action plan updated to include changes to service provision following Covid-19 pandemic and increased risk to BAME and vulnerable groups. Separate action plan completed in response to the recommendations made in the 2 named reports Action plans presented in Maternity Safety Champions Report 02/02/21	C&M LMS Support Strategy in place in response to risks identified for high risk, vulnerable and minority ethnic women	*Compliant*
e	Board Level Safety Champion actively supporting capacity (and capability) building for staff to be involved in the following areas: • Maternity and neonatal quality and safety improvement activity, including response to Covid-19 safety concerns • Specific national improvement work and testing lead by MatNeoSIP	Good Day Collaborative information using SCORE data presented in Maternity Safety Champions Report to QAC 03/03/2020 +01/09/2020 Board Level Safety Champion and Non-Executive safety Champion attended NWC Safety Summit 19/03/2021 Board Level and Maternity Safety Champions participated in a review of Halton maternity services to ensure maternity models and pathways meet the needs of stakeholder and service users.	Associate Clinical Director Women's Health provided additional support to C&M LMS Board Safety Champion is C&M LMS DoN Representative	Compliant

Safety action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
a	Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme.	6 HSIB cases accepted for investigation 2019 4 HSIB cases reported for investigation 2020 1 HSIB case reported for investigation 2020 NHSR Early Notification Report available for cases prior to 31/03/2020 HSIB Notification Report for cases 01/04/2020 onwards. HSIB update report included in 02/02/2021 Safety Champions Report to QAC HSIB quarterly report presented at Women's and Children's CBU governance meeting 22/04/21 HSIB compliance report presented at Women's health Governance Meeting 15/07/21	*Shadow validation by NHS Resolution to cross reference Trust reporting against HSIB database and the National Neonatal Research Database for the number of qualifying incidents recorded and externally verify that standard a) and b) have been met*	*Compliant*
b	Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21.			
c	For qualifying cases which have occurred between 01/10/20 to 31/03/21 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and 2. there has been compliance with duty of candour.			

Recommendations

- Trust Board are asked to note the contents of the final MIS Safety Action report
- Women's and Child Health CBU to develop the assurance reporting process and SOP to support future reporting of MIS progress

- **MIS Safety Action (SA) Specific Monitoring**
- Women's and Child Health CBU to monitor progress of neonatal medical staffing action plan (SA 4)
- The Maternity Service to develop an action plan to monitor achievement of 90% training compliance for fetal monitoring, PROMPT and NLS training requirements (SA 6+8)
- Maternity Service to continue audit of SBLCBv2 elements until a threshold of 95% has been achieved (SA 6)

List of Evidence

Warrington and Halton Teaching Hospitals NHS

Safety Action 1	Safety Action 6
• PMRT Quarterly Report • PMRT Letters to parents • Maternity Safety Champions Reports, Jan 2020 – March 2021	• SBLCBv2 Quarterly Survey Reports 2020-2021 • Governance Meeting minutes as evidence of monitoring • GAP/GROW SGA Detection Report • Individual Audit Report for Elements 1,2,3 and 5
Safety Action 2	**Safety Action 7**
• CNST Scorecard – December 2020 Data received Match 2021 • Letter to NHS Digital Feb 2021 • MIS Implementation plan	• Completed MVP Toolkit
Safety Action 3	**Safety Action 8**
• Copy of ODN quarterly Reports • Copy of CBU Governance Meetings where report has been discussed • Covid-19 Neonatal Service review of Term Admissions, final report • ATAIN Action Plan • Maternity Safety Champions Reports Jan 2020 – March 2021	• PROMPT Digital Training Materials • PDM HLBP outlining training compliance • NLS Training Database for Obstetrics, Midwives, Neonatal Nurses and Medical staff. • Minutes from QAC confirming Trust Board support for face to face training.
Safety Action 4	**Safety Action 9**
• ACSA preliminary assessment report • Paediatric Medical Workforce Action Plan • Neonatal Nursing Workforce Paper within Trust Biannual Nursing and Midwifery Staffing Report	• QAC Minutes for Safety Champions Reports Jan 2020 - present • Safety Champions Pathway • COC Action Plan • BAME Covid-19 Action Plan
Safety Action 5	**Safety Action 10**
Midwifery Workforce Paper within Trust Bi Annual Nursing and Midwifery Staffing Report Copy of Workforce Meeting minutes where report was discussed	• Completed HLBP

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/107**
SUBJECT:	**Director of Infection Prevention and Control Annual Report**
DATE OF MEETING:	28 July 2021
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.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain.
EXECUTIVE SUMMARY	This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2020 to March 2021 financial year. Covid-19 had an impact of achieving the annual work plan as activity was redirected in response to the pandemic. All members of the Infection Prevention and Control Team (IPCT) responded proactively providing education, briefings, development of policies and standard operating procedures and participation in contingency planning to ensure a high level of preparedness across the Trust. The IPCT structure has been revised and strengthened by an additional whole-time equivalent nurse. There were: - • 39 Covid-19 outbreaks • 168 Hospital onset/probable healthcare associated cases • 186 Hospital onset/definite healthcare associated cases The Trust scored 83% for very clean environment in the national inpatient survey which was above the national average of 80%. Improvements were noted in compliance with the Code of Practice on Prevention of Healthcare Associated Infections (HCAIs) by

	increasing isolation capacity and installing additional hand washing facilities. HCAI case numbers are comparable with similar sized Trusts. Totals for HCAIs were: - • 45 Clostridium difficile cases - 1 over threshold (decrease by 4 cases) • 1 MRSA bacteraemia case - considered avoidable (decrease by 1 case) • 24 MSSA bacteraemia cases (increase by 6 cases) • 45 E. coli bacteraemia cases (decrease by 6 cases) • 16 Klebsiella bacteraemia cases (increase by 1 cases) • 7 Pseudomonas cases (increase by 3 cases) HCAI prevention plans have been developed and are in place as per the NHS standard contract for 2021/22 and GNBSI reduction is included in the quality priorities for 2021/22. This report builds on previous annual reports submitted to the Board of Directors to give a full year account of infection prevention and control activity.			
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**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT		AGENDA REF:	BM/21/07/107

1. BACKGROUND/CONTEXT

Executive Summary

Organisation

Warrington and Halton Teaching Hospitals NHS Foundation Trust is a secondary care organisation providing healthcare services across the towns of Warrington, Runcorn, Widnes and surrounding areas. The Trust has 3 hospitals across two sites and operates within the mid-Mersey Health Economy. The Trust has circa 680 beds, an annual budget in the region of £246 million, employs over 4,500 staff and delivers 500,000 individual appointments, procedures and inpatient stays.

The Trust's mission is to be 'outstanding for our patients, our communities and each other', with a vision that 'we will be a great place to receive healthcare, work and learn'. We always put our patients first through high quality, safe care and an excellent patient experience.

Good infection prevention and control practices are a fundamental part of this mission and vision. Effective prevention and control of infection is part of everyday practice and is embedded at all levels of this organisation.

Infection Prevention Annual Work Plan

The IPCT worked towards delivery of the annual work plan. The Covid-19 pandemic had a significant impact on completion as efforts were appropriately re-directed.

A robust annual work plan (appendix 1) has been devised for the 2021/22 financial year. The work plan includes attendance at other committee meetings to ensure integration of infection prevention and control across the organisation; compliance with all mandatory surveillance requirements; monitoring of environmental cleanliness standards; audits of practice/policies; policy/guideline reviews and a programme of education and awareness raising events.

The work plan will link to the Infection Prevention and Control Strategy which is being revised in 2021 and progress will be monitored by the Infection Prevention and Control Sub-Committee.

Covid-19 Pandemic

A vast amount of activity has been undertaken throughout the financial year in response to the evolving pandemic. This involved surveillance of the international, national and local situation to implement a proactive response to escalating case numbers. In June 2020, NHS England/Improvement (NHSE/I published definitions for hospital onset cases as: -

- Hospital-Onset Indeterminate Healthcare-Associated (HO-iHA) – First positive specimen date 3-7 days after admission to Trust
- Hospital-Onset Probable Healthcare-Associated (HO-pHA) – First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Definite Healthcare-Associated (HO-dHA) – First positive specimen date 15 or more days after admission to Trust

This guidance also outlined definitions for outbreaks as two or more cases to occur within the same ward environment within 14 days.

The Trust complied with recommendations for reporting outbreaks and investigation of hospital onset cases with figures dating from 01 June 2020 to 31 March 2021 as detailed below: -

- 39 Outbreaks
- 168 HO-pHA cases
- 186 HO-dHA cases

RCAs for all Covid-19 cases detected from June 2020 have been completed and findings highlighted to each CBU with learning at individual ward level.

Code of Practice on Prevention of Healthcare Associated Infections

Good progress has been made to achieve the requirements of the Health and Social Care Act (2008) Code of Practice on Prevention of Healthcare Associated Infections (2015) which is directly linked to Regulation 12 of the Health and Social Care Act (2008). The Trust is working towards full compliance with the 10 criterions: -

- 8 are fully compliant
- 2 have minor non-compliances

These minor non-compliances relate to old estate i.e. lower number of side room facilities and lower ratio of hand washing sinks to patient number than current guidance. Several improvements have been made including increasing side room capacity for isolation and installation of additional hand washing facilities as part of the Covid-19 response. Several capital projects have been carried out to improve the Trust estate and additional inpatient bed capacity has been created.

The annual Patient Led Assessment of the Care Environment (PLACE) was deferred due to the Covid-19 pandemic. The National Inpatient Survey for 2020 was completed and included a question on environmental cleanliness. The Trust scored 83% for very clean which was higher than the national average of 80%.

Healthcare Associated Infections

There are three healthcare associated infection reduction action plans, linked to mandatory reporting requirements which were reviewed on a quarterly basis. The bacteraemia apportionment rule changed at the start of quarter 2 (Q2) to include community onset/healthcare associated (COHA) cases (samples obtained from patients discharged within the preceding 28 days) alongside hospital onset cases. Terminology was changed from hospital onset to hospital onset/healthcare associated (HOHA) cases. Addition of the COHA cases to Trust apportionment affects direct comparison with previous years data.

Hospital onset (Q1) and hospital onset/healthcare associated cases (Q2-Q4) have been combined throughout the report for all bacteraemia data and will be referred to as HOHA cases for consistency. COHA and HOHA cases combined will be referred to as Trust apportioned cases.

HCAI figures were as follows: -

- Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia
    - 1 Trust apportioned case (HOHA) - reduction by 1 case

- Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia
    - 24 Trust apportioned cases: 19 HOHA/5 COHA – increase by 6 cases

- Gram Negative Bloodstream Infection (GNBSI)
    - 45 Trust apportioned Escherichia coli (E. coli) cases: 34 HOHA/11 COHA – reduction by 6 cases
    - 16 Trust apportioned Klebsiella spp. cases: 12 HOHA/4 COHA increase by 1 case
    - 7 Trust apportioned Pseudomonas aeruginosa (P. aeruginosa) cases: 6 HOHA/1 COHA – increase by 3 cases

Despite the apportionment rule changing, which resulted in an additional eleven E. coli bacteraemia cases being apportioned to the Trust, an overall reduction of six E. coli bacteraemia cases was made.

The increase by one Klebsiella spp. cases includes four COHA cases and the increase by three P. aeruginosa cases includes one COHA case.

The increase by six MSSA bacteraemia cases included five COHA cases.

The national target to reduce GNBSI published in the Tackling Antimicrobial Resistance 5-year plan (January 2019) remains in place. This publication recommends a systematic approach to preventing infections and delivering a 25% reduction by 2021-2022 and 50% by 2023-2024. There was a decrease in targeted work on prevention of GNBSI due to the Covid-19 response. This workstream has been re-established and is included in the Trust's quality priorities for 2021/22.

- Clostridium difficile
    - 45 Trust apportioned Clostridium difficile (C. difficile) cases 34 HOHA/ 11 COHA

All Trust apportioned C. difficile cases undergo root cause analysis (RCA) investigation. Cases considered unavoidable are submitted to the Clinical Commissioning Group (CCG) review panel. RCAs have been competed however there was a delay in completing reviews and submission to the CCG due to the Covid-19 pandemic. A recovery plan is in place to ensure completion.

Actions in place to prevent C. difficile include; hand hygiene (staff and patients), environmental cleanliness and antimicrobial stewardship.

This report outlines the arrangements, activities and achievements during 2020/21. The report builds on previous annual reports submitted to the Board of Directors to give a whole year account of infection prevention and control activity.

Kimberley Salmon-Jamieson
Chief Nurse & Deputy Chief Executive
Director of Infection Prevention and Control (DIPC)
July 2021

Acknowledgements

Allen Hornby	Lead Nurse Critical Care
Julie McGreal	Facilities Manager
Lesley McKay	Associate Director of Infection Prevention and Control
Dr Zaman Qazzafi	Consultant Medical Microbiologist
Jacqui Ward	Lead Pharmacist in Antimicrobial Stewardship

2. KEY ELEMENTS

Description of Infection Control Arrangements

Infection Prevention and Control Team

The IPCT are scheduled to meet fortnightly. Meeting frequency was affected as efforts were redirected to the Covid-19 response. Additional staffing was provided to support the IPCT Covid-19 response including a temporarily redeployed Band 6 and funding increase for a permanent Matron post.

Membership includes: -

- Consultant Medical Microbiologists: -
  - Dr Zaman Qazzafi (Deputy DIPC and Infection Control Doctor)
  - Dr Toong Chin
  - Dr Janet Purcell (0.6 WTE)

- Associate Chief Nurse for Infection Prevention and Control: -
  - Lesley McKay (Associate DIPC)

- Interim Matron post (from October 2020) Covid-19 support
  - Michelle Ridings

- Infection Prevention and Control Nurses: -
  - Charlene Liptrot
  - Katherine Summers
  - Joanne Oldfield

- Covid-19 Support Nurse
  - Kristina Sta Maria

- Lead Pharmacist in Antimicrobial Stewardship
  - Jacqui Ward

- Infection Control Administrator: -
  - Amanda Millington

- Operational Estates Manager
  - Darren Wardley (until December 2020)

- Head of Estates Maintenance, Compliance and Risk
  - Robert Lamb (From March 2021)

Infection Control Sub-Committee

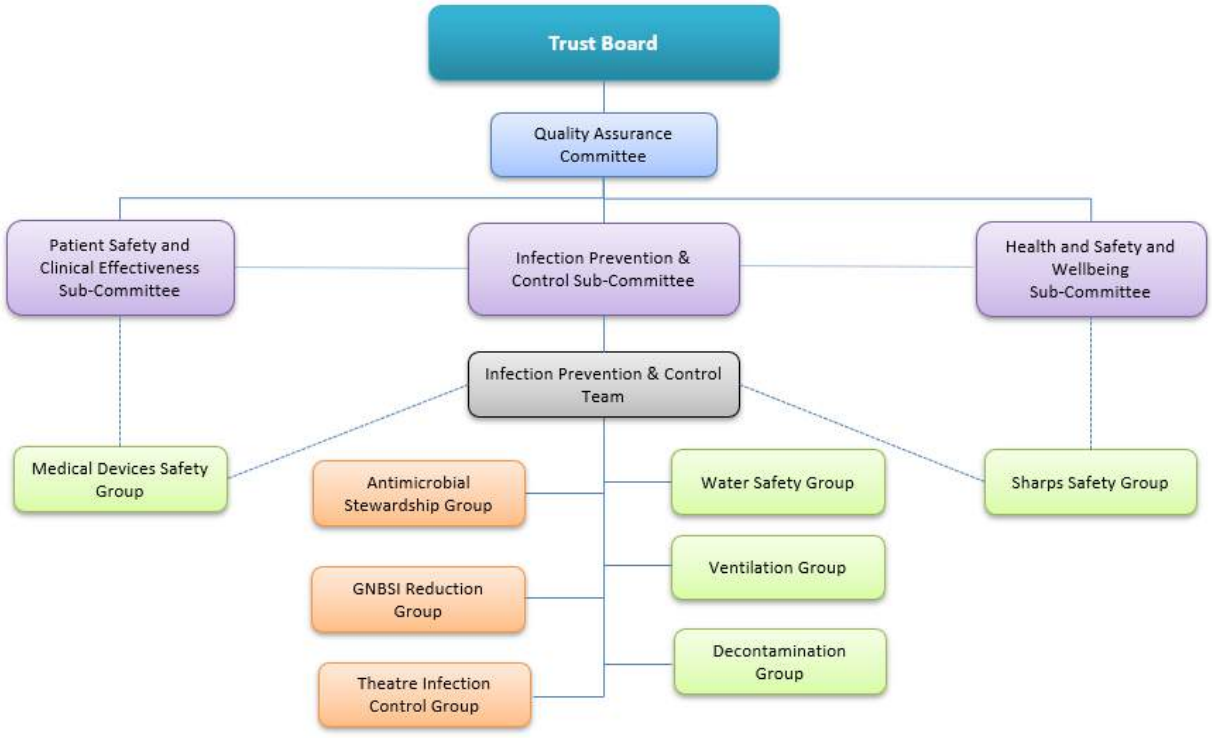
The Infection Control Sub-Committee is chaired by the Consultant Medical Microbiologist/Deputy DIPC/Infection Control Doctor. The committee meeting frequency changed in response to the pandemic and met 8 times during the year.

Membership comprises of the DIPC, IPCT, Lead Nurses from each Clinical Business Unit (CBUU), Estates and Facilities Managers, Lead Allied Health Professional and the Occupational Health and Wellbeing Manager.

The Lead Nurses for each CBU and the Lead for Allied Health Professionals submit reports at each meeting as a standing agenda item. This allows the Infection Control Sub-Committee to give assurance to the Quality Assurance Committee and Trust Board of Directors on activity within the Trust and that compliance with the Code of Practice is maintained and that there is a programme of continued improvement.

High level briefing papers are submitted by the Infection Control Sub-Committee Chair to the Health and Safety Sub-Committee, Patient Safety and Clinical Effectiveness Sub-Committee and the Quality and Assurance Committee. The reporting line to Trust Board is detailed in figure 1.

Figure 1 Reporting Line to Trust Board



There is a link to the Drugs and Therapeutics Committee via: -

- Consultant Medical Microbiologists
- Lead Pharmacist in Antimicrobial Stewardship
- Antimicrobial Management Stewardship Group

From October 2021 an Infection Control and Microbiology Cell operated within the Covid-19 Tactical Management Board Structure with responsibility for providing Trust-wide advice, education and training, support with patient placement and surveillance of Covid-19 cases. This Group was chaired by the Chief Nurse/Deputy Chief Executive/DIPC and reported to the Covid-19 Tactical meetings with escalation to the Senior Executive Oversight Group where appropriate.

DIPC Reports to Trust Board

Reports and high-level briefing papers, which included Covid-19 specific reports, key performance indicators, HCAI surveillance data, outbreak/incident details and root cause analysis/post infection review findings were submitted to the Quality and Assurance Committee with onward reporting to Trust Board: -

- IPC Board Assurance Framework Compliance Report - May 2020
- Personal Protective Equipment (PPE) for Covid-19 - May 2020
- IPC Board Assurance Framework Compliance Report - August 2020
- IPC Q4 (2019/2020) - August 2020
- Q1 Report (2020/2021) - August 2020
- DIPC Annual Report in previous financial years activity - October 2020
- IPC Board Assurance Framework Compliance Report - October 2020
- IPC Q2 - Report January 2021
- IPC Board Assurance Framework Compliance Report - December 2020
- Position statement on 10 Key actions - January 2021
- IPC Q3 Report - March 2021

Annual work plan

The IPCT work plan was developed to give assurance that each element of the Code of Practice for prevention of healthcare associated infections (HCAIs), which underpins the Health and Social Care Act (2008) linked to Regulation 12 is adhered to and that appropriate evidence of compliance is available.

This work plan is underpinned by action plans for key performance indicators/mandatory healthcare associated infections and a programme of audit that provides evidence of policy/guideline compliance. Progress against planned activity was impacted by the volume of Covid-19 cases.

The annual work plan has been revised for 2020/21 and is included at appendix 1.

Covid-19

A vast amount of activity was undertaken in response to the pandemic. Covid-19 cases peaked in April in wave one with the highest number of confirmed cases on one day reaching 126 inpatients. The pandemic escalation plan was put into place and expanded from the initial location identified (A7) to other wards including A4, A5 and A8. Critical Care expanded its bed base into theatres as per the pandemic plan.

Discharge to Care Home screening was introduced on 16 April 2020. Screening of all patients admitted by the emergency route was introduced on 24 April 2020. In house testing for Covid-19 commenced on 16 June 2020 and text message alerting of confirmed results was put in place with alerts to the Infection Prevention and Control Nurses (IPCNs) and the Covid Consultant on call.

Additional support was provided from medical staff that were redeployed from front line working. The IPCNs provide a 7 day and an out of hours on call service. A business case was developed and approved to increase IPCT staffing.

The following documents were developed and revised throughout the year as per new/updated guidance being published: -

- Novel Coronavirus Policy
- Patient Placement SOP
- Isolation of Vulnerable Patients SOP
- Qualitative Fit Testing SOP
- Reusable PPE Decontamination SOP
- Hospital Onset Covid-19 Investigation and Outbreak Management Plan
- Hospital Onset Covid-19 RCA Template
- Quantitative Fit testing Sop
- Covid-19 screening SOP

The IPCNs and Microbiology Consultants provided education and roadshows including where staff raised concerns about PPE guidance. Several Royal and Chartered Societies produced PPE guidance that differed from that of Public Health England (PHE). Visits took place to Theatres, Therapy teams, Phlebotomy Staff, Security Team and a DIPC led visit to Estates and Facilities staff. Return visits took place where staff continued to have concerns or raised new queries. Concerns emerged from non-front-line staff and visits also took place to Medical/Surgical Secretaries, finance and clinical coding offices.

The programme of Fit Testing of Face Filtering Piece (FFP) 3 respirators was expanded following purchase of additional testing equipment (Portacount) to conduct quantitative fit testing. Training on the use of the device was provided by an accredited Fit2Fit company. The rota to provide a fit testing service functioned over 14 hours per day. It was not possible to successfully fit test some members of staff and alternative respiratory protective equipment (powered hoods) were provided for these groups of staff. A specialist PPE distribution room was set up on 10 April 2020 to deliver this service. Where re-usable PPE was supplied, written guidance on maintenance and decontamination was provided.

Visiting restrictions were lifted nationally. However due to reported higher local incidence of Covid-19, a decision was taken by all Trusts in Cheshire and Merseyside not to lift visiting restrictions. Compassionate visiting arrangements were in place and visitors were supported with training on use of PPE.

PHE introduced the concept of ‘Shielding’ (minimising all interaction) to protect people who are clinically extremely vulnerable and at very high risk of severe illness from Covid-19 because of an underlying health condition. All healthcare workers that required shielding were supported to work from home.

Recovery Board meetings began 07 May 2020 to establish plans for return of elective activity. The IPCT provided advice on setting up Covid-19 protected patient pathways. Ward B18 was set up for urgent surgical cases and visits also took place to the Halton site to provide guidance on setting up elective

activity. All Clinical Business Units were asked to estimate PPE usage rates as part of service redevelopment plans.

PPE

The procurement team provided an extended hours service and maintained availability of PPE throughout the pandemic with stock levels under constant review. The Trust's Finance Director chaired a regional Mutual Aid Group which provided PPE at times when supplies were running low. A national managed inventory was implemented to ensure Trusts had a 7-14 days' supply (dependant on storage capacity) and additional steps with quality control were taken at national level. Due to the plans implemented there were no outages of PPE stock.

During April the Secretary of State for Health advised the risk of shortages of fluid resistant gowns. Guidance on sessional use of gowns had been published on 2 April 2020. Alternative choices including reusable fluid repellent theatre gowns and coveralls were put in place by the Chief Nurse/Deputy CEO/DIPC and Associate Chief Nurse for IPC on 3 April 2020 as per the contingency plan for gown shortage Scrub Suits were offered throughout the year as an alternative to home laundering of uniforms.

Further national guidance introduced on 15 June 2020, stipulated use of face masks in all areas. This guidance was put in place on 12 June 2020 with distribution of face masks to all non-clinical areas.

An Environmental Action Plan was developed jointly with the Associate Director of Estates and Facilities and the Deputy Chief Nurse for Patient Safety. This action plan incorporated: - reduction of entrances/exits, signage promoting social distancing, Perspex barriers at reception desks, ensuring high standards of cleanliness and risk assessments to create Covid-19 secure areas for staff and a risk assessment tool was implemented across the Trust.

Where surveillance detected outbreaks of Covid-19, Outbreak Control Team meetings were established and the situations reported to external partners including: - NHSE/I, Public Health England (PHE), Clinical Commissioning Group (CCG), Care Quality Commission (CQC) and the northwest incident control centre (NW. ICC) as per regional guidance.

The Trust supported trial of the NHSE/I draft Hospital Onset Covid-19 Infection Outbreak Investigation SOP. A virtual meeting was held between the CEO, Chief Nurse/Deputy CEO, Executive Medical Director, Consultant Microbiologist and Associate Chief Nurse for IPC with the Regional Medical and Nursing Directors, IPC Lead NHSE/I and PHE.

A Covid-19 PPE audit tool was developed and is used to monitor standards of compliance.

Board Assurance Framework

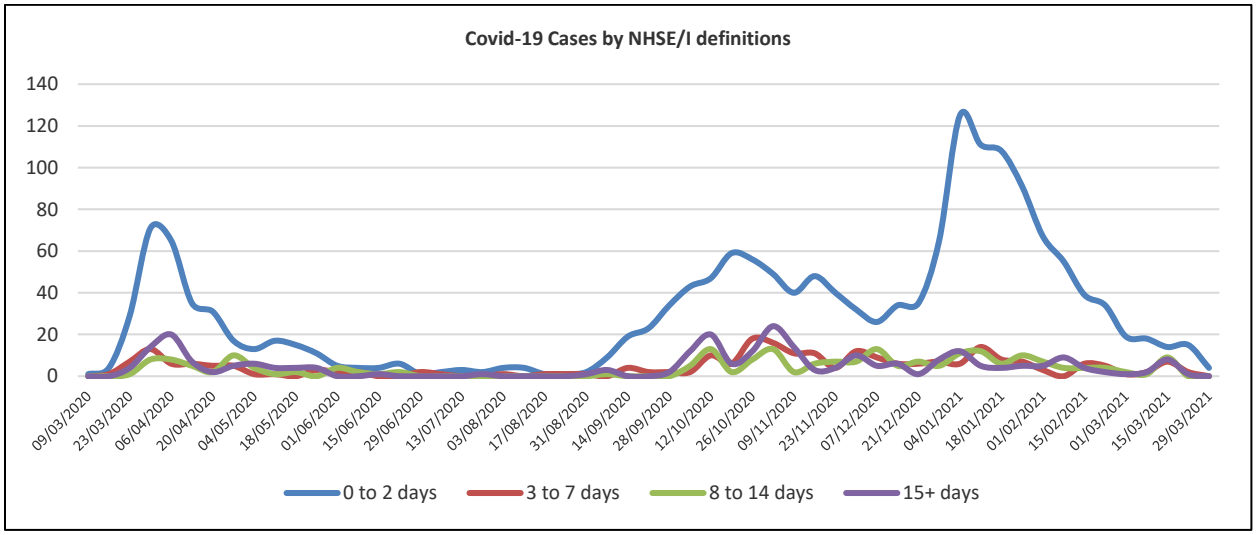
NHSE/I published an Infection Prevention and Control (IPC) Board Assurance Framework (BAF) document, linked to the Code of Practice on prevention of HCAIs. This document was populated and submitted to the Trust Board of Directors with updates bimonthly and to the CQC as requested. Revision were made to the IPC BAF following publication of updates to the national document and an action plan is in place for minor gaps in assurance.

A decrease in the local incidence of Covid-19 was observed in July and August with cases rising in September 2020. The IPCT continued to support all CBUs with advice on restoration of elective services, appropriate precautions and risk assessments. The pandemic escalation plan was revised with the Emergency Planning Officer in preparation for wave 2. The IPCNs continued to provide a 7 day and out of hours on call service with text message alerting of confirmed Covid-19 results to ensure timely management of cases.

A risk assessment to support the re-introduction of visiting was developed and ratified by the Tactical Group in September. However due to rising local incidence of Covid-19, the decision taken by all Trusts in Cheshire and Merseyside not to lift restrictions was held. Compassionate visiting arrangements remained in place and visitors were supported with training on use of PPE.

Inpatient cases peaked in November at 179 inpatient cases, dipped slightly in December to 150 inpatient cases and then rose sharply in January to 232 inpatient cases followed by a steady decline through to March 2021. Figure 2 shows inpatient cases according to NHSE/I definitions.

Figure 2 Covid-19 Cases by NHSE/I definitions



Covid-19 Nosocomial cases

From June 2020 there were: -

- 168 HO-pHA cases
- 186 HO-dHA cases

All cases detected ≥ day 8 of admission underwent root cause analysis investigation (RCA). The RCAs have been reviewed by the IPCT with the Associate Director of Governance and the Deputy Chief Nurse. Learning from the cases has identified several themes including: -

- Length of stay and Multiple ward moves
- Missed admission screening (low number)
- Missed day 3 and day 5 screening
- Missed swabbing opportunities - symptomatic
- Clinically Covid-19 but negative swab result
- Wander some patients
- Decrease in nursing cleaning score
- Occasional PPE non-compliance

Covid-19 Outbreaks

From June 2020 there were 39 Covid-19 outbreaks affecting staff and or patients. Outbreak Control Groups are set up to manage outbreaks and learning has been shared Trust-wide including: -

- Car sharing - without face masks
- Social distancing in break room - less than 2 metres apart whilst eating /drinking
- Accuracy of office/ break room risk assessments - sitting less than 2 metres apart
- Missed admission screening (low number)
- Missed day 3 and day 5 screening
- Possible missed opportunity to test – hospital acquired pneumonia (HAP)
- Patients in neighbouring bed < 2 metres
- Wander some patients
- Incorrect /missed equipment decontamination
- Lack of 2 negative tests before moving patients from ED
- Multiple ward moves
- Having positive and negative patients on the same ward
- Occasional concerns with compliance with PPE
- Length of stay

In response to the initial outbreaks, NHSE/I visited the Trust on 30 September 2020. The inspection team advised the visit was intended to be supportive and not for performance management. A small number of suggestions were made which included purchase of additional hydrogen peroxide vapour (HPV) machines for environmental decontamination. A business case was developed, and four additional HPV machines purchased and put into operation to ensure appropriate levels of decontamination are achieved.

Challenges to managing Covid-19 included: -

- Old estate – limited side/break rooms/offices
- Less clearly defined pathways (in-patients high/low risk areas)
- Patients and staff movements from/to high risk areas
- Test with possible sub-optimal performance
- Areas with non-compliance with PPE/social distancing
- Poorly ventilated bays/wards
- Environmental hygiene – some areas of concern

- Bed pacing <2 metres
- 'Presenteeism' – coming to work despite having symptoms

Action taken included: -

- Introduction of point of care admission screening
- Installation of physical barriers clear curtains where inpatient beds are < 2 metres apart
- Increased uptake of Lateral Flow Device Testing
- Repeated communications and updates on Covid-19 IPC precautions
- Staff vaccination programme
- Streaming of patients to Covid/non-Covid wards timely to avoid both cohorts being on the same ward as far as reasonably practicable

The IPCT members continued to provide education and road shows where staff raised concerns about PPE guidance. The programme of Fit Testing of FFP3 respirators has continued throughout the year.

Health and Social Care Act (2008) compliance assessment

A compliance assessment against the 10 criteria, specified in the *Health and Social Care Act 2008 Code of Practice for preventions and control of infections and related guidance* (Department of Health 2015), linked to regulation 12, is carried out biannually.

The Care Quality Commission (CQC) uses this code to judge registered provider compliance with the cleanliness and infection control requirement set out in the regulations. Compliance with the Code of Practice at the end of March 2021 and areas requiring further action are detailed in table 1.

Table 1 Compliance with the Code of Practice on prevention of HCAIs

Criterion	*Assessment*	*Action required/in progress*
1. *Systems to manage and monitor the prevention and control of infection.*	*Compliant*	*Training required on surveillance software. Report templates to be developed*
2. *Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.*	*Partially compliant*	*Upgrades to some hand washing sinks required (design and location). Audit of handwashing facilities scheduled with Estates Team*
3. *Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.*	*Compliant*	
4. *Provide suitable accurate information on infections to service users and their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.*	*Compliant*	
5. *Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.*	*Compliant*	
6. *Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.*	*Compliant*	

Criterion	Assessment	Action required/in progress
7. *Provide or secure adequate isolation facilities.*	*Partially compliant*	*Continuous liaison with the Patient Flow Team to optimise use of side rooms for appropriate patient isolation*
8. *Secure adequate access to laboratory support as appropriate.*	*Compliant*	
9. *Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.*	*Compliant*	
10. *Providers have a system in place to manage the occupational health needs of staff in relation to infection.*	*Compliant*	

Healthcare Associated Infection Statistics

The Trust participates in mandatory reporting of HCAIs. There are 3 HCAI reduction action plans, linked to mandatory reporting requirements which were reviewed on a quarterly basis. Post infection reviews/root cause analysis investigations are completed. These reports are reviewed with the Chief Nurse/Deputy CEO/DIPC and learning points are added to action plans to promote learning from cases.

Clostridium difficile

For the financial year 2020/21, the Trust reported 67 Clostridium difficile (C. difficile) toxin positive cases:

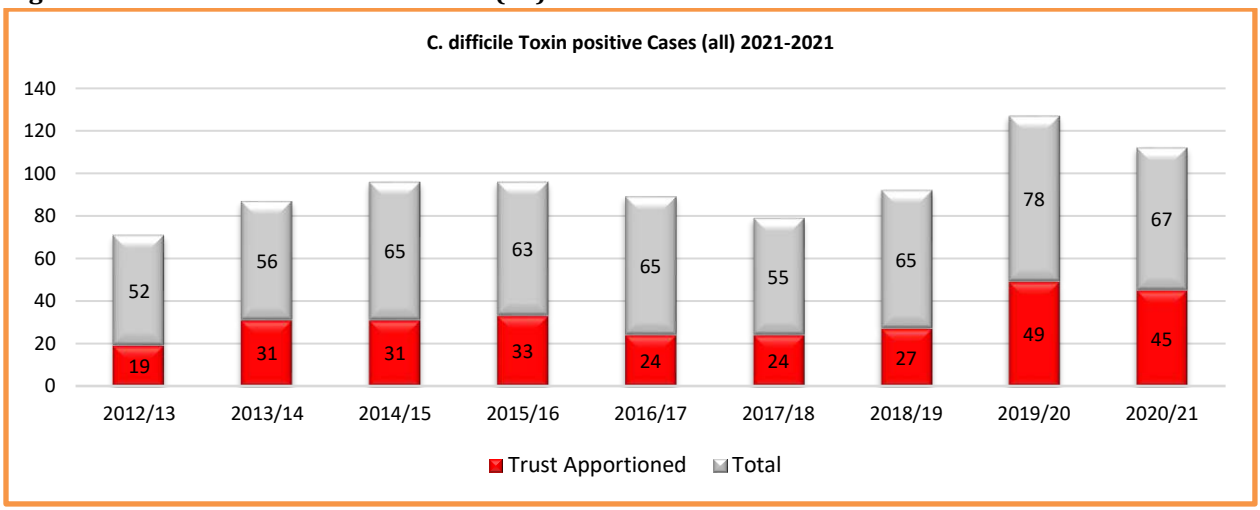
- hospital onset/healthcare associated = 34
- community onset/healthcare associated = 11

} 45 Trust apportioned cases

- community onset indeterminate association = 5
- community onset community associated = 17

The national C. difficile objective was not published for the 2020/21 financial year and a locally agreed threshold of 44 or less hospital apportioned cases was set. The Trust was 1 case over threshold with a total of 45 cases. A comparison with previous year's data is displayed in figure 3.

Figure 3 C. difficile Toxin Positive Cases (all) 2012 - 2021

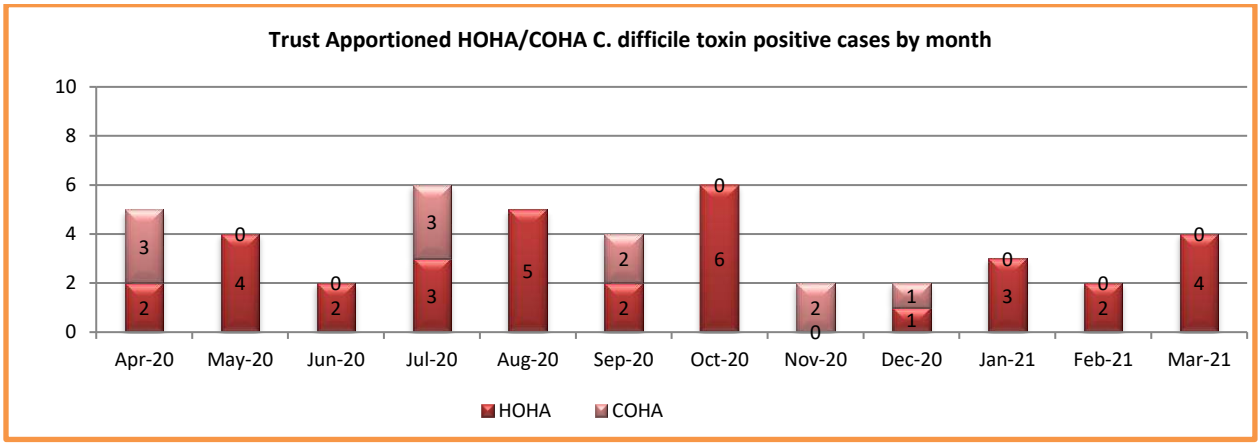


The rise in cases from 2019/20 is related to the revised apportionment rules:

- reduction in the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) following admission
- community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks

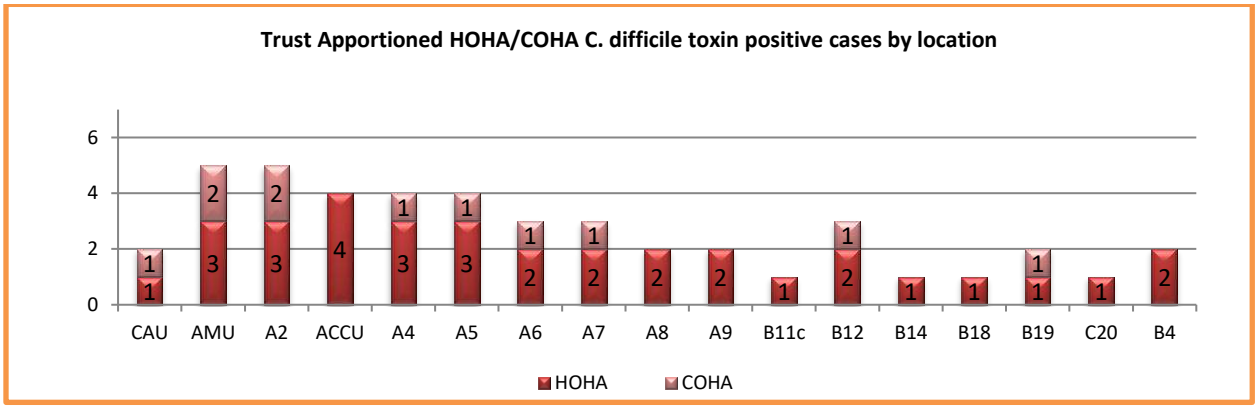
Figure 4 shows C. difficile toxin positive Trust Apportioned (HOHA/COHA) cases by month.

Figure 4 Trust Apportioned HOHA/COHA C. difficile toxin positive cases by month



HOHA cases by location when the sampled and COHA cases by the discharging ward are displayed in figure 5. The location the specimens were obtained from is not necessarily where the infection was acquired as patients may have been on the ward/department for less than 48 hours when tested.

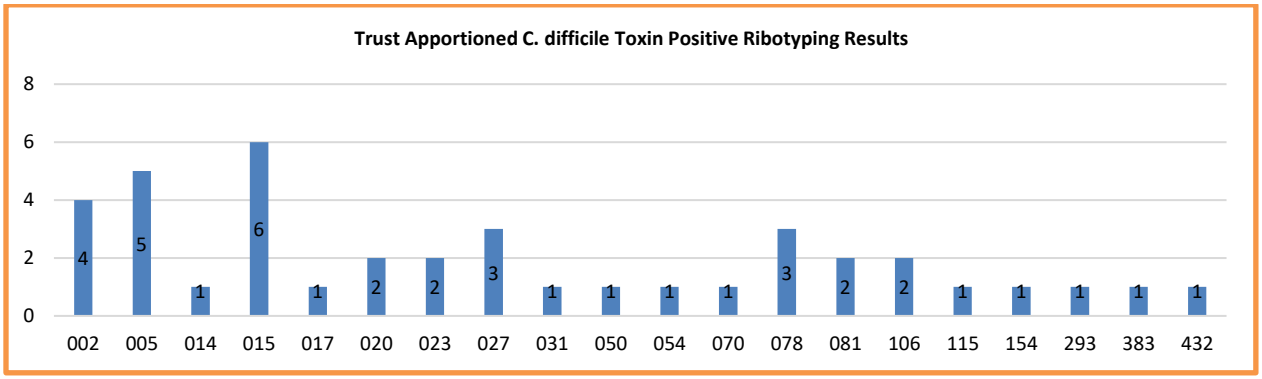
Figure 5 Trust Apportioned HOHA/COHA C. difficile toxin positive cases by location



All Trust apportioned C. difficile cases undergo root cause analysis (RCA) investigation. The investigations are completed by Ward Managers with input from the patients' Consultants'. Completed investigations are reviewed internally and if considered unavoidable are submitted to the CCG review panel. There was a delay in completing RCA reviews due to the Covid-19 pandemic. A recovery plan is in place to ensure completion.

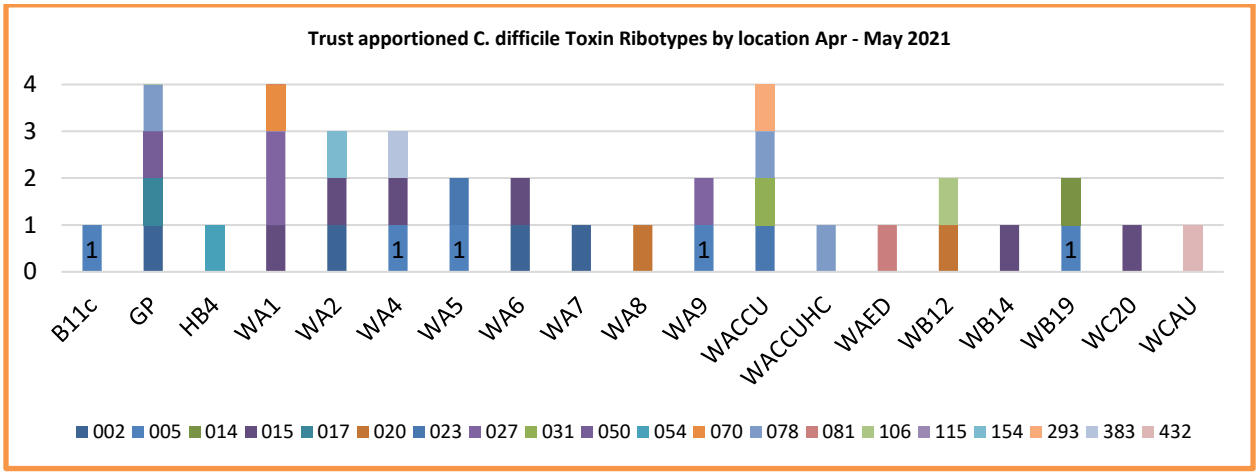
All Trust apportioned C. difficile toxin positive isolates are submitted for ribotyping. From the 45 isolates, 20 different Ribotypes were identified. C. difficile was not recovered from 5 of the samples submitted for ribotyping. Results are shown in figure 6 and demonstrate 015 ribotype is seen most frequently.

Figure 6 HOHA/COHA C. difficile Toxin Positive Ribotyping Results



Ribotyping results by ward are shown in figure 7. There were no periods of increased incidence (two or more cases within a 28-day period) and therefore no cross infection/outbreaks identified.

Figure 7 C. difficile Toxin Positive Ribotyping Results by Location



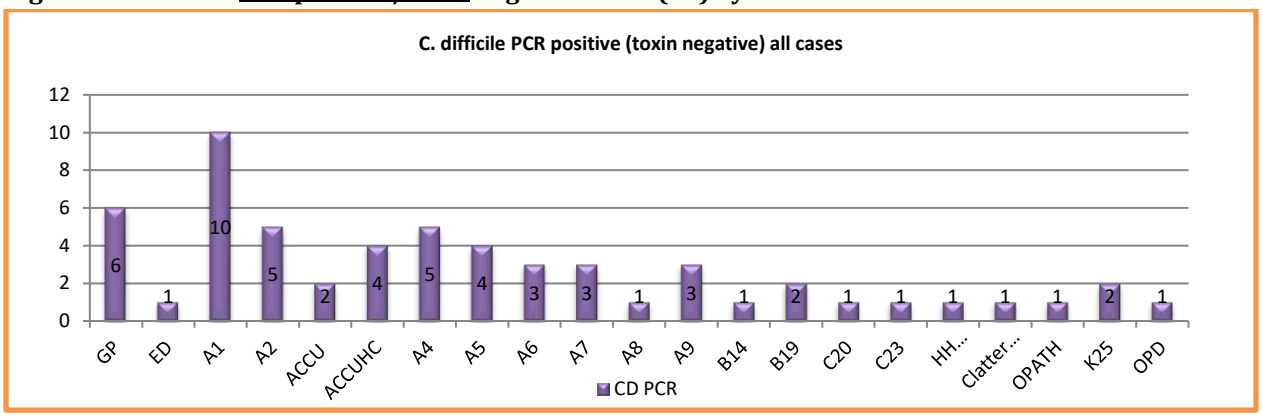
Clostridium difficile (toxin negative/PCR positive)

Diagnostic testing methods for C. difficile infection distinguishes between patients who are colonised with C. difficile (toxin negative/PCR positive), and those with C. difficile toxins present. Presence of toxins indicates infection is more likely.

The IPCT conduct local surveillance on the patients who are C. difficile toxin negative/PCR positive. These patients are at a higher risk of developing C. difficile infection than non-colonised patients. Inpatients falling into this category are reviewed and patients exhibiting symptoms are nursed in isolation and treatment advice is provided.

Figure 8 shows the results for all patients (no apportionment) who were C. difficile toxin negative/PCR positive and location at the time of testing.

Figure 8 C. difficile PCR positive/toxin negative cases (all) by location when tested



The IPCT focussed activity on C. difficile reduction by: -

- Surveillance of cases/monitoring for periods of increased incidences
- Antimicrobial Management Stewardship Group
- Hand hygiene awareness raising events
- Weekly multi-disciplinary team review of patients with C. difficile
- Promoting improvements to standards of environmental hygiene
- Use of hydrogen peroxide vapour for environmental decontamination

The C. difficile objective for 2021/22 has not been published. An internal threshold of 44 cases has been set for 2021/22 as per last year's objective.

Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia

The Trust reported two cases of MRSA bacteraemia, one of which was a HOHA case. This was a reduction of Trust apportioned cases by one. Data for comparison with earlier financial years is shown in figure 9.

Figure 9 MRSA bacteraemia cases (all) 2012 – 2021

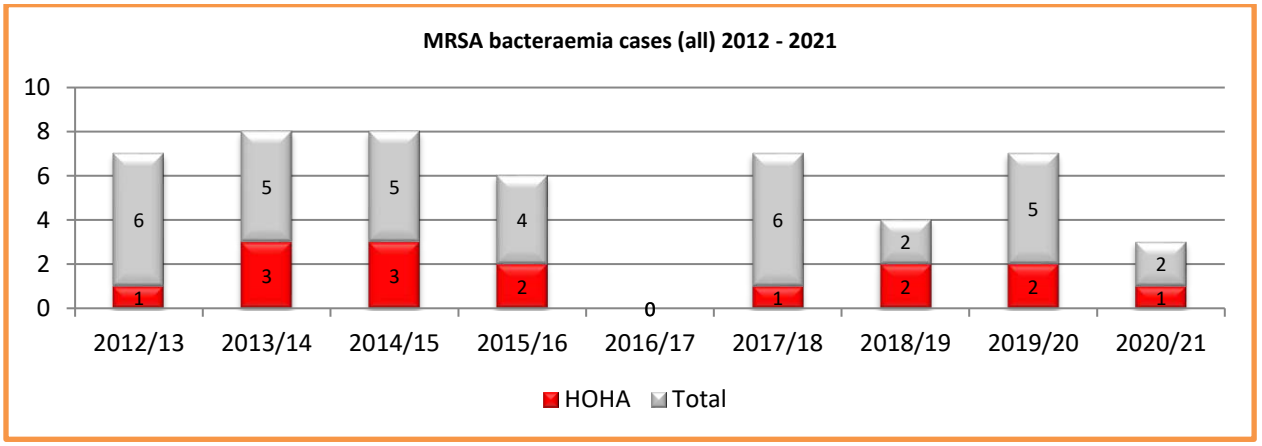
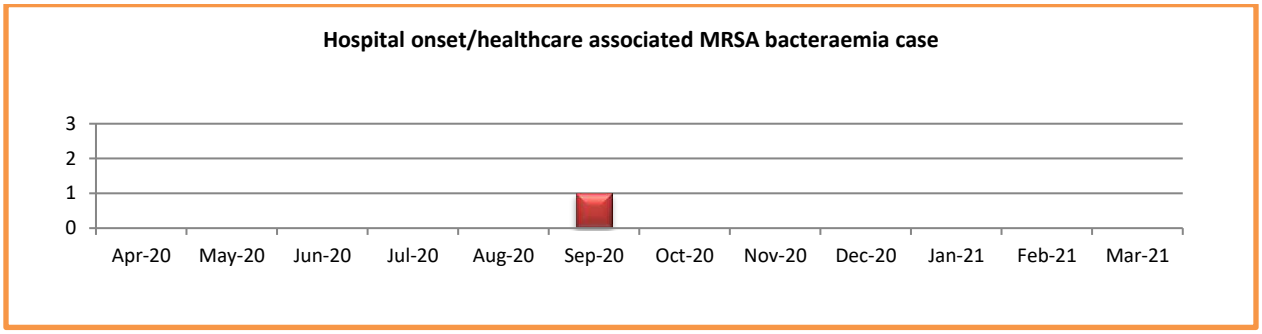


Figure 10 shows the HOHA MRSA bacteraemia case identified within the financial year.

Figure 10 Trust Apportioned MRSA bacteraemia cases by month



The hospital onset case occurred on ward B19. Review of this case highlighted an elderly female patient, living with dementia and negative MRSA admission screen. During the admission the patient developed a unilateral facial swelling and received an ENT review. Antibiotic treatment was given, and an ultrasound scan revealed no sign of abscess. The post infection review identified dehydration and areas for improvement with peripheral cannula monitoring. The infection was considered avoidable.

MRSA screening

The Trust continues to provide MRSA screening for patients in line with the Department of Health guidance. Work is in progress with the data warehouse team to provide a more robust screening compliance report against the MRSA policy screening requirements.

Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia

The Trust reported 45 cases of MSSA bacteraemia (21 community onset and 24 Trust apportioned). This was an increase of 6 Trust apportioned cases compared to the previous financial year. The Department of Health has not set targets for the reduction of MSSA bacteraemia. Data for comparison with previous financial years is shown in figure 11.

Figure 11 MSSA bacteraemia cases (all) April 2012 – March 2021

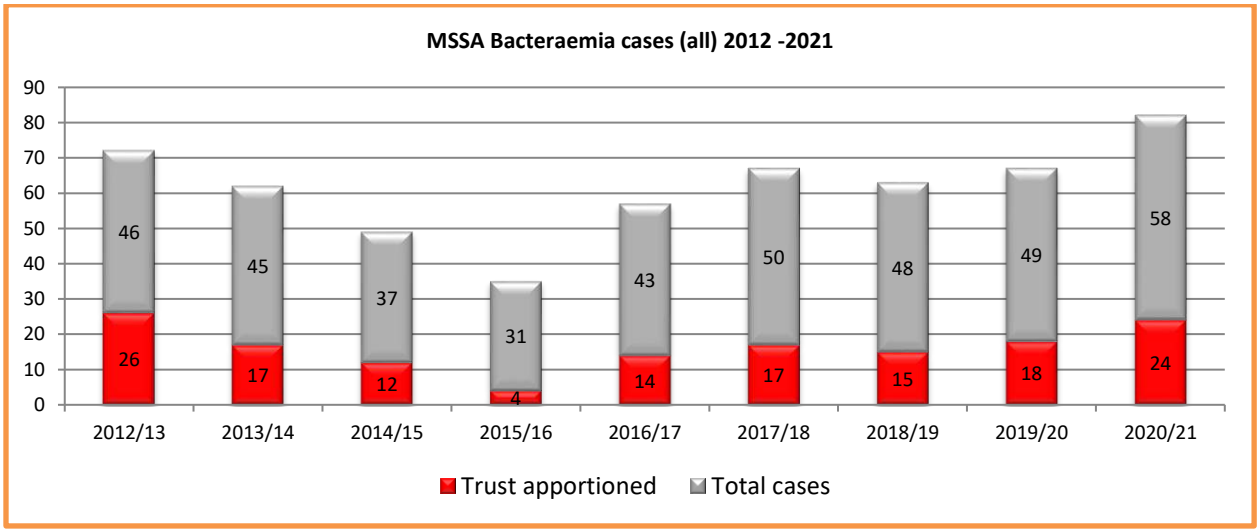


Figure 12 shows the Trust apportioned MSSA bacteraemia cases by month.

Figure 12 Trust Apportioned MSSA bacteraemia cases by month

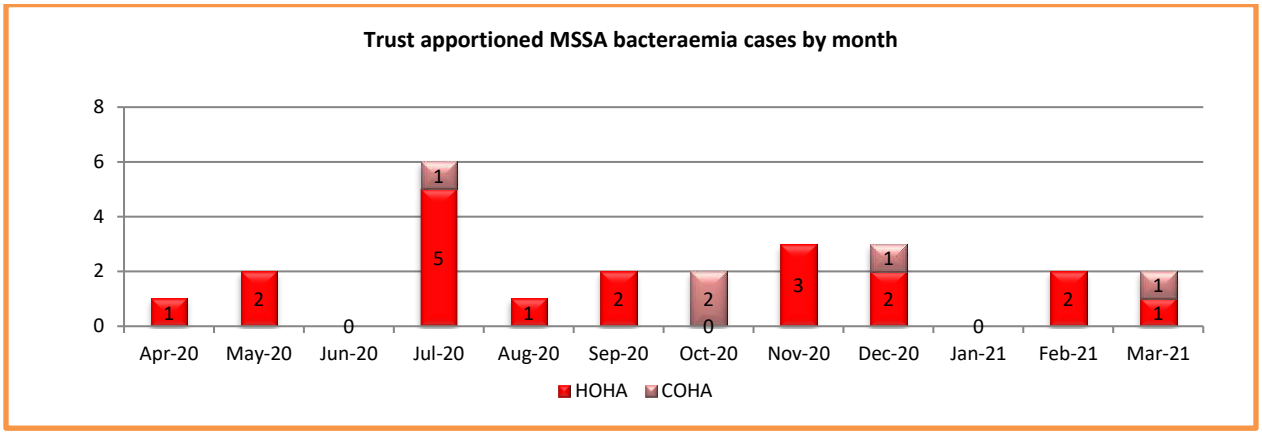
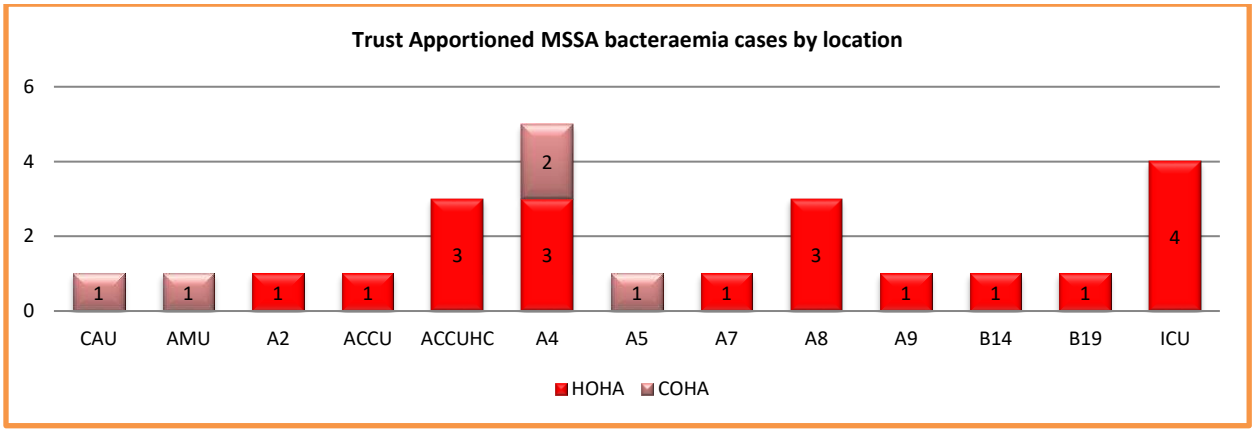


Figure 13 shows the patients location at the time the specimen was obtained for HOHA cases and discharging ward for COHA cases.

Figure 13 Trust Apportioned MSSA bacteraemia cases by location



Case reviews identified several different sources for infection including: - pneumonia, septic arthritis, skin and soft tissue infection, peripheral cannula and urinary tract infection. An action plan is in place linked to learning from these incidents that sets out the work required to prevent the risks of MRSA/MSSA bacteraemia cases.

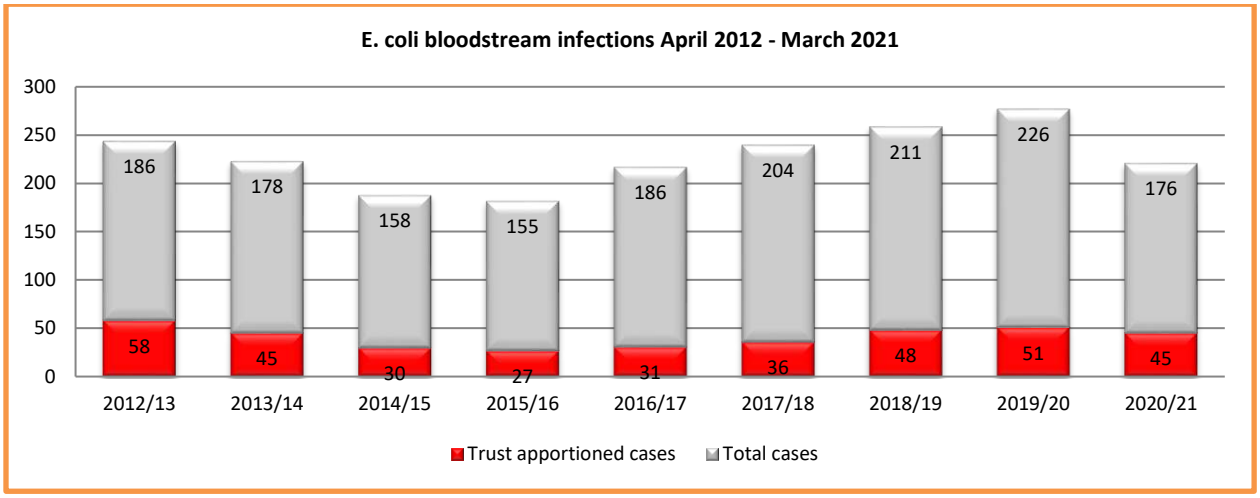
Gram Negative Bloodstream Infection (GNBSI)

The national target to reduce GNBSI (E. coli; Klebsiella spp. and Pseudomonas aeruginosa) published in the Tackling Antimicrobial Resistance 5-year plan (January 2019) remains in place. This publication recommends a systematic approach to preventing infections and delivering a 25% reduction by 2021-2022 and 50% by 2023-2024. The plan to introduce individual provider objectives has not been published. For the baseline year (2016) the reduction target is set against, the Trust reported a total of 181 E. coli bloodstream infections and 36 of these were hospital onset cases.

E. coli bacteraemia

Mandatory reporting of E. coli bacteraemia commenced in June 2011. In order to show whole year figures for comparison, data is shown in figure 14 from April 2012.

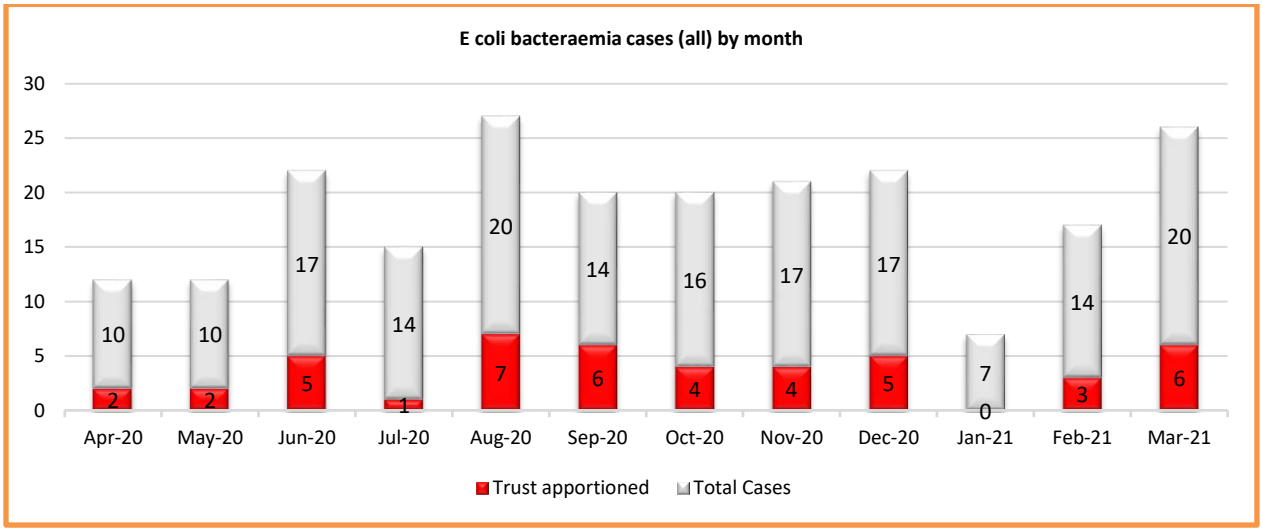
Figure 14 E. coli bacteraemia cases (all) April 2012 – March 2021



During in 2020/21 financial year the Trust reported a total of 176 E. coli bacteraemia cases, 45 of these were Trust apportioned cases. There was a decrease of 6 Trust apportioned cases and an overall decrease of 50 cases across the health economy compared to the previous financial year.

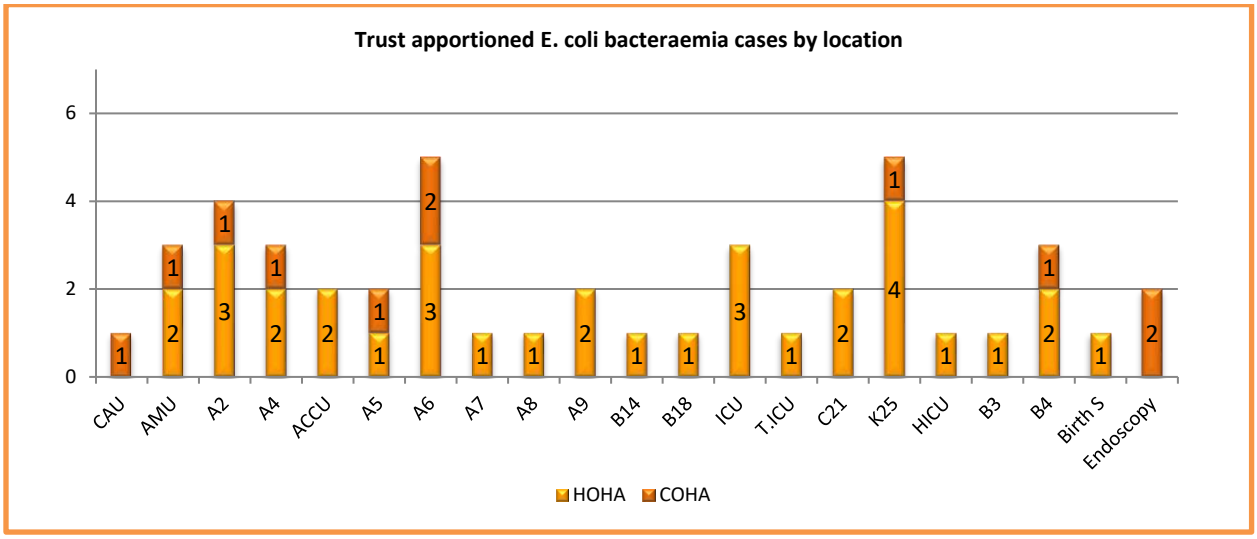
Figure 15 displays the total number of cases reported each month against the number of Trust apportioned cases during the financial year.

Figure 15 E. coli bacteraemia cases (all) by month



The Trust apportioned E. coli bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases are shown in figure 16.

Figure 16 Trust apportioned E. coli Bacteraemia Cases by Location

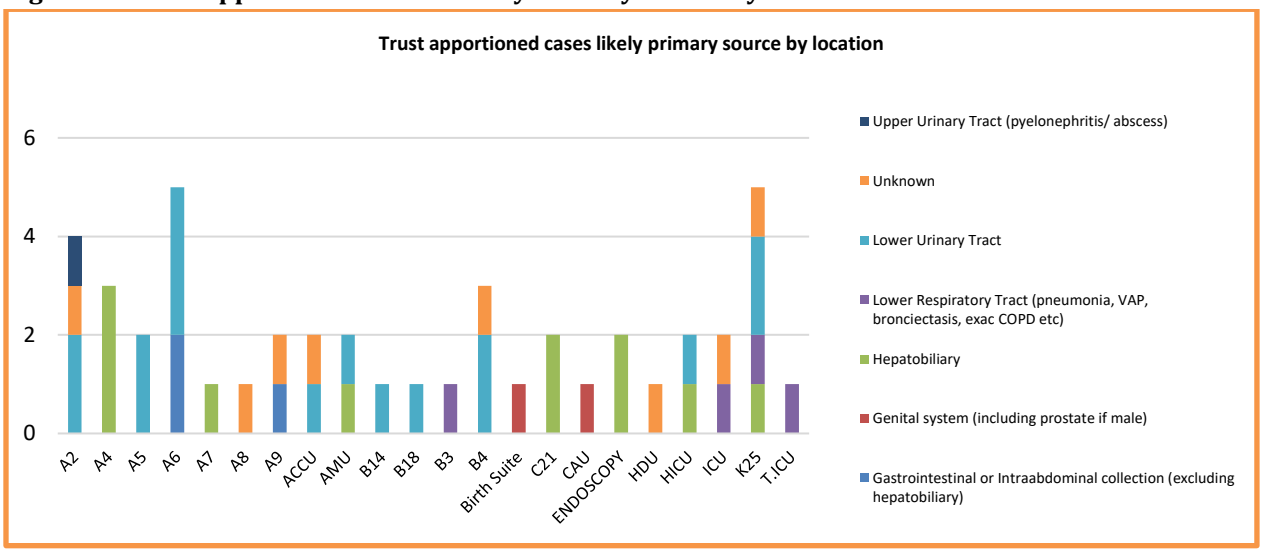


Of the 45 Trust apportioned cases the likely primary focus was assessed as being associated with: -

- urinary tract – 17 cases
- hepatobiliary - 11 cases
- unknown source – 8 cases
- respiratory tract - 4 cases
- gastrointestinal or Intraabdominal collection (excluding hepatobiliary) – 3 cases
- genital system – 2 cases

A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 17.

Figure 17 Trust Apportioned Cases - Likely Primary Source by Location



The planned actions to reduce GNBSI were delayed due to Covid-19. The IPCT are recommencing work with the Quality Academy and Clinical Business Units (CBUs) to improve patient safety. Improvement work will be focussed against the likely primary sources.

Klebsiella spp. bacteraemia

Reporting of Klebsiella spp. bacteraemia became mandatory from April 2017. A comparison with previous year's data is shown in figure 18.

Figure 18 Klebsiella spp. bacteraemia (all) April 2017 – March 2021

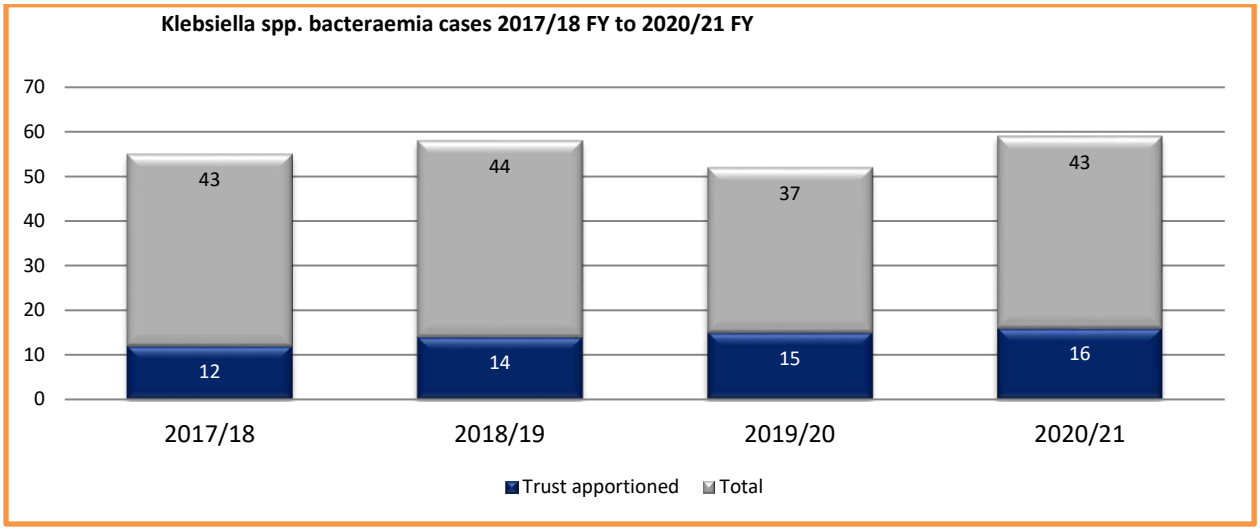


Figure 19 displays the total number of cases and the number of hospital onset cases reported each month during the 2020/21 financial year.

Figure 19 Klebsiella spp. bacteraemia (all) cases by month

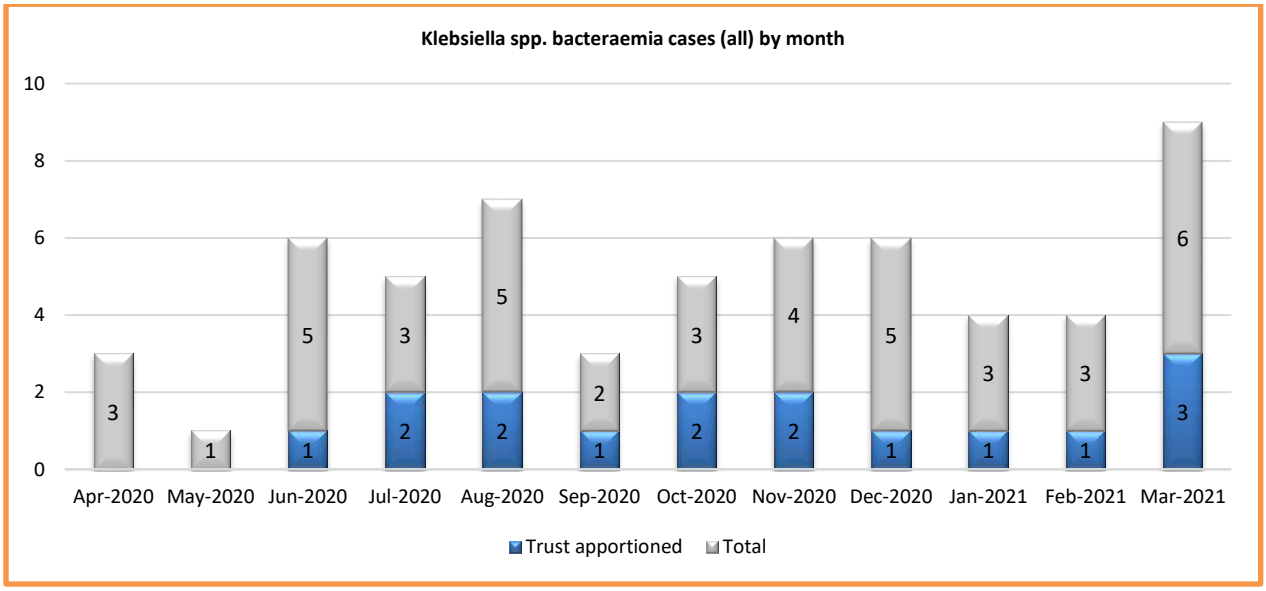
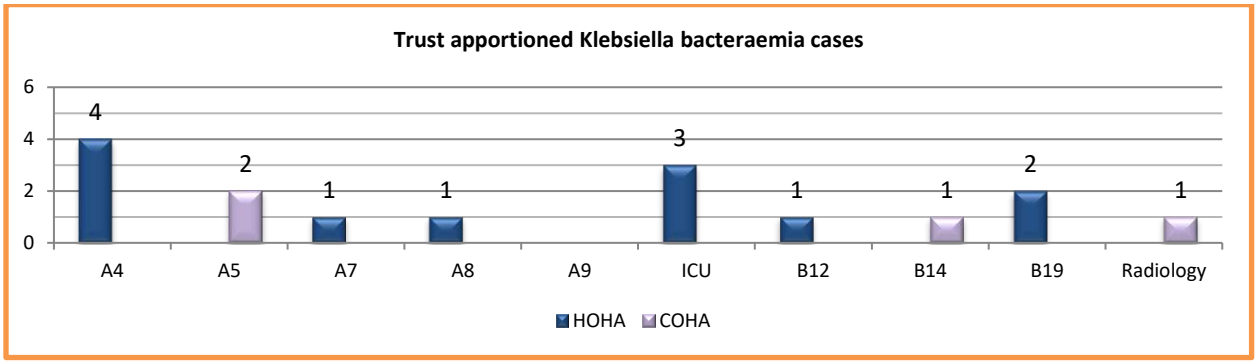


Figure 20 show Trust apportioned Klebsiella bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases.

Figure 20 Trust Apportioned Klebsiella bacteraemia cases by ward location



Pseudomonas aeruginosa bacteraemia

Reporting of Pseudomonas aeruginosa (P. aeruginosa) bacteraemia was made mandatory from April 2017. A comparison with previous year's data is shown in figure 21.

Figure 21 Pseudomonas aeruginosa bacteraemia cases April 2017 – March 2021

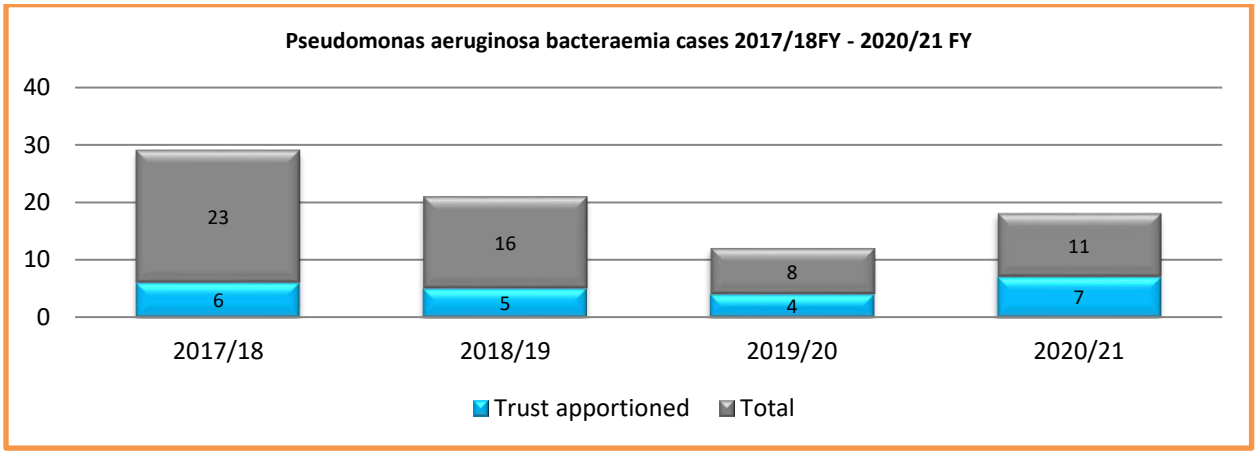


Figure 22 displays the total number of cases and the number of Trust apportioned cases reported each month.

Figure 22 Pseudomonas aeruginosa bacteraemia cases (all) by month

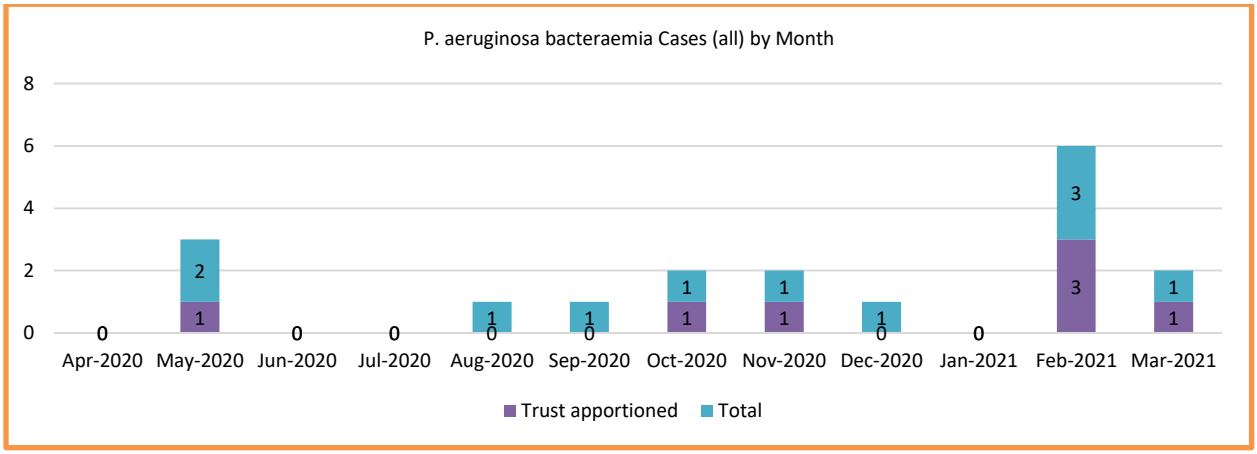
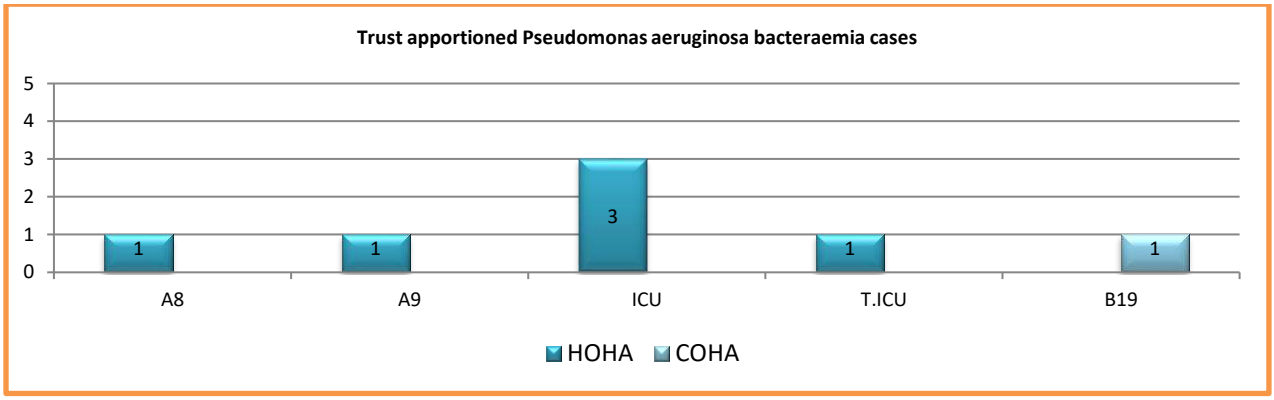


Figure 23 show Trust apportioned Pseudomonas aeruginosa bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases

Figure 23 Pseudomonas aeruginosa bacteraemia cases by loaction



The Pseudomonas aeruginosa bacteraemia cases were associated with: -

- lower respiratory tract infections – 2 cases
- upper respiratory tract infections – 1 case
- lower urinary tract – 2 cases
- hepatobiliary tract – 1 case
- unknown – 1 case

GNBSI prevention activity has recommenced with action that includes: -

- reduction in use of urinary catheters
- improvements to care of urinary catheters - urinary catheter policies are being reviewed
- competency assessments incorporating ANTT
- patient hand hygiene strategy
- patient hydration

Information on all mandatory reported healthcare associated infections is circulated weekly with up to date information on cases and learning from reviews. Dashboards are circulated monthly after data validation. Work is in progress with Governance Teams to ensure completion of Action Plans from HCAI incidents.

Incidents/outbreak reports

Pseudomonas

Surveillance identified an increase in Pseudomonas isolates in theatre recovery (expanded Critical Care area) in November/December 2020. A cluster of six patients were identified with Pseudomonas in either, blood, sputum or wound swab samples. The patients had moved between Theatres and recovery (Critical Care escalation). An environmental sample from the handwash basin in the sluice also grew Pseudomonas. Typing was not possible as the sample was not kept. The water outlet was disinfection and repeat sampling was clear of Pseudomonas. As a result of the incident routine Critical Care admission screening for Pseudomonas was introduced.

Scabies

Ward B3

In February 2021 a patient on Ward B3 was diagnosed with Norwegian Scabies by the Consultant Dermatologist. An incident meeting was held, and decision taken to carry out mass treatment of staff and patients. Surveillance post the incident has not identified any additional cases.

Viral gastroenteritis (Norovirus)

There were no outbreaks of viral gastroenteritis during the financial year.

Influenza

There were no inpatient cases of influenza during the financial year.

Carbapenemase Producing Enterobacteriaceae screening

Antimicrobial resistance is viewed as a major threat to public health globally. Of concern is the risk posed by Carbapenemase-producing Enterobacteriaceae (CPE) and other Carbapenem-resistant organisms.

The Infection Prevention and Control Team conduct CPE screening for all patients admitted by inter hospital transfer. During the reporting period just over 1, 522 patients were screened for CPE carriage with 1 positive case identified which was OXA-48. A further 2 isolates were identified from urine samples (one of which was from the same patient as the screening sample). The IPCNs visit wards daily, where patients with multi-drug resistant organisms are cared for, to support staff with high standards of practice to prevent transmission and no additional CPE cases were identified.

Hand Hygiene and Aseptic Protocols

Audits of compliance with the Hand Hygiene Policy are undertaken weekly at ward and department level. The average compliance rate for the year was 98%. Overall results by month are shown in table 2.

Table 2 Trust wide hand hygiene audit results by month

Month	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Compliance	98%	98%	98%	98%	99%	98%	98%	98%	98%	98%	98%	98%

Decontamination

All surgical instruments are decontaminated off site by a company that provides decontamination services for several Trusts within the region. There is a programme of internal and external validation. The Trust is compliant with Department of Health and NHS Estates guidance. The terms of reference for the Decontamination Group have been revised and meetings are held quarterly.

Cleaning Services

MANAGEMENT ARRANGEMENTS

Warrington and Halton Hospitals Domestic team are employed as an in-house service and are part of the Trust Estates and Facilities Team. The team is led by a Head of Facilities and on a day to day basis managed by a Domestic and Portering Services Manager on each site.

The Domestic Team provide 24 hour, 7 days per week cover, this includes out of hours support by the Portering Team at Halton. The team are also supported by 'as and when' staff who cover vacancies and partially cover annual leave and sickness.

The Domestic Task Team at Warrington provides a valuable service, dealing with emergency leaks/spills, routine and emergency curtain changes, terminal cleaning and any cleaning required following infection outbreaks. They also form the core team progressing deep cleans in clinical areas. The Trust also uses hydrogen peroxide fogging machines to assist with decontamination of the environment. This is operated by the Task Team.

BUDGET ALLOCATION

The budget allocation for domestic services was £4.4m with 151 whole time equivalent (WTE) staff.

CLEANING ARRANGEMENTS

In line with the national specifications for cleanliness in the NHS the functional groups are divided into four levels of cleaning intensity, based on the risks associated with inadequate cleaning in that specific area:

Very high risk: Consistently high levels of cleaning are maintained. Areas include Theatres, Critical Care (ICU) and Neonatal Unit.

High risk: Outcomes are maintained by regular and frequent cleaning with 'spot' cleaning in between. Areas include general wards, public thoroughfares and sterile supplies.

Significant risk: In these areas high levels of cleanliness are required for both hygiene and aesthetic reasons. Outcomes are maintained with regular and frequent cleaning. Significant risk areas include pathology, out-patient departments and mortuaries.

Low Risk: In these areas high levels of cleanliness are maintained for aesthetic and to a lesser extent hygiene reasons. Outcomes are maintained with regular cleaning and 'spot' cleaning in between. Low risk areas include offices, record storage and archives.

MONITORING ARRANGEMENTS

There is a dedicated Monitoring Team within Facilities, who monitor standards of cleanliness within clinical and non-clinical areas at both sites. This team is led by a Facilities Manager to ensure there is no conflict of interest. The team are all trained to British Institute of Cleaning Science BICS standard.

The monitoring of ward kitchens is undertaken by the Catering Department, who monitor cleanliness and food hygiene standards. A schedule is in place to routinely monitor ward kitchens. Any serious breaches of food hygiene are dealt with immediately. An annual inspection of ward kitchens is also carried out by the Local Authority's Environmental Health Team.

The monitoring programme complies with the Department of Health Specifications, covering domestic cleaning, patient equipment and estates issues.

The monitoring frequency is dictated by the risk grading of areas, which are as follows: -

Very High-Risk Areas	Theatres, Neonatal Unit, ICU, Endoscopy
High Risk Areas	Wards, Accident & Emergency, Public areas, Pharmacy, Ward Kitchens Main Outpatients and X-Ray
Significant Risk Areas	Outpatient Areas
Low Risk Areas	Chapel, Offices

Copies of the monitoring reports are circulated to the Lead Nurses, Matrons, Ward Managers, Domestic and Portering Managers and Estates, to address any remedial action required.

Ward Housekeepers are responsible for ensuring any actions on Monitoring forms are dealt with promptly. If there are any specific areas of concern, this is reviewed, and focus is given to address the issue. When necessary, the frequency of monitoring is increased to address any problem areas.

To positively encourage high standards, the Domestic Team working on any area which achieves 100%, are presented with a certificate in recognition of the hard work and commitment.

Terminal Cleaning

Terminal cleaning is carried out by the Task team on request by a Ward when there is an infection or when a patient has been discharged outside normal working domestic hours. In 2020/21 staff responded to 10,464 terminal clean requests – table 3 (a 100% increase from 19/20) and 3242 curtain changes Table 4 and 267 Hydrogen peroxide vapour (HPV) requests.

Table 3 Terminal cleans

Terminal cleans	A	M	J	J	A	S	O	N	D	J	F	M	Total
2019/2020	433	463	359	426	485	290	221	402	612	393	341	790	**5215**

2020/2021	1231	1273	775	653	617	848	957	907	921	988	867	427	**10464**

Table 4 Curtain changes

Curtain changes	A	M	J	J	A	S	O	N	D	J	F	M	**Total**
2019/2020	332	302	239	323	256	183	363	276	420	230	191	547	**3662**
2020/2021	521	191	201	242	265	298	339	360	325	208	197	95	**3242**

Table 5 HPV Cleans

HPV use	A	M	J	J	A	S	O	N	D	J	F	M	**Total**
2019/20	5	15	14	15	11	7	12	12	7	9	12	12	**131**
2020/2021	3	9	13	40	9	20	18	19	30	23	57	26	**267**

CLEANLINESS SCORES

The 2020/21 cleanliness monitoring scores (Domestic only) for clinical areas were as follows:

- Warrington: 96.5%
- Halton: 98%

No monitoring was carried out in the first quarter due to the Covid-19 situation.

Table 6 Cleaning scores - Warrington

WARRINGTON 2020/21	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Cleanliness Scores %	-	-	-	**93.5**	**96**	**98**	**96.5**	**96.5**	**96.5**	**96**	**98**	**98**

Table 7 Cleaning scores - Halton

HALTON 2020/21	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Cleanliness Scores %	-	-	-	**95.5**	**97.5**	**97.5**	**98**	**99**	**98**	**99**	**98**	**99**

PLACE (Patient Led Assessments of the Care Environment)

PLACE assessments were not carried out in 2020/21.

CORPORATE REPORTING

A monthly report is submitted by Facilities to the Infection Control Sub-Committee regarding cleanliness standards scores, number of terminal cleans/curtain changes, process audits for cleaning hand wash sinks and PPE, ward kitchen monitoring, linen and pest control and waste.

TRAINING

The domestic staff receive specific theoretical and practical cleaning training as part of their induction, which includes infection control elements, and this is supported by subsequent refresher training.

Random process audits are carried out to ensure that staff follow the correct procedure and wear the correct personal protective equipment (PPE) when cleaning hand washing sinks. Staff competency audits are also carried out to ensure that domestics are working in accordance with their training and the Trust Cleaning Standards Policy and Cleaning manual.

CLINICAL ACCESS/RESPONSIBILITY

The domestic staff are centrally managed by the Facilities Team; however, the Ward Managers and the Housekeepers can direct the domestic staff based on each ward regarding day to day priorities. There is also close liaison with the Matrons, who have a specific responsibility for cleanliness standards for their Clinical Business Unit.

Facilities also have a close working relationship with the Ward Housekeepers. The Domestic Task Team at Warrington liaises closely with the Infection Prevention and Control Team and Estates when responding to terminal/deep cleans on the Wards.

There are cleanliness standards notices displayed in wards, departments, public corridors and sanitary areas highlighting the frequency of cleaning in that area and giving details of who to contact with any issues relating to cleanliness.

National inpatient survey 2020

The Trust National Inpatient Survey 2020 included a question on cleanliness. Responses were received from 400 patients and the Trust scored 83%. This compares favourable to the national average of 80% from 10,461 respondents.

Audit

High Impact Interventions

The Clinical Business Units have continued a rolling programme of audit to assess compliance with the Department of Health's High Impact Interventions Toolkit. Audit scores are mostly in the region of 90-100%. The results are discussed at the Infection Control Sub-Committee and fed back to the ward teams. Action plans are produced by wards and departments for areas where care improvements are required.

An increase in auditing frequency is requested when scores are below accepted standards. Matrons are directed to show the audits drive improvements rather than being a monitoring process.

Antibiotic Prescribing

From 1 April 2020 - 31 March 2021, there were 69 joint Consultant Microbiologist and Antimicrobial Pharmacist ward rounds carried out at Warrington hospital.

This year we saw a slight decrease in the number of ward rounds carried out when compared to the previous year when there were 71 joint Consultant Medical Microbiologist and Antimicrobial Pharmacist ward rounds carried out. This small reduction in activity can be explained by the COVID-19 pandemic which has impacted on the whole Trust since March 2020. The weekly Outpatient Parenteral Antimicrobial Therapy (OPAT) MDT has continued throughout the COVID-19 pandemic.

Joint Consultant Medical Microbiologist and Antimicrobial Pharmacist Ward Rounds

Public Health England's Antimicrobial Stewardship Toolkit, states that improving antimicrobial prescribing and stewardship is dependent on strong clinical leadership. They recommend that antimicrobial quality improvement should be done in collaboration with a Consultant Microbiologist/infectious diseases specialist and the Antimicrobial Pharmacist. Within this Trust we aim to undertake two joint Consultant Microbiologist and Pharmacist ward rounds each week at Warrington hospital. These ward rounds target patients who are prescribed specific "target antimicrobials", wards with higher rates of antimicrobial prescribing or wards where there are concerns about compliance with the Trust antimicrobial formulary (picked up through the quarterly antimicrobial point prevalence audit) or higher incidence of HCAIs.

"Target antimicrobials" are antimicrobials that we have determined require closer monitoring than other antimicrobials because they are either:

- broad-spectrum antimicrobials that should be reserved for the treatment of more complicated infections that are not responding to the Trusts first line antimicrobials or
- antimicrobials that are more commonly associated with the development of *C. difficile* infection

The "target antimicrobials" within the Trust are:

- piperacillin/tazobactam (Tazocin®)
- meropenem
- cephalosporins
- co-amoxiclav
- linezolid
- clindamycin
- quinolones.

Patients prescribed "target antimicrobials" are picked up from a prescribing report that pulls directly from the electronic prescribing and medicines administration (EPMA) system. The ward rounds are a way of gaining assurance that the "target antimicrobials" are being prescribed appropriately across the Trust.

Ward pharmacists are also able to refer patients for a review on the antimicrobial ward round. Common reasons for ward pharmacist referral are: -

- Patient is deteriorating from an infection point of view and clinical team have requested a review
- Patient is prescribed antimicrobials that are non-compliant with the antimicrobial formulary and clinical team are refusing to change antimicrobials despite being challenged
- Culture and sensitivity results are available to allow rationalisation of antimicrobials but not actioned by clinical team
- Patient clinically well and suitable for oral step down or cessation of antimicrobial therapy but the team with clinical responsibility for the patient are not undertaking this or are requesting CMM advice

Summary of Antimicrobials Reviewed

A total of 550 patients and 676 antimicrobials were reviewed on the ward rounds between 1st April 2020 and 31st March 2021.

Table 8 Total Number of Antimicrobials Reviewed

Time period	Number of patients reviewed	Number of antimicrobials reviewed
April 2013 – March 2014	592	770
April 2014 – March 2015	420	579
April 2015 – March 2016	395	545
April 2016 - March 2017	713	829
April 2017 - March 2018	654	905
April 2018 – March 2019	667	828
April 2019 – March 2020	739	919
April 2020 – March 2021	550	676

Summary of Ward Round Interventions

Of the 676 antimicrobial prescriptions reviewed, we were able to add a stop date/course length to 355 prescriptions. A further 159 prescriptions were de-escalated, and 64 prescriptions were escalated.

For the purpose of this audit de-escalation is defined as:
- a change in IV antimicrobial regimen to a narrower spectrum agent
- IV to oral step down

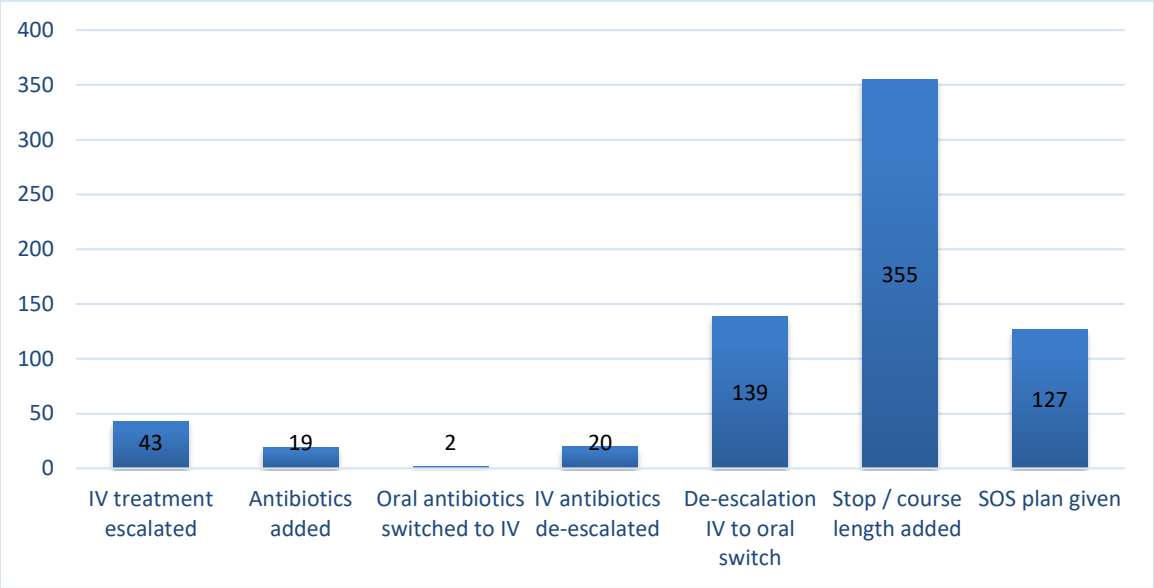
Escalation is defined as:
- additional antimicrobial cover added
- oral to IV switch

Changes to antimicrobial therapy were only made if the team with clinical responsibility for the patient could be contacted and the proposed changes were discussed and agreed.

Further advice and a "SOS" plan was provided for 127 patients. The "SOS" plan provides the clinical teams with advice in case of clinical deterioration. In addition to the antibiotic escalation plan it will include details of further investigations or microbiological sampling.

Figure 24 summarises the outcome of the antimicrobial reviews in more detail. (Note total exceeds 676 prescriptions, often multiple actions for 1 prescription i.e. de-escalation and addition of stop date)

Figure 24 Outcome of Antimicrobial Reviews



Benefits of the ward round

Patient Safety

During or prior to each ward round a review is undertaken of each patient's recent microbiology samples to see if any organisms have been isolated. Other factors are also considered that influence prescribing decisions such as; history of multi-drug resistant organisms or *C. difficile* infection. The interventions made on the ward rounds ensure that patients are exposed to fewer days of antimicrobial treatment or changed to more appropriate antimicrobial treatment in a timelier manner. This improves patient safety because if patients are exposed to fewer days of unnecessary broad-spectrum antimicrobial therapy then the risk of the patient going on to develop a HCAI such as *C. difficile* infection is reduced. The ward rounds also have other patient safety benefits; they allow a review of patients with complex histories/infections who specifically need input from a Consultant Microbiologist i.e. patients with infective endocarditis and patients who are prescribed antimicrobials with a narrow therapeutic window, providing specific advice on dosage adjustment and duration of treatment.

Junior Doctors & Antimicrobial Stewardship

The Consultant Microbiologists and Pharmacist use the ward rounds as an opportunity to build up relationships with ward teams and provide education to junior doctors. Good prescribing is only one part of good antimicrobial stewardship (AMS), timely and appropriate microbiological sampling and regular clinical review of both the patient and the diagnosis are also vital parts of the Start Smart, Then Focus SSTF) antimicrobial prescribing algorithm. The ward rounds seek to engage all doctors (but in particular, junior doctors) and promote these vital steps and allow them to develop a wider understanding of antimicrobial stewardship. The antimicrobial formulary is actively promoted on each ward round and the junior doctors are reminded of the importance of AMS and their vital role in slowing down antimicrobial resistance (AMR). Junior doctors are encouraged to participate in the ward rounds, and they are informed of the reasons for any suggested changes to antimicrobial therapy which develops their knowledge of

microbiology. It is hoped that the education provided during the ward rounds will influence their prescribing practice as they progress in their career and develop their confidence around diagnosis and management of different infections.

Financial benefits

Cost savings are made through the ward rounds by stopping unnecessary antimicrobials, changing antimicrobials to more appropriate treatment and adding stop dates to courses of antimicrobials. Nursing time can also be saved by the appropriate stopping of antimicrobials, particularly intravenous antimicrobials.

Referring patients to the OPAT team to complete their antimicrobials in the community also has financial savings by reducing bed days.

Compliance with NICE Guidance

NICE guideline NG15 recommends that all care settings should establish an antimicrobial stewardship programme. This ward round is part of the Trusts AMS programme and ensures compliance with NICE guidance. It provides an opportunity to feedback to individual prescribers, monitor prescribing habits and provides education and training (see above).

Other benefits

The ward rounds also help the Trust to manage antimicrobial shortages.

Future developments

Ideally the antimicrobial ward rounds could be expanded so that more patients on antimicrobials are reviewed but this is limited by Consultant Microbiologist and Antimicrobial Pharmacist availability.

Within pharmacy there is currently a plan to train and rotate junior pharmacists through the antimicrobial ward round to expand their knowledge of antimicrobials and AMS.

More regular teaching and feedback to prescribing teams would drive further improvements in antimicrobial stewardship within the Trust. The team has been looking at developing an online web page on the Trusts intranet to hold this information and this is in progress.

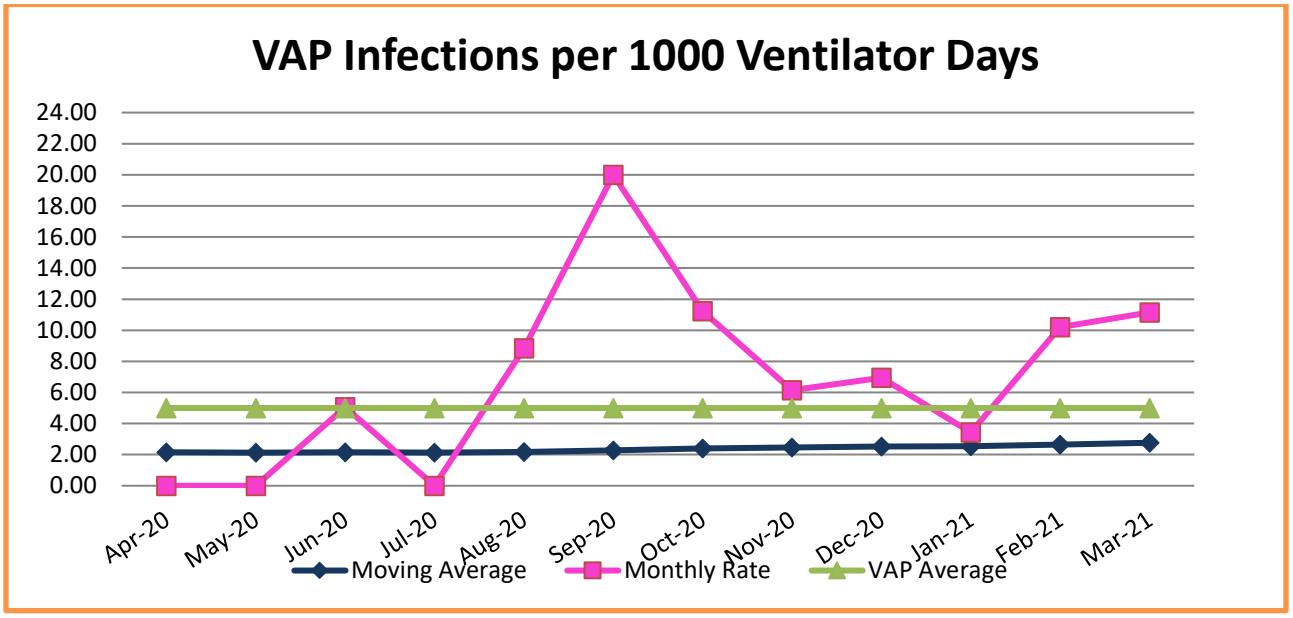
Critical Care Surveillance

The Critical Care Unit conducts enhanced surveillance of bloodstream infections and ventilator associated pneumonias. During 2020/21 MSSA bacteraemia cases were monitored and five cases were observed. One case was related to respiratory tract infection, one case related to septic arthritis, two cases to skin/soft tissue infections and one case with unknown primary source.

The Critical Care Unit also collates data on ventilator associated pneumonias (VAP). This facilitates identification of trends of bacterial pneumonia in ICU patients who are mechanically ventilated.

Data for the 2020/21 year is displayed in figure 25. The unit has implemented use of tracheal tubes with subglottic suction ports in a bid to further reduce the incidence of VAP.

Figure 25 VAP data



Targets and Outcomes

Activities

The Infection Prevention and Control Team has been involved in several initiatives within the Trust to promote the importance of infection prevention and control. These included: -

- Hand hygiene awareness raising events
- Unannounced spot checks
- Global hand hygiene day
- Matron/Facilities Walkabouts
- World Antibiotic Awareness Week
- Response to complaints
- Response to FOI requests

Updated policies and guidelines

Policies and guidelines were developed as per the Covid-19 section of this report.

Other documents

Other documents were revised including: -

- Urinary Catheter Passport – adapted from the National Catheter Passport
- Clostridium difficile – toolkit for case investigation
- MSSA bacteraemia - post infection review toolkit

- MRSA bacteraemia - post infection review toolkit
- Gram Negative Bacteraemia post infection review toolkit
- Assurance framework – Infection Prevention and Control Team reporting structure
- Infection Control Sub-Committee Work Plan 2019/20
- IPC Board Assurance Framework (Covid-19)

Revised and updated infection control policies, procedures and information leaflets are available from the Trust's intranet for staff to access.

Contribution to other initiatives

Capital Projects

All areas that have undergone upgrade work have been reviewed and signed off by the IPCT prior to re-occupation by patients.

External groups

The Infection Prevention and Control Team participated in the following external groups: -

- North West Boroughs Partnership Mental Health Trust Infection Control Committee
- 3 Boroughs Public Health Infection Control Committee
- Public Health Forum (Public Health England)
- Health Protection Forum – Warrington Borough Council

Training Activities

The Infection Prevention and Control Team continue to provide a structured annual programme of education. This includes an Infection Control E-Learning package for clinical staff. Overall attendance at mandatory infection prevention and control training fell below 85% as face to face training sessions were cancelled. Virtual training sessions were implemented and provided 4 times per week to ensure improvements.

The following sessions are included in the infection control training plan:

- Trust corporate induction: all new starters via E-Learning
- Mandatory training: all staff
  - Patient facing staff – annual
  - Non-patient facing staff – 3 yearly

Other training was provided to:

- Student Nurses – spoke placements
- Newly Registered Nurses - Preceptorship
- Trainee Nursing Associates
- Trainee Assistant Practitioners
- F1/F2 Doctors
  - Induction and updates

- Blood culture specimens (indications; aseptic technique and performance management)
- Prudent use of antibiotics

Grand Round Presentations

- 18 June 2020 – SARS-CoV-2 Laboratory Testing and IPC
- 22 January 2021 - Covid-19 Wave 3

Medical Students

- Infection Prevention and Control
- Various infection/microbiology topics

Ad hoc clinical based teaching

Single point lessons are provided in response to incidents for: -

- Clostridium difficile management
- CPE screening
- Isolation priorities
- Linen Management
- MRSA screening and suppression therapy
- Outbreak Management
- Personal protective equipment
- Sharps Safety
- Viral gastroenteritis outbreak management

Training attended/ provided by Infection Prevention and Control Team Members

Dr Zaman Qazzafi - Consultant Microbiologist

17 Jun 2020	SARS-CoV2 Antibody testing - presentation at Medical Cabinet
24 Sep 2020	Teaching FY1 doctors on 'Antibiotics stewardship' and 'taking blood cultures - aseptic technique'.
16 Oct 2020	Grand round presentation - 'Pandemics: from Influenza to COVID-19
28 Oct 2020	Gilead – Anti-infective Forum – Steroids treatment and risk of invasive fungal disease
22 Jan 2021	Grand round presentation on third wave of COVID-19, nosocomial infections and lessons learnt.
Apr 2020 – Mar 2021	Attending various Grand rounds
27 Jan 2021	Webinar - Keith Willett - Updates for System Leaders
25 Feb 2021	PHE SIREN update Webinar
9 Mar 2021	Every Action Counts' - IPC resources – By Sue Tranka, Deputy Chief Nurse, Safety and Innovation, and Prof Matthew Cripps

18 Mar 2021	Webinar - Keith Willett: the Supply Disruption Issue – Becton Dickinson Administration
25 Mar 2021	How to minimise errors during outbreaks – an NHSE Webinar

Dr Janet Purcell

Nov 2020	FIS/HIS Virtual Conference

Lesley McKay – Associate Chief Nurse for Infection Prevention and Control

7 Aug 2020	NHSE/I update
Sep 2020 – Mar 2021	MBA programme LJMU
1 Oct 2020	Halton Schools COVID19 Q&A Webinar
9 Mar 2021	Every Action Counts' - IPC resources – By Sue Tranka, Deputy Chief Nurse, Safety and Innovation, and Prof Matthew Cripps

Katherine Summers – Infection Prevention and Control Nurse

9 May 2020	Covid-19 Infection control resources completed via E-learning
20 May 2020	Understanding hospital-onset and hospital-acquired Covid-19 Webinar
21 May 2020	Covid-19: Challenges and solutions
10 Jun 2020	Managing ventilation in the context of Covid-19 Webinar
24 Jun 2020	The role of the environment in Covid-19 transmission Webinar
23 Sep2020	Winter planning Covid-19 webinar
16 Nov 2020	IV Therapy and OPAT e-conference
Jan-April 2021	Infection control for healthcare course at LJMU

Joanne Oldfield

Jan-April 2021	Infection control for healthcare course at LJMU

Jacqui Ward – Antibiotics Pharmacist

Quarterly	North West Antimicrobial Pharmacist Group educational session

Conclusion

The IPCT have worked at an exemplar level throughout the year to provide education and guidance in response to the Covid-19 pandemic and deliver the annual work plan.

The successive waves of the Covid-19 pandemic created additional challenges on top of an already demanding role. The experience, skills and vast knowledge of the IPC Team members resulted in a high

output of education, guidance and positive outcomes for the Trust. It is to their great credit that all team members stepped up to meet the additional requirements for education, production of policy documents, service reviews and meeting attendance alongside a proactive agenda to address Clostridium difficile and bloodstream infections from MRSA/MSSA and GNBSI.

Assurance on the prevention and control of infections is provided by a matrix approach of updating policies to incorporate best practice/legislation; robust and regular auditing of policies and practice; spot checks and self-assessment. Although there was a reduction in auditing and mandatory training there was a vast amount of proactive and responsive activity for Covid-19.

High level briefing papers and reports submitted to the Patient Safety and Clinical Effectiveness Committee, Quality Assurance Committee and Board of Director reports, provide assurance on infection control activities and outcomes.

Gratitude is extended to the Infection Prevention and Control Team for maintaining their proactive leadership of a challenging and extremely busy agenda.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Quality Committee is asked to receive the Infection Prevention and Control DIPC Annual Report and note the progress made.

4. IMPACT ON QPS?

Q = Improvements to quality by reducing cases of healthcare associated infection

P = Training of staff to care for patients with suspected/diagnosed infections

S = Risk of contractual penalties if healthcare associated infection thresholds are exceeded

5. MEASUREMENTS/EVALUATIONS

Monitor: -

Progress against the Infection Control Sub-Committee work plan

- Healthcare associated infection surveillance data
    - Clostridium difficile
    - MSSA bacteraemia
    - MRSA bacteraemia
    - E. coli bacteraemia
    - Pseudomonas aeruginosa bacteraemia
    - Klebsiella spp. bacteraemia
    - Covid-19 – Hospital onset probable and Hospital onset definite cases
    - Covid-19 Outbreaks

- Progress against HCAI prevention plans
    - Gram negative bloodstream infection reduction

- *Staphylococcus aureus* bacteraemia reduction (MRSA/MSSA)
- Clostridium difficile infection reduction

- Redevelopment of the Infection Prevention and Control Strategy for the next 3 years
- Education and training compliance figures
- Audit findings and non-compliance actions
- Progress with policy revisions

Progress against the IPC Strategy and Annual Action Plan will be monitored at the Infection Control Sub-Committee.

Compliance assessment against the Health and Social Care Act (2008), Code of practice on preventing infections and related guidance (2015).

Compliance assessment against the Covid-19 IPC Board Assurance Framework, bimonthly updates.

6. TRAJECTORIES/OBJECTIVES AGREED

- Clostridium difficile local threshold 44 cases
- Zero tolerance to avoidable MRSA bacteraemia cases
- Gram negative bloodstream infections (GNBSI) national reduction Target 25% by 2022 and 50% by 2024. Local objective to be confirmed – Trust quality priority

7. MONITORING/REPORTING ROUTES

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

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

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

Verbal updates are provided to Trust Board monthly as part of the IPR (in full) report.

A Director of Infection Prevention and Control Report is submitted to Trust Board annually.

8. TIMELINES

Financial year 2020/21

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

The Quality Assurance Committee is asked to receive and note the report.

Kimberley Salmon-Jamieson
Chief Nurse & Deputy CEO
Director of Infection Prevention and Control (DIPC)
July 2021

APPENDIX 1 ANNUAL WORK PROGRAMME 2020/21

Progress against this action plan will be monitored at the ICSC bimonthly. Updates will be made where additional activities are identified.

Governance													
	Target date	**Leads**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Review of ICSC Terms of Reference	Annual	Deputy DIPC												✓
Review of IPCT infrastructure	Annual	ADIPC				✓								✓
DIPC annual report	Annual	ADIPC												
Quarterly reports to Quality and Assurance Committee	Quarterly	ADIPC		✓			✓			✓			✓	
Quarterly DIPC reports to Trust Board	Quarterly	ADIPC		✓			✓			✓			✓	
Risk register review	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HLBP submission to PSCE; QA; and H & S committees	Bimonthly	ADIPC	✓		✓		✓		✓		✓		✓	
RCAs/PIR of HCAI incidents: MRSA; CDT; COVID	Per case	LNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Infection Prevention Programme	3 / annum	LNs					✓			✓			✓	
Submission of C. difficile RCA findings to the CCG panel for review to assess for lapses in care	Quarterly	LNs / ADIPC		✓			✓			✓			✓	
Review of revised C. difficile Objective for 2021/22 =44	Annual	ADIPC	✓											
IPCT team building session	Sep 2021	ADIPC						✓						
Review of progress against this work plan and the IC strategy, Infection Prevention Plan	Bimonthly	ADIPC					✓			✓				✓
Provision of commentary for Trust Quality Account	Annual	ADIPC	✓											
Code of Practice for prevention of HCAIs – compliance assessment	Biannual	ADIPC						✓						✓
Review of HCAI reduction action plans GNBSI	3 / annum	ADIPC				✓			✓			✓		
Revise investigation toolkit for GNBSI	March 2021	ADIPC												✓
Revise toolkit for investigation of MSSA bloodstream infections	March 2021	ADIPC												✓
Revise toolkit for investigation of Clostridium difficile cases	March 2021	ADIPC												✓
Revise toolkit for Nosocomial Covid-19 cases (8-14 days and 15+ days)	March 2021	ADIPC												✓
Committee/Group attendance														
Antimicrobial Stewardship Group Meetings	Quarterly	AMSG Lead CMM	✓			✓			✓			✓		
Bed meetings	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CCG CDT review panel meetings	Quarterly	ADIPC		✓			✓			✓			✓	
CDT MDT	Weekly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Decontamination Group	Quarterly	ICD / ADIPC				✓			✓			✓		
Event planning group	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GNBSI operational group – external	Bimonthly	TBC	✓			✓				✓				✓
GNBSI Expert Faculty – internal	Monthly	Deputy DIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Target date	Lead	A	M	J	J	A	S	O	N	D	J	F	M
GNBSI Expert Faculty – internal	Monthly	Deputy DIPC				✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI Network PHE	TBC	TBC												
To Health and Safety Sub-committee	Bimonthly	ADIPC		✓		✓		✓		✓		✓		
Health Protection Forum WBC	Quarterly	IPCNs												
ICSC	Monthly	IPCT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Submit HCAI data to Communications team	Monthly	ADIPC			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI Prevention Plan for next financial year	Annual	ADIPC												✓
ICU/IPCT meetings	TBC	Deputy DIPC	✓			✓			✓			✓		
Incident meetings	As required	IPCT												
IPCT meetings	Weekly	IPCT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IPS meetings	Biannual	IPCNs												
Medical Devices group	Quarterly	IPCNs	✓			✓			✓			✓		
Nursing & Midwifery Forum	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nutritional steering group	Monthly	TBC												
NWB ICC	TBC	Deputy DIPC												
Patient Safety and Clinical Effectiveness Committee	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Experience Sub-Committee	Monthly	Matron IPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality and Assurance Committee	Bimonthly	ADIPC/DIPC		✓		✓		✓		✓		✓		✓
Safer sharps group meeting	Monthly	TBC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Theatre IC group	Monthly	TBC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ventilation Assurance Group	Quarterly	ICD / ADIPC												
Water safety group	Quarterly	ICD / ADIPC												
Workplace Health & Wellbeing Meetings	Biannual	TBC												
Surveillance														
Compliance with mandatory reporting of MRSA; MSSA; C. difficile; GNBSIs (E. coli, Klebsiella and Pseudomonas)	Monthly	IPCNs/ ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mandatory reporting data validation and timely sign off	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Covid-19 outbreak reporting	Per incident	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MSK compliance with Mandatory orthopaedic surveillance	Quarterly	LN MSK	✓			✓			✓			✓		
Zero tolerance to MRSA bacteraemia cases	Monthly	ALL												
SSSI	Quarterly	LN DD	✓			✓			✓			✓		
HCAI surveillance reports – weekly to Chief Nurse, Associate Chief Nurses, Lead Nurses and Matrons	Weekly	IPC Admin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Surveillance of HAI alert organisms (MRSA, VRE, CDT etc.)	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI reporting for Trust dashboards with commentary	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI reporting to ICSC dashboards	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pseudomonas surveillance in Augmented care area (ICU and NNU – A7 T.ICU)	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Target date	Lead	A	M	J	J	A	S	O	N	D	J	F	M
VRE surveillance	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complete Quarterly Mandatory Laboratory returns and submit to PHE	Quarterly	Deputy DIPC	✓			✓			✓			✓		
Antibiotic ward rounds daily on ICU	Daily	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Antibiotic ward rounds	Weekly	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Environmental cleanliness monitoring														
Environmental cleanliness monitoring	Monthly	Facilities Manager			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participate in PLACE assessments	TBC	IPCNs/ LNs	To be confirmed											
Matron and IPC Walkabouts/ Covid Roadshows	Monthly	Matrons /IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Estates PAM assessment	Annual	ADE												
Legionella Assessments and compass flushing reports	TBC	ADE												
Implementation of revised NHS Cleaning standards and Cleanliness Charter	TBC	TBC												
Audit														
Audit Programme (IPC led) against standard precautions with reporting to ICSC	Annual	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hand hygiene audits	Weekly	LNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MRSA pre-operative screening audit	Quarterly	LN DD	✓			✓			✓			✓		
MRSA screening compliance audits	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Support areas requiring improvements identified on the Quality Metrics programme	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Policy /guideline/SOP/leaflet reviews														
CJD Instrument Handling	Jun 2021	IPCNs												
CJD Nursing Management	Jun 2021	IPCNs												
Tuberculosis	Jun 2021	IPCNs												
Scabies	Jun 2021	IPCNs												
MRSA	Jun 2021	IPCNs												
Measles	Jun 2021	IPCNs												
Surveillance and data collection (local)	Jun 2021	IPCNs												
Glycopeptide resistant enterococci MDRO	Jun 2021	IPCNs												
Admission/transfer and discharge of infectious patients and risk assessment	Jun 2021	IPCNs												
Uniform and Workwear	Jun 2021	IPCNs												
Specimen handling	Sept 2021	IPCNs												
Pandemic Influenza	Sept 2021	IPCNs												
Hand hygiene training strategy	Sept 2021	IPCNs												
Aseptic technique	Sept 2021	IPCNs												
Mattress inspection SOP	Sept 2021	IPCNs												
Personal Protective Equipment	Sept 2021	IPCNs												
Standard Precautions	Sept 2021	IPCNs												
Mandatory reporting of HCAIs to PHE	Sept 2021	IPCNs												

	Target date	Lead	A	M	J	J	A	S	O	N	D	J	F	M
Infection Control Policy	Sept 2021	IPCNs												
Hand Hygiene Policy	Sept 2021	IPCNs												
Terminal Cleaning Policy	Sept 2021	IPCNs												
Clostridium difficile	Oct 2021	IPCNs												
Chickenpox	Oct 2021	IPCNs												
Viral Gastroenteritis	Oct 2021	IPCNs												
Notification of Communicable Diseases	Oct 2021	IPCNs												
Closure of rooms wards, departments and premises to new admissions	Dec 2021	IPCNs												
Outbreak policy	Dec 2021	IPCNs												
Viral haemorrhagic fevers	Dec 2021	IPCNs												
Safe handling and disposal of waste	Dec 2021	IPCNs												
Isolation of immunosuppressed patients	Dec 2021	IPCNs												
Care of deceased patients	Feb 2022	IPCNs												
Spillage of blood and body fluids	Feb 2022	IPCNs												
Isolation of service users with an infection	Feb 2022	IPCNs												
Awareness raising events														
Global Hand washing Day	Jun 2021	IPCNS		✓										
GNBSI and ANTT	Oct 2021	IPCNS							✓					
Uniform and workwear promotion	TBC	All												
October IC week – Topic Boards	Oct 2021	IPCNs							✓					
Trust wide Safety Brief – IPC promotion	Oct 2021	ADIPC							✓					
November World Antibiotic Awareness Week	Nov 2021	IPCNs								✓				
Seasonal flu campaign with WHWB	Dec 2021	WHWB							✓	✓	✓	✓		
Covid PPE refresher training	TBC	TBC												
Education														
Provide Mandatory training for IPC supporting areas with low compliance figures	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participate in CLiPs training	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participate in Preceptorship training	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mandatory training sessions as per timetable	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Induction training sessions as per timetable	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Single Point Lessons as requirement identifies	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

D = deferred
✓= Planned
✓= Completed

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/108**	
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**	
DATE OF MEETING:	28 July 2021	
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 through high quality, safe care and an excellent patient experience.	√
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	√
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain.	
EXECUTIVE SUMMARY	To provide the Board of Directors with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	

PURPOSE: (please select as appropriate)	Information	Approval	To receive ✓	Decision

RECOMMENDATIONS:	The Board of Directors are asked to receive the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/21/07/184
	Date of meeting	06 July 2021
	Summary of Outcome	Report to Board
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	IPC BAF	AGENDA REF:	BM/21/07/108

1. BACKGROUND/CONTEXT

Guidance on the required infection prevention and control measures for Covid-19 have been published, updated and refined to reflect learning. Further guidance and mitigating guidance has been advised as new variants of the virus have emerged.

This assessment against the framework provides internal assurance on actions in place to meet legislative requirements relating to: -

- *Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance* (2015), which is linked directly to Regulation 12 of the *Health and Social Care Act 2008*
- Personal Protective Equipment at Work Regulations 1992
- Workplace (health, safety and welfare) Regulations 1992
- *Health and Social Care etc. Act 1974*

In the context of COVID-19, there is an inherent level of risk for NHS staff that are treating and caring for patients. Within the healthcare setting, transmission risks can arise from: patient to staff, staff to staff, staff to patient and patients to patient. Robust risk assessment processes are central to ensuring that these risks are identified, managed and mitigated effectively.

The risk assessment process will be continuous alongside review of emerging information to ensure that as an organisation the Trust can respond in an evidence-based way to maintain the safety of patients, services users and staff.

This Assurance Framework and Action Plan will be reviewed monthly by the Infection Prevention and Control Team and submitted to Infection Control Sub-Committee and Quality Assurance Committee bimonthly, with an action plan to address any areas of concern identified.

2. KEY ELEMENTS

Please see Appendix 1 for compliance assessment.

Please see Appendix 2 for Action Plan arising from the compliance assessment.

3) ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Include in cycle of business for Infection Control Sub-Committee and keep under continuous review to identify any emerging information that would require addition to the action plan
- Monitor the action plan to address gaps in assurance until completion

4) IMPACT ON QPS?

- **Q**: Visiting restrictions due to risk of infection may have a negative impact on patient experience. Several communication mechanisms have been implemented.

- **P**: Risk to staff health and wellbeing from anxiety associated with the unknown situation and risk of infection of self and family members. Risk from continuous high pressure/demand on healthcare services. Several staff are absent from work due to Clinically Extremely Vulnerable (CEV) status

- **S**: Financial impact of a global pandemic and major interruption to business as usual

5) MEASUREMENTS/EVALUATIONS

- Incident reporting
- IPC BAF Action plan monitoring
- Environmental Action Plan monitoring
- Nosocomial case monitoring and outbreak detection and reporting

6) TRAJECTORIES/OBJECTIVES AGREED

- To ensure compliance with the Code of Practice on prevention of Healthcare Associated Infections

7) MONITORING/REPORTING ROUTES

- Infection Control Sub-Committee
- Quality Assurance Committee
- Senior Executive Oversight Group
- Trust Board

8) TIMELINES

- For the duration of the Covid-19 pandemic at all stages which is yet to be determined

9) ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10) RECOMMENDATIONS

- The Board of Directors are asked to receive the report

We are WHH & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 IPC BAF Compliance Assessment 06 2021

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• infection risk is assessed at the front door and this is documented in patient notes	• Where patients are conveyed by the Ambulance Service with possible or confirmed infection risk for COVID-19 they are risk assessed pre-hospital by the Ambulance staff to inform destination decision. Government guidance for Ambulance Trusts is used for decision making. https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts • ED are pre-alerted by the Ambulance Service of suspected Covid-19 cases • Patient placement government guidance flow chart in place Mandatory surveillance\ncv2019\COVID-19 information\COVID-19 - Effective Patient Placement v2.1.docx • ED reorganized to have Hot and Cold respiratory assessment zones to segregate patients presenting with suspected Covid-19 from other non-Covid suspected attendees	• Asymptomatic positive patients	• Abbot ID now screening in ED • ED Triage Tool • Maternity emergency admission screening	

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• All patients admitted via ED are screened for Covid-19			
	• Electronic infection risk assessment tool in Lorenzo (Electronic Patient Record)		• Audit of compliance with admission infection risk assessments	
	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab and updated with additional swab results • **>3229** Covid-19 alerts added to individual patient records on Lorenzo (11/02/2021) • Covid-19 Clinically Extremely Vulnerable Alerts added to Lorenzo		• IT surveillance system in place to track day of admissions, day 3 and day 5 screening. Matrons and Lead Nurses review result daily to ensure Trust Covid-19 screening SOP is adhered to • Audit of screening compliance monthly	
	• Alerting system in place for other healthcare associated infections: (MRSA; CDT; GRE; CPE; MDROs)		• Infection alert flag added to Lorenzo patient records according to specimen results	
• there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status and clinical specialty need • The Trust is following PHE national guidance with admission screening and repeat swabbing undertaken 3 days and 5 days post admission or sooner if initial test was negative and patient exhibits	• Change in placement requirements identified – specialist care	• SOP for patient placement in place which is in line with PHE national guidance • Operational Manager/Silver Command oversight of patient placement at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand) • Patient Flow Oversight Group establish 12/04/2021 to review operational processes	

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	symptoms. Further repeat screening if symptoms develop • Screening data • Safe transfer systems in place, including a transfer team and security escort with corridor clearance to limit exposure risks		• Additional plan to implement screening if a patient is moved to another ward • Covid-19 screening audit	
• that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance	• Covid-19 PPE audits (for aerosol and non-aerosol generating procedures) are in place for all clinical areas • Vacated areas are decontaminated using Hydrogen Peroxide Vapour (HPV). In the event HPV is unavailable areas are decontaminated using a 1,000ppm chlorine-based solution			
• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice - Staff adherence to hand hygiene - Social distancing across the workplace - Staff adherence to wearing fluid resistant	Effective systems in place to support prevention of HCAI including: - training, policies and audit plan: - • Hand hygiene audits weekly • PPE (readily available) audits of AGP and non-AGP weekly • Environmental audits according to risk category • High impact intervention audits • Supplies monitoring of PPE levels daily • Social distancing check included on the daily Clinical Area Action Card	• Auditing of non-clinical areas	• Non-clinical area Action Card to be developed • Escalation of concerns from any staff group to the Infection Prevention and Control Team	

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
surgical facemasks (FRSM) in: - a) clinical - b) non-clinical settings	• Spot checks on break rooms • Signage and refresh campaign aligned to national campaign • Infection Prevention and Control Team visibility on wards			
• monitoring of staff compliance with wearing appropriate PPE within the clinical setting	• PPE (AGP/non-AGP) audit programme in place • Refresh PPE Champions role in February 2021 • DIPC communications on the importance of IPC compliance • Sharing good practice Trust-wide via Patient Safety huddle • Challenge to staff where non-compliance is observed			
• consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• PPE Champions implemented with role defined • Refresh PPE Champions role in February 2021			
• implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor	• Staff screening in place for: symptomatic staff and asymptomatic staff in outbreaks • Occupational Health Service monitor staff cases and areas where clusters of cases are identified are reported to the IPC team	• Compliance with staff reporting and using LAMP	Communication strategy to improve uptake including CEO led team brief June 2021	

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
results and staff test and trace	• Self-testing – lateral flow implemented November 2020 with electronic test result reporting system including guidance on action to take according to results. Compliance monitored at Tactical meetings • Review underway and plan in progress for introducing LAMP testing • Staff absence monitoring including staff absent following contact by Test and Trace			
• additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health Team	• Additional staff testing as part of outbreak investigation			
• training in IPC standard infection control and transmission-based precautions are provided to all staff	• Local induction and mandatory IPC training includes standard infection control and transmission-based precautions • Practical demonstrations of donning and doffing have been provided to PPE Champions for cascade training		• 4 training sessions per week are being provided in addition to induction and mandatory training • Compliance with IPC training is monitored at Infection Control Sub-Committee and areas with lower compliance set recovery targets	

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	• Induction and mandatory IPC training updated to include guidance on COVID - 19 • Copies of training presentations • Training session have been recorded and information on Covid-19 added to face to face mandatory training session E-learning session is being updated • Department specific training provided to ICU; ED and theatres • Bespoke training sessions available		• 4 training sessions per week are being provided in addition to induction and mandatory training • Compliance with IPC training is monitored at Infection Control Sub-Committee and areas with lower compliance set recovery targets	
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• PPE guidance included in the Covid 19 Policy is line with PHE national Guidance • PPE Trust Board paper • Trust wide risk assessment • Local risk assessments in place for the use of PPE • Infection Prevention and Control Team support staff education for PPE • PPE training records • Face Masks distributed to all Non-clinical areas on Friday 12th June ahead of the change in guidance for PPE to be worn in non-clinical areas • Risk assessments include details on Covid-19 secure and when face masks are required			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• PPE training for visitors where compassionate visiting requirements are indicated • PPE champions (58) support staff education/face to face training • PPE audit tool developed for aerosol/non-aerosol generating procedures – weekly audit • PPE Audit records • Covid-19 PPE staff information booklet (x2) • PHE PPE training video website links shared and compliance monitored • Supplies including PPE is a standing agenda item at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • A protocol is in place for both in and out of hours access to PPE • Further PPE training with PPE champions in July and August 2020 and February 2021			
• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and	• PPE booklet (version 2) distributed in Dec 20 • Sharing of learning from incidents including social distancing in break areas and car sharing • PPE posters in all clinical areas	• Updated NHSE/I communications package	• Plan in development with Communications team to revise signage	

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
maintaining physical distance both in and out of the workplace	• Desk top messages • Daily (weekdays) Covid-19 Safety huddle • PPE posters revised 02/2021 • Use of electronic desk top messages on hands, face, space, clean workplace • Safety briefings • Daily Covid-19 safety huddle • Signage at all entrances			
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7) shared at Trust Wide Safety Briefing (TWSB) and via Covid daily Bulletin • Control Room with dedicated email address receives national updates which are distributed as and when received for timely action • Compliance framework tracking compliance with national guidance under clearly defined work streams with nominated leads • Coronavirus Assessment Pod decontamination SOP • Coronavirus Policy version 7. Updates shown in different coloured font to support staff more easily identify latest changes/ updates			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• SOP for patient placement during Covid-19 pandemic • Quantitative Fit Testing SOP • Qualitative Fit Testing SOP • Reusable PPE Decontamination SOP • Covid-19 Screening SOP • Hospital onset Covid 19 and Outbreak Management SOP • Staff screening SOP • Review of compliance against national guidance – Survey report • Policies, guidelines and SOPs and updates are distributed by Trust Wide Safety Brief			
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Covid-19 Tactical Group Meetings and Recovery Board Meetings in place with clear escalation route to Trust Board • Tactical meetings (initially daily (weekdays) from 18/03/20 and stepped down to 3 times per week 01/05/20 and then to weekly from 06/07/20, timescale revised according to local prevalence • Recovery Board Meetings were twice per week starting on 05/05/20 feed into Strategic Executive Oversight Group (SEOG) meeting and this feeds into Board. The Associate Director of IPC attends Tactical and Recovery meetings			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	as do the DIPC and Deputy DIPC/Consultant Microbiologist Infection Control Doctor. Recovery meetings stepped down for wave 3 • COVID Non-Executive Director Assurance Committee (COVNED)			
• risks are reflected in risk registers and the Board Assurance Framework (BAF) where appropriate	• A Covid-19 specific Risk Register has been created with risks escalated to the corporate Risk Register and Trust BAF as appropriate. Updates are discussed at the Quality Assurance Committee • Corporate Risks include impact on activity • Local risk assessments in place for the use of PPE • 2 risks on the BAF linked to: - national shortage of PPE - oxygen supply • PPE is a standing agenda item for monitoring levels at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • Oxygen daily SitRep continued beyond national reporting requirements to provide local assurance • HSIB interim bulletin on oxygen January 2021 is under review			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Existing IPC policies in place: - Chickenpox - Clostridium difficile - Scabies - Shingles - Meningitis - MRSA - Multi-drug resistant organisms - Influenza - TB/ MDR TB - Viral Gastroenteritis - Viral haemorrhagic fevers - Isolation of immunosuppressed patients • SOPs for rapid testing for CPE/ MRSA and enteric and respiratory pathogens • Isolation for other infections and pathogens is prioritised based on transmission route • Clostridium difficile Guidelines (2018) in place and all patients with a C. difficile toxin positive or PCR positive result are isolated • Ribotyping of all community onset healthcare associated and hospital onset healthcare associated cases • Root Cause Analysis investigation for all hospital apportioned cases			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Compliance with Mandatory HCAI reporting requirements • Distribution of HCAI surveillance data weekly • Re-establishing the C. difficile Cohort Ward is included in Recovery Plans • GNBSI reduction Action Plan has been revised and work stream is being reinstated			
• the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner	• Chief Nurse/DIPC signs off data submissions • Sign off process in place for daily nosocomial SitRep • Daily data validation process for new admissions and inpatient Covid-19 tests prior to forwarding for sign off • Covid-19 data is reviewed at Tactical meetings and Silver IPC Cell meetings • The IPC Board Assurance Framework is reviewed at QAC and Trust Board of Directors meeting bimonthly			
• this Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	• QAC submission papers bimonthly • Board Submission papers • Board meeting minutes			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• ensure Trust Board has oversight of ongoing outbreaks and action plans	• Information on outbreaks included in daily executive summary and discussed at the daily Senior Executive Oversight Group Meeting • Learning from Outbreaks included in Nosocomial Board Paper 01 2021 • Nosocomial learning action plan in place reviewed at Silver IPC cell meetings. Plan to feedback at CBU level with drill down to individual ward learning			
• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Matron and IPC Walkarounds • Senior nursing team checks that action cards are being completed • Executive Team walkabouts • Ward Accreditation with IPC reviewer membership • Challenge occurs at the following meetings: - Tactical - Silver IPC Cell - Quality Assurance Committee - Infection Control Sub-Committee - Senior Executive Oversight Group - Covid NED Group - Increased Microbiology support/ briefings delivered to medical cabinet			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• SOP for patient placement (agreed ward and critical care locations). Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status. Respiratory Step-down Unit SOP • Bespoke simulation training for patient transfer • Availability of rapid SARS-CoV2 testing • Ongoing discussion at Nursing and Midwifery Forum, Medical Cabinet and Allied Health Professionals Forum as mitigation • Discussed at the Care Group Meetings and action agreed to update guidance • Matrons provide oversight of staffing levels to ensure all areas are appropriately and safely staffed • IPC team regularly review and have visible presence in all areas		• Increased IPC support to wards/departments caring for patients with Covid-19 • Increased staffing in IPC team to support training requirements, skilling up of senior staff to disseminate training • Increased Microbiology support/ briefings delivered to medical cabinet	
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	• Task Team and Domestic Assistant training for Covid-19 cohort ward areas has been carried out • Fit Testing for FFP3 masks undertaken for Domestic Assistants in areas where aerosol generating procedures are performed • Task Team support areas where there are Domestic Assistant shortfalls			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Four additional HPV decontamination machines purchased and training on use provided			
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Terminal cleaning and Decontamination polices in place including guidance on environmental disinfectant required to decontaminate the environment. Decontamination included in the Covid-19 policy • All policies are used in conjunction with any updates provided by COVID-19 national guidance • Terminal Cleaning Guidelines 2018 • Decontamination Policy 2019 • Novel Coronavirus Policy (version 7) • 4 additional HPV machines purchased • CEO meeting and Chief Nurse/Deputy CEO and ADIPC meeting with domestic staff • Associate Director of Estates is a member of Silver IPC cell			
• assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• Sign off checklist in place for terminal cleans			
• increased frequency, at least twice daily, of cleaning in areas that	• Twice daily cleaning of in-patient areas • Cleaning of frequently touched surfaces is included in cleaning policies			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
have higher environmental contamination rates as set out in the PHE and other national guidance	• Cleaning audits - Ward/Department audits findings are emailed to the Ward/ Department Managers for action • Domestic Supervisory team ensure standards are adhered to • Additional monitoring of standards during outbreaks			
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	• Alternative disinfectant used in CT scanning room. Chlorine based disinfectant diluted to 1,000ppm available chlorine is used for terminal cleaning, wards where C. difficile cases are cared for or Hydrogen Peroxide Vapour for cases of C. difficile • Consultant Microbiologists and IPCNs included in discussions on alternative products to ensure effective against coronaviruses	• Specialist cleaning plan in place in the CT scanning room	• CT Manufacturer provided alternative decontamination guidance	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance: • 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards	• Information on contact time is included in the decontamination policy • Ring the bell it's time for Clinnell campaign • Domestic staff record when they have cleaned areas • Enhanced cleaning – all areas, including non-clinical, supplied with desk wipes • Increased cleaning frequency in all public areas including toilets, communal spaces, lifts • Cleaning of workstations is included in the Environmental Action Plan			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
should be cleaned a minimum of twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Domestic staff time cleaning activity when areas are vacant • Included in ICU Bioquell pod SOP			
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Process for managing linen is included in the COVID-19 policy. All linen from COVID-19 possible and confirmed positive patients is treated as infectious and placed in alginate bags which are tied and then placed in a white plastic bag • No DATIX reports on non-compliance with double bagging of used/infected linen • Scrub suits made available to all staff with a central collection point • Scrub suits laundered by the Trust's laundry contractor • Uniform and workwear policy is under review			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• single use items are used where possible and according to single use policy	• Decontamination Policy in place which includes single use/single patient use guidance used in conjunction with any updates provided by national guidance in response to COVID-19 • Chlorine releasing agents are the nationally advised disinfectant of choice for decontamination • Hydrogen Peroxide Vapour has been used for environmental decontamination as part of a deep clean programme for vacant patient rooms/wards			
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	• Decontamination Policy in place used in conjunction with any updates provided by National Guidance in response to COVID-19	• Decontamination Meetings suspended in wave 1	• Meetings reconvened from 17/08/20 • A SOP for decontamination of reusable PPE is in place	
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Cleaning monitoring programme in place • Monitoring result are circulated to managers for corrective action where standards are not met at time of auditing • Housekeepers accompany monitoring officers where on duty and corrective action is taken at time of auditing or as soon as possible			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• Windows within the waiting space are opened to ventilate the area and any space having forced ventilation is adequate to keep the area ventilated so windows can be kept closed • Signage on social distancing, hand hygiene and face coverings are displayed in ED waiting areas • Ventilation Group meetings with terms of Reference	• Old Estate with limited mechanical ventilation/ air conditioning units • Not all areas will be provided with ventilation or can open windows	• These areas are ventilated by keeping doors and windows open where possible/ patient comfort allows • Review of ventilation across the whole Trust estate in progress (June 2021) with recommendations being finalised	
• monitor adherence of environmental decontamination with actions in place to mitigate any identified risk	• Programme of cleaning audits in place with feedback requested on action taken to rectify any areas requiring attention • Ring the bell it's time for Clinell campaign			
• monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	• Programme of cleaning audits in place with feedback requested on action taken to rectify any areas requiring attention			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Arrangements around antimicrobial stewardship are maintained	• Consultant Medical Microbiology daily Ward Round in Critical Care • Ward based Pharmacist support • Prescribing advice available by telephone (in and out of hours) • Infection Control Doctor presentations to Medical Cabinet • Formulary review as evidence/guidelines are updated • Antibiotic prescribing guidelines for COVID suspected patients have been published • Antimicrobial Management Steering Group Meetings will be reconvened from September • C diff outliers ward rounds recommenced in July			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Quarterly Point Prevalence audits with concerns discussed at Medical Cabinet and Infection Control Sub-Committee			
• Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of HCAIs has continued • Data on HCAIs is included on the Quality committee and Infection Control Sub-Committee Dashboards • DIPC reports HCAI data at Trust Board • Information on Data Capture System • Distribution of HCAI surveillance data weekly • HCAI review meetings being reconvened from April 2021			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Implementation of national guidance on visiting patients in a care setting	• Restricted visiting implemented 17 March 2020; Visiting fully suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020. Paper on visiting arrangements taken to SEOG • Visiting the dying guideline in place with training provided by the Palliative Care Team • Trust wide Communication via email on visiting restrictions then cessation • Environmental Safety Plan includes site lock down to restrict access • Compassionate visiting arrangements agreed for the following patient groups where close family and friends		• Guidance regularly updated in-line with national guidance • Visitor risk assessments • Pre-visit symptom screening checklist • Visitor information leaflet • Family Liaison Officer team • Virtual visiting/ ipads	

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	visiting may be admitted: • Patients in critical care • Vulnerable young adults • Patients living with Dementia • Autism • Learning difficulties • Loved ones who are receiving end of life care • Signage at entrances • Information on Trust website • FLOgrams • Trial wards agreed to re-introduce visiting week commencing 7 June 2021 limiting numbers and visiting time period of 1 hour			
• Areas in which suspected or confirmed COVID-	• Coronavirus posters with details on Red, Amber or Green			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	pathway, displayed outside areas where patients with suspected or confirmed COVID-19 are cared for • Family Liaison service in place to keep relatives (virtually) updated on care of loved ones • Refresh of Infection Control communications campaign using national toolkit			
• Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information on COVID-19 is available on the Trust Web Site and at entrances			
• Infection status is communicated to the receiving organisations or department when a possible or confirmed COVID-	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab (to date **>3828** alerts added – 09/06/2021) • Covid-19 status included on SBAR form			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
19 patient needs to be moved	• Covid-19 has been added to e-discharge summary template • Pre-admission information provided to patients being admitted electively • Policy for patients being discharged to care homes			
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	• Information on the Trust website (updated 16/10/2020) • Signage at all entrances • Hand gel and face masks provided at hospital entry points • Entrances are manned (part time) to support visitor compliance – visiting restrictions are currently in place	Lack of concordance by visitors as restrictions are lifted		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Triage in ED includes questions on Covid-19 symptoms/ pre-admission testing results where available • Information provided prior to attending Outpatient Departments and further symptom screening in place on arrival • Triage tool in ED includes questions on recent travel			
• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• Patients conveyed to hospital by Ambulance are pre-assessed to determine where they are taken to in ED • ED reorganised to have Hot and Cold respiratory assessment zones to segregate patients presenting with suspected Covid-19 • Triage tool in ED and segregated areas for patients suspected to have COVID-19 • Environmental Safety Action Plan with proposal to lockdown of 25% of entrances • Manned mask stations at main entrance Warrington site (part time) and mask available at other	• Asymptomatic patients subsequently identified as COVID-19 positive • Old estate, limited number of side rooms	• Process in place to isolate and close the bay to admissions when exposure incidents occur • **Plan for a new ED plaza**	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	entrances with access to hand sanitisers • ED and IPC meetings established			
• Staff are aware of agreed template for triage questions to ask	• Triage tool in ED includes questions on recent travel – revised tool discussed at Tactical Meeting on 11 June 2021 • Staff trained in triage questions			
• Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• Senior ED staff are rostered to carryout Triage • POCT (Abbot ID Now) testing introduced in ED			
• Face coverings are used by all outpatients and visitors	• Observational checks carried out in Departments • Safety teams at entrances from ****	• Patient lack of concordance or inability to wear a face covering due to an underlying condition	• Social distancing maintained where patients and anyone accompanying them cannot wear a face mask • SOP required to support staff decision making in relation to continuing with procedure with reasonable adjustments to ensure staff safety where patients are exempt	
• Face masks are available for all patients and they are	• Face masks available for all inpatients and at entrances • Lock down plan for entrances	• Some patients are unable to tolerate face masks	• Social distancing maintained where patients and anyone accompanying them cannot wear a face mask	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
always advised to wear them				
• Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	• Masks are offered to patients where O_2 therapy is not required and 2 metre distancing is not possible • Mask use is recorded in Lorenzo and on care and comfort rounds • Masks are worn when transferring between wards/departments	• Some patients are unable to tolerate face masks	• Use of clear curtains to create a physical barrier and protection from droplets	
• monitoring of inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	• Compliance recorded on care and comfort round forms and documented in Lorenzo EPR			
• Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to	• Estate work has been carried out to install additional doors within ED • Where available, doors are closed on ward corridors to separate Covid and non-Covid areas			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
protect reception staff	• Perspex screens have been installed in reception areas			
• to ensure 2 metre social & physical distancing in all patient care areas	• Some patients cared for in single room • Patients are socially distanced as far as reasonably achievable	• Some bed spaces less than 2 metres apart in bays	• Clear curtains in place to create physical barrier and protection from droplets • Individual ward/department risk assessments	
• For patients with new-onset symptoms, isolation, testing and instigation of contract tracing is achieved until proven negative	• Symptomatic screening is advised if previous screening results were negative • Routine swabs for Covid have been added to the sepsis screening packs • Isolation facilities are prioritized for patients with suspected infections transmitted by the respiratory route • Contact tracing is including in the Covid-19 Hospital Onset and Outbreak Investigation SOP	• Limited number of available side rooms	• Patients are isolated where possible • Clear curtains are used as barriers where isolation rooms are not available • Patients are socially distanced as far as reasonably achievable • Individual ward/department risk assessments	
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	• Repeat patient testing in place where there are on-going concerns about COVID-19 and initial swab was negative • SOP on Covid-19 screening and isolation and PPE in place • Contact tracing is including in the Covid-19 Hospital Onset and Outbreak Investigation SOP	• Low number of available side rooms	• Patients are isolated where possible. Clear curtains are used as barriers where isolation rooms are not available • Patients are socially distanced as far as reasonably achievable	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Letter in place for follow-up of discharged patients who have had contact with Covid-19			
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	• Daily monitoring system in place to achieve full screening compliance for admission, day 3 and day 5 swabs • Weekly screening implemented	• RCAs are identifying a very small number of routine samples are being missed	• Daily senior nurse oversight to ensure compliance • Electronic systems support identification of patients who have not be screened as per routine testing protocol • Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	
• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Rapid testing available 7 days per week • Routine appointments have been stepped down. Social distancing measures are in place in Outpatient Departments • Recovery plan for Outpatients (28/05/2020) includes providing information not to attend if unwell with Covid-19 symptoms • Risk rated appointment schedule based on clinical priority • Virtual 'attend anywhere' clinics • Rooms identified for shielding patients	• Public lack of concordance with social distancing measures	• Social distancing measures are in place in Outpatient Departments • Signage in place to keep left on corridors, walk in single file and socially distance • Seating arranged in Outpatient waiting areas to support social distancing	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	• Environmental Action plan in place • Keep left signage in place for internal walkways • Restricted key codes/controlled entry in place • Green pathway for surgical patients at CSTM building and Ward A5 elective • Wards identified for care of patients with Covid-19 as per Trust escalation plan • Signage at ward entrances denotes red, amber or green pathway area • Refresh of the communications IC Strategy			
• All staff (clinical and non- clinical) have appropriate training, in line with latest national guidance,	• PPE Champions (58), roving training on donning and doffing of PPE • Links to PHE videos have been distributed.	• Staff returning to work, including after pregnancy, long term sick leave or due to Extremely vulnerable status	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where there are shortfalls in staff training	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
to ensure their personal safety and working environment is safe	Individual booklets on COVID-19 and PPE produced and distributed • Training records from all CBUs that staff have read the Covid-19 policy, receive the PPE booklet, watched the PHE videos, received face to face training, read the Covid-19 swabbing SOP • PPE training videos included in mandatory training programme • Record of staff training to carrying Fit testing • Fit testing for FFP3 respirators records	may not be fully informed with the latest guidance	• IPC Team provide ongoing training to PPE champions on donning and doffing of PPE • Links to PHE videos are available and distributed and included in IPC mandatory training sessions	
• All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Links to PHE videos have been distributed. Posters are displayed in clinical areas on donning and doffing • Information recirculated to Planned and Unplanned Care Groups • Bespoke training	• Posters not displayed in all areas • Staff returning from absence may not be fully informed/ updated with latest guidance	• Additional posters ordered and site survey to be completed by IPCNs with PPE champions for each area • IPC team provide ongoing training on donning and doffing of PPE • Links to PHE videos are available and distributed	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Information circulated on Trust Wide Safety Brief • PPE training included in mandatory training programme			
• A record of staff training is maintained	• Record of training is held and maintained • Induction and Mandatory training records are held in ESR	• Follow up of staff training records required in train	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where staff training is required or bespoke training	
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• Observational audits completed and feedback received from PPE Champions • Electronic Audit Tool developed and launched 15/05/20 • Audits are carried out weekly and repeated in a shorter timescale where issues are identified • Datix reporting of compliance issues • Discussion on the importance of compliance takes place			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	where PPE risks are identified			
• Hygiene facilities (IPC measures) and messaging are available for all patients/ individuals, staff and visitors to minimise COVID-19 transmission such as: - hand hygiene facilities including instructional posters - good respiratory hygiene measures - maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care - staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public	• Hand hygiene audits • Hand washing signage – wash hands more frequently & for 20 seconds • Catch it Bin It Kill Posters displayed throughout the Trust • Social distancing signage in place Trust-wide • Information provided in staff Covid-19 booklet on safe travel arrangements		• Hand washing technique posters to be refreshed	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
health guidance outside of the workplace - frequent decontamination of equipment and environment in both clinical and non-clinical areas - clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	• Ring the bell cleaning initiative implemented • Office risk assessments in place including use of masks if not in a single person office			
• Staff regularly undertake hand hygiene and observe standard infection control precautions	• Programme of hand hygiene audits in place – carried out weekly in areas operational. Overall compliance • April – December 2020 =98% - 99%; • January – May 2021=98% - 99%			
• The use of hand air dryers should be avoided in all clinical areas. Hands should	• Hand air dryers not in place in clinical areas			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	• Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan • Hand towel dispensers have been installed and waste collection schedule put in place			
• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• Signage on hand washing technique is displayed on all soap dispensers. • HM Government signage has been displayed detailing 20 second handwashing			
• Staff understand the requirements for uniform laundering where this is not provided for on site	• Guidance on home laundering is included in the COVID-19 PPE information leaflets • Scrub Suits have been offered as an alternative to uniforms and are laundered centrally • Trust wide emails with guidance on laundering			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	• Screening for COVID-19 is undertaken in line with national guidance • Monitored by the Occupational Health and Wellbeing Team and overseen by the Workforce and Organisational Development Team			
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/ organisation onset cases (staff and patients/ individuals)	• Local statistics included in Tactical meetings agendas • Surveillance on hospital onset patient cases included on the Integrated Performance Report • Information on staff cases/outbreaks reported at Senior Executive Oversight Group by DIPC			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Briefings by Consultant Microbiologist/Infection Control Doctor to Medical Cabinet/ Nursing and Midwifery Forum • CEO trust-wide briefings			
• Positive cases identified after admission that fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	• Root Cause analysis investigation requested for all cases ≥ day 8 of admission • Outbreak reporting protocol in place including to: - Trust board - NW.ICC; PHE; CCG; CQC; NHSE/I via web-based reporting system • Process in place for RCA review with IPCT and Governance Department and terms of reference agreed • Learning themes from RCA findings are shared with staff • Outbreak Meeting Terms of Reference and			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	Microbiology DIPC or Deputy presence etc • IIMARCH completed and submitted to NHSE/I			
• Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	• Daily surveillance in place of ≥ day 8 cases and location tested to promptly identifying clusters and initiate outbreak investigation accordingly • Occupational Health and Wellbeing Team monitor for clusters of staff cases			

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Restricted access between pathways if possible, (depending on size of the facility, prevalence/ incidence rate low/high) by	• Green pathway for Surgical cases at CSTM building and A5 elective ward • ICU expansion into theatre for non-Covid ICU			

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
other patients/ individuals, visitors or staff	cases in theatre pods and use of recovery for patients with Covid-19			
• Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	• Signage in place stating Covid-19 cases on wards • Red, Amber Green pathway signage at ward entrances • Barriers in place to support • Keep left signage • Distancing in waiting areas • Signage clearly states areas are Red, Amber or Green and written information to state what this means			
• Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status	• Limited number of single rooms for isolation (65)	• Cohorting in place as advised by the Infection Prevention and Control Team • Operational Manager/Silver Command oversight at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand) • Abbot ID now testing in ED provides rapid results to support patient placement	
• Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with	• Additional hand washing facilities in anterooms on ward A7 • Side rooms in use for non-clinical activity converted	• Old Estate with limited side room capacity	• Daily review of side room utilization at bed meetings • 4 additional Bioquell pods being installed on ward B18	

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
the environmental requirements set out in the current PHE national guidance	back for clinical inpatient use • 2 single rooms on A2 • 1 single room on A7 • 4 additional single rooms: 2 between A5 and A6; and 2 between A8 and A9 • 3 single room pods built in AMU • 1 outside ACCU • ED 1 Bioquell Pod • Critical Care 5 Bioquell Pods			
• Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Isolation Policy and Alert organism policies in place • Datix completed when it has not been possible to isolate patients	• Limited number of side rooms further reduced by ward closures • Potential non-compliance of patients with shielding pre-operatively	• Isolation priority protocol in place based on transmission-based precautions • Daily liaison with Patient Flow Team to support risk prioritisation	

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
There are systems and processes in place to ensure:				

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
• Testing is undertaken by competent and trained individuals	• Training on swabbing technique provided verbally and by video	• Small number of samples rejected due to insufficient cellular material or incorrectly labelled	• Swabbing SOP and training provided • Competency assessment tool launched	
• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Swabbing SOP in place covering day of admission, day 3, day 5, weekly thereafter if previous results negative, symptomatic, pre-admission elective and discharge screening • Lateral Flow testing in place for staff with plan in place to introduce LAMP testing	• RCAs are identifying some routine samples are being missed	• Daily senior nurse oversight to ensure compliance • Electronic systems support identification of patients who have not be screened as per routine testing protocol • Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• Testing turn around times are monitored at Silver IPC cell			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
• Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• LION BIS used to monitor testing in line with guidance and follow-up of omitted tests on admission/ day 3 /day 5/ weekly from day 5 • Documentation of IPC advice on receipt of positive results • RCA requests for cases ≥ day 8 of admission, with monitoring system in progress • Daily data validation process for Sit Rep signoff and external reporting			
• Screening for other potential infections takes place	• Other routine admission screening (CPE, MRSA, VRE) in place			
• that all emergency patients are tested for COVID-19 on admission	• All patients being admitted to the Trust have Covid admission tests taken in ED using POCT (Abbot ID Now) testing			
• that those inpatients who go on to develop	• Covid is considered as a differential diagnosis for	• A small number of RCA investigation	• Discussion took place at Medical Cabinet to advise timely testing for Covid in patients developing Hospital acquired pneumonia	

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
symptoms of COVID-19 after admission are retested at the point symptoms arise	inpatients developing respiratory symptoms	findings identified missed testing opportunities		
• that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	• Daily monitoring system in place to achieve full screening compliance for admission, day 3 and day 5 swabs • Weekly screening implemented	RCAs are identifying a very small number of routine samples are being missed	• Daily senior nurse oversight to ensure compliance • Electronic systems support identification of patients who have not be screened as per routine testing protocol • Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	
• that sites with high nosocomial rates should consider testing COVID negative patients daily	• Community prevalence increasing 06/06/2021 • Reduced nosocomial case numbers • Increased testing in outbreak areas as advised be the Infection Control Doctor			
• that those being discharged to a care home are being tested for COVID-19 48 hours prior to	• Discharge screening in place with results shared accordingly prior to patient discharge			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge				
• that those being discharged to a care facility within their 14 days isolation period should be discharged to a designated care setting, where they should complete their remaining isolation	• Named community facility for care of patients who require continued isolation for Covid-19			
• that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	• Elective admission screening in place with results reviewed prior to admission • Where result is positive procedures are deferred			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
• Staff are supported in adhering to all IPC policies, including those for other alert organisms	• PPE Champions in place • Clinical advice for management of patients with suspected infections continued • IPC on call service to provide advice 7 days per week • PPE donning and doffing included in Induction and Mandatory training sessions			
• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7). TWSB and Covid daily Bulletin used to communicate updates	Update required to include pathway guidance in line with latest guidance	• Subscription and daily review of Gov. UK email updates • Control Room inbox is monitored 7 days per week and guidance issued over the weekend- out or of hours is escalated for action • Additional posters ordered Links to PHE videos are available on the Trust Hub and distributed • Meeting held with Critical Care to review PPE levels (15/04/21)	
• All clinical waste and linen/laundry related to confirmed or suspected COVID-	• Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a HCID. Waste was quarantined			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
19 cases is handled, stored and managed in accordance with current national guidance	and disposed of by incineration • Guidance included in the Coronavirus Policy • Used linen is processed as infected via red alginate stitched bag stream			
• PPE stock is appropriately stored and accessible to staff who require it	• Stock control in place • In and out of hours access protocol in place • Specialist PPE equipment office with access available 7 days/week			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
• Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical	• An integrated risk assessment has been produced for staff who are 'extremely vulnerable', at 'increased risk', pregnant and Black, Asian and Minority Ethnic (BAME) staff. For BAME staff, based on the number of BAME staff recorded on ESR, there is			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
and wellbeing is supported	97% compliance (05/06/2021). All BAME staff risk assessments will be quality checked and a sample audit will take place in July 2020 to ensure agreed actions have been undertaken • Chief People Officer and Chief Executive Officer and Chairman attended the BAME Staff Network Group in June 2020 to receive feedback • Individual letters have been sent to BAME members of staff, outlining support available • Named midwife contact within Maternity Department provided for pregnant staff • All staff who are considered clinically extremely vulnerable are supported by robust workforce support and the Trust are in the process of having one to one discussion to agree support and adjustments • All staff working at home have been provided with a 'working from home pack', including access to mental health support			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
	• Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy and the British Psychological Society • Electronic system in place for Covid-19 Workforce risk assessment • Access to face to face counselling			
• That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	• Process in place for electronic self-assessment followed by manager assessment if risks are identified – compliance with completion of risk assessments is monitored by the HR Department			
• Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	• Fit testing programme, including quantitative and qualitative testing, in place • Qualitative Fit testing SOP • Quantitative Fit testing SOP • Records are added to a central database • Powered Hoods are offered as an alternative where it has not been			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
	possible to Fit close fitting face masks • Only EN 149:2001 compliant masks are accepted as fit for use for Aerosol Generating procedures			
• Staff who carry out fit test training are trained and competent to do so	• Programme of Fit Testing in place which is only carried out by trained Fit testers • An accredited Fit2Fit company or the Department of Health virtual training provided staff training			
• All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	• Programme of Fit Testing in place • Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021			
• A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• Database with Fit testing details including those staff requiring specialist respiratory equipment which is updated as additional fit testing is completed	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records	
• For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation	• Spreadsheet with Fit testing details included	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
of repeated testing on alternative respirators and hoods				
• For members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	• Alternative respiratory protection is offered i.e. powered hood • Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed • Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE			
• A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational Health	• Provision of specialist PPE equipment is recorded	• Documented evidence of discussion and central holding of this record	• Process under review to capture this data	
• Following consideration of reasonable adjustments e.g.	• Provision of specialist PPE equipment is recorded	• Documented evidence of discussion and	• Process under review to capture this data	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record		central holding of this record		
• Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	• Spreadsheet with Fit testing details included • Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records • Information on Fit testing figures is reported at Tactical meetings and included at Senior Executive Oversight Group Meetings • Report to QAC 02/2021	
• Consistency in staff allocation is maintained, with reductions in the	• Staffing reviews undertaken for all COVID areas			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
movement of staff between different areas and the cross-over of care pathways between planned/elective care pathways and urgent/ emergency care pathways, as per national guidance	• Staff movements managed by the senior nursing team at daily meetings • Senior Nurse presence 7 days per week 8am-8pm to support staffing management • Planned elective areas have designated teams, who are not moved to any other area in the Trust • Where it is necessary to move staff between different areas to support patient safety, this is discussed with the Infection Control Team. This cross over has not occurred between Elective and Emergency Care pathways			
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Signage in place along corridors to socially distance, keep left and walk in single file • Risk assessments of all areas to achieve Covid-19 Secure spaces • IPC Team and/or Health and Safety Team review where concerns have been raised	• Compliance in office spaces	• Non -clinical area daily action card in development	
• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace	• Risk assessment in place to reduce risk • Agile working policy includes home working			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
risk(s) are mitigated maximally for everyone				
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas	• Guidance on PPE distributed by email, PPE booklet, posters			
• Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place • Data reported to Tactical meetings			
• Staff that test positive have adequate information and support to aid their recovery and return to work	• A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce • The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and when required	• Test and Trace Service hours of operation	• National guidance for 16 hour per day service (cover in place for 11.5 hours per day) • Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
	• Retesting is in place as appropriate and is set out in Staff Testing SOP			

APPENDIX 2 Action Plan for IPC BAF 06 2021

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
1	Audit compliance with infection risk assessment completion in Lorenzo	Jun 2021			ADIPC	IT		
2	Audit non-clinical area compliance with mitigation identified in risk assessments. Develop daily action card for non-clinical areas to be developed	Jun 21			ADIPC			
3	Improve compliance with level 2 IPC training to ≥ 85%	Jun 21		Three additional training sessions per week are being provided	IPCN	ACNs Planned & Unplanned Care	May 2021 = 82% compliance increased from 73% compliant in March 2021	
4	Improve compliance with LAMP testing currently 433 staff participating	Jul 21		Revise introduction plan Communication strategy to improve uptake including CEO led team brief June 2021	CPO	CBU Triumvirate Leads		
5	Update Signage aligned to Every Action Count resources	Jun 21		Agreement for roll out with DIPC and Communications Team	DIPC Interim Communications Lead	ADIPC	Posters designed and roll out plan being devised	
6	Revision to Trust Covid-19 Policy – updated national guidance June 2021	Jun 21			ADIPC	CMMs		

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 2 Provide and maintain a clean and appropriate environment								
7	Training of core group of staff to use the HPV decontamination machines	Jul 21		Provision of training by the supplier Agreement in place to train all Housekeepers	ADE	DCN IPCNs DCN	Training provided to Warrington site task team members	
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes – Nil actions identified								
Criterion 4 Provide suitable and accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion– Nil actions identified								
Criterion 5 Ensure prompt identification of people who have or are at risk of developing an infection								
8	Confirmation that Triage in ED includes questions on travel to countries with variant SARS-CoV-2 strains	Jun 21	Jun 21	Draft triage template provided for implementation	AC/ SR/ SFD	CMM	SOP updated by IPC Team, Triage form from ED Team	
9	Template to be implemented and shared with all appropriate staff	Jun 21		Education of all staff on the revised Covid-19 triage process	AC/ SR/ SFD	CMM		
10	SOP to support decision making in relation to provision of treatment where patients are unable or refuse to wear a face mask	Jun21		SOP required to support staff decision making when patients refuse or can't wear a mask	ADG	ADIPC	Decision taken at individual department level Datix completed when patients refuse to wear a mask	
Criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection								
11	Education on Covid-19 PPE for staff returning to work, including after pregnancy, clinically extremely vulnerable or long-term sick leave	Jun 21		Awaiting Occupational Health guidance. Clinical areas not classed as Covid secure.	ADIPC	ACNs Unplanned & Planned Care Groups	Clinically extremely vulnerable staff are currently excluded from the workplace	

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 7 Provide or secure adequate isolation facilities								
12	Install additional Bioquell pods	Jul 21		Plan developed to install 4 Bioquell pods in ward B18	MC CBU Manager	ADE	Building work in progress	
Criterion 8 Secure adequate access to laboratory support as appropriate								
13	Daily swabbing compliance review to ensure compliance with Day of admission, Day 3 and Day 5 and weekly Covid screening	Jun 21			ADIPC	IPC Admin	Work in progress to align data on outstanding swabs on the BI LION report and E-outcome	
Criterion 9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections – Nil Concerns								
Criterion 10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection								
14	Centralised records of FFP3 Fit Testing	Jun 21		Add records to ESR	DCN Patient Safety	DCPO	Spreadsheet includes all staff records	
15	Documented (centrally held records) process for supporting staff who fail fit testing including redeployment options. Records should be held centrally of discussions with employees	Jun 21			DCPO		Alternative respiratory protection (powered hoods). Redeployment Hub established for vulnerable staff	

RAG Legend	
Action not commenced	
Action in progress	
Action completed	

Key Personnel

ACNs	**Associate Chief Nurses**
ADIPC	**Associate Director of Infection Prevention and Control**
ADG	**Associate Director of Governance**
AMD	**Associate Medical Director**
CBU	**Clinical Business Managers**
CMM	**Consultant Medical Microbiologists**
DCN	**Deputy Chief Nurse**
DCOO	**Deputy Chief Operating Officer**
DCPO	**Deputy Chief People Officer**
DD HR	**Deputy Director of Human Resources and Organisational Development**
IPC Admin	**Infection Prevention and Control Administrator**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/109**	
SUBJECT:	**Medicines and Controlled Drugs Annual Report**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):	Diane Matthew, Chief Pharmacist	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	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.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#224** Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	

	#1290 Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report highlights the current status of aseptic services within the Trust and highlights the intention to provide an Options Paper for the Executive Team to consider with respect to the needs of the Trust and the benefits/risks of possible modes of delivery. Within the report the Department has highlighted the need to recruit to a temporary position in order to maintain current medicines information services. The Report provides data on Pharmacy related KPIs and the Committee is asked to note the actions taken during the pandemic to adhere to infection control measures whilst avoiding any resultant waste given that shortages of critical medicines was being anticipated and the changes made to Ward Pharmacy Services in order to maintain/improve medicines safety. Production of Medicines related NICE Guidelines and new medicines introductions were reduced during the pandemic, therefore the Medicines Governance Committee worked remotely to approve guidelines as needed and undertook Guideline activities in a timely manner when meetings re-started. Recent senior appointments to the Pharmacy Department will ensure this work continues and standards are maintained. EPMA related safety develops are continuing in accordance with the Digital Operational Group/Digital Board approved road map, this includes the final phase of EPMA roll out to NNU and ITU, implementation of GP Connect when the required fixes have been implemented and tested, roll out of Parts 3 and Parts 4 following testing and outpatient e-prescribing. Other medicines safety initiatives underway include preparation of an antimicrobial stewardship strategy/plan, polypharmacy and de-prescribing, cross-sector project, extension of the ETCP communications to Community Pharmacy and the Medicines Improvement Group workstream

	which includes an ongoing commitment to reducing harm from omitted critical medicines. Data is provided for Phase One of the Pharmacy Transformation Business Case and the rationale for the switch from delivering medicines reconciliation work within ED to delivering it across all wards is described. Support for Phase two and three are requested so that providing a service within ED can be re-started. Incident reporting of medicines was maintained at a level similar to that in the 2 preceding years 2018/19=1065, 2019/20=1186, 2020/21=1107 with a no harm rate of reporting of 92%. This is comparable with the level seen within other Trusts. 2 major harm incidents were investigated and action plans for improvement put in place. One included respiratory arrest following administration of repeated doses of morphine. Learning from incidents was disseminated via Trust communication channels including delivery at medical handovers where appropriate. This report also describes actions undertaken to improve medicines safety and more recently with the delivery of a safe effective vaccination service.			
PURPOSE: ***(please select as appropriate)***	Information √	Approval	To note	Decision
RECOMMENDATION:	Support the content of the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/21/06/168**		
	Date of meeting	1st June, 2021		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Medicines and Controlled Drugs Annual Report	AGENDA REF:	BM/21/07/109

1. BACKGROUND/CONTEXT

The terms medicines management or medicines optimisation describe the processes and behaviours that drive the way in which medicines are selected, procured, delivered, prescribed, administered and monitored. The Care Quality Commission regulatory framework 'Fundamental Standards of Quality and Care' includes medicines management within the 'Safe' domain, serving to maintain its position as a high-priority governance issue for health provider organisations. In their 'Market Report' (2012), the CQC identified medicines management as representing one of the areas of highest non-compliance across health and adult social services care sectors.

The Chief Executive delegates responsibility for medicines management within the Trust and contributions to medicines management within the wider health economy, to the Chief Pharmacist, as indicated within Standards for Better Health (SfBH) and by the Care Quality Commission (CQC)). Medicines Management has two components, safe and secure handling of medicines (SfBH Core Standard C4d) and clinical and cost effectiveness (SfBH Core Standard C5a&d).

Improving medicines management controls is part of the national agenda and is included in the NHS Litigation Authority (NHSLA) standards, as well as the Standards for Better Health Core Standards and the CQC acute hospitals portfolio review.

The Chief Pharmacist discharges medicines management responsibilities through the pharmacy services and through membership of medicines related committees within the Trust and wider health economy, in particular through the Trust Medicines Governance Committee and the Area Prescribing Committee.

The Chief Pharmacist is the Trust designated accountable officer for controlled drugs and is required to take organisational responsibility for controlled drugs, ensure that arrangements for identifying and investigating concerns and monitoring and reporting arrangements are in place and ensure that the Trust has systems in place to notify the CQC if the accountable officer changes.

2. KEY ELEMENTS

Aseptic Services

In June 2014, Lord Carter of Coles became Chair of the NHS Procurement & Efficiency Board directing the NHS Procurement & Efficiency Programme and its portfolio of projects which included a review of hospital pharmacy and medicines optimisation in the work of the Board. In September 2014, Dr Keith Ridge, Chief Pharmaceutical Officer joined the NHS Procurement & Efficiency Board and became chair of the Hospital Pharmacy and Medicines Optimisation Project (HoPMOp).

In the final report[1] in February, 2016, Lord Carter stated that the NHS could save at least £800million through transforming hospital pharmacy services and medicines

optimisation and made recommendations for transforming hospital pharmacy services and medicines optimisation.

Within the report there was a recommendation that Aseptic Service provision was an area that required review and new ways of thinking to improve delivery and maximise efficiencies.

Within Cheshire and Merseyside and Nationally, aseptic services was considered to be an important area for review and a National survey of aseptic service provision was conducted. Since then, limited progress has been made in determining an overarching aseptic service strategy.

The Trust's 20 year old Aseptic Unit had operated with limited staffing resource since the Radiopharmacy closed and was forced to close due to problems with repairs/replacement of parts for the plant responsible for maintaining the required air changes within the Unit. In keeping with the ethos of working collaboratively with St Helens and Knowsley NHS Trust (StHK) and the recommendations of Lord Carter of Cole, the Trust's parenteral chemotherapy, biologic and total parenteral nutrition needs are currently provided by a combination of StHK, homecare and approved private sector providers. Whilst supplies of products were maintained throughout 2020/21 and the COVID pandemic waves, this was, at times, challenging with some substitution of products occurring with the agreement of affected clinical teams.

During COVID, demand for adult total parenteral nutrition increased, this trend is continuing, ophthalmology requests increased and this trend is expected to continue,

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

urology and gynaecology requests decreased but it is expected that these will return to pre-COVID levels.

Table of Aseptic Product Transactions between 2018 and 2021

	2018/19	2019/20	2020/21
Transactions	1931	1602↓	1423↓
Value	£85,807	£91,652↑	£137,739↑
Adult TPN	1079	825↓	1254↑
Neonatal TPN	320	272↓	273↔
Ophthalmic preparations	112	116↑	128↑
Urology preparations	175	187↑	35↓
Gynaecology preparations	136	127↓	92↓
Antiviral infusion (CMV)	14	15↔	6↓

The Trust has a gap in relation to the provision of some pre-prepared products for which suppliers have not yet been identified. This has been highlighted within the Cheshire and Merseyside healthcare partnership Pharmacy forum. During COVID-19 we re-visited external options and were able to source additional pre-prepared products to support intensive care. This piece of work highlighted that there was greater access to pre-filled syringes than infusion bags and this in turn highlighted differences in ways of working between our trust and others in relation to use of pumps and syringe drivers. This warrants further discussion within the Trust regarding the future strategy for purchasing syringe pumps or infusion pumps.

Although relying on external partners for our aseptic products has proved to be satisfactory in the past, as care pathways change, specialist skills are introduced into the Trust and as we move towards a greater reliance on intravenous preparations, monoclonal antibodies and potentially gene therapies within secondary care the balance is shifting towards this creating more risk / service sustainability issues which will be discussed in an Option Paper.

As part of the 2021/22 action plan, an Aseptic Services Option Paper will be submitted for Executive review. The Chief Nurse/Deputy Chief Executive has agreed to act as sponsor for this paper.

Medicines Information Services

The WHH medicines information service is audited on behalf of Specialised Pharmacy Services by the North West Medicines Information service.

This service supports healthcare professionals with evidence-based answers to medication related problems and a medicines hotline for patients. Around 45% of enquiries are raised by patients and 55% by healthcare professionals.

Table of enquiries raised with the Medicines Information Service (this data does not include the frequent level 1 enquiries answered by ward based pharmacy staff each day or the on call pharmacy service)

KPI	2018/19	2019/20	2020/21
MI Enquiries	435	553	600
MI enquiries answered within agreed timescales (%)	94%	99%	99%
Level 1 enquiries (%)	40%	55%	52%
Level 2 enquiries (%)	55%	42%	42%
Level 3 enquiries (%)	5%	3%	6%
ADR yellow cards submitted from MiDatabank	18	66	50

The Medicines Information Pharmacist attends and feeds back from the Area Prescribing Committee Formulary and Guidelines Group and supports the Medicines Governance Committee work program by reviewing NICE Guidelines and compiling a report identifying the impact based on any medicines content.

The Department has recruited a Medicines Information Pharmacist (fixed term contract, internal promotion) to cover a period of absence.

Procurement and Supply Services

Pharmacy has a focus on minimising waste and assessing and recycling Trust medicines that are suitable for use is one of the important ways that this is achieved by Pharmacy. During the pandemic, the process of issuing medicines had to be re-engineered as we needed to take into consideration the need to conserve medicines that were in short supply due to increase in demand for those medicines and the potential for waste in the context of infection control concerns. This was against the competing background of reduced access to areas such as Theatres/Intensive Care when PPE also needed to be conserved.

Infection control requirements were complied with whilst minimising the potential for waste by installing drug cupboards (purchased and waiting to be installed

elsewhere) into areas that could be accessed readily by Pharmacy, by altering the type and quantity of ward stock held on wards, by reducing the quantity of medicines issued to wards and the interval between supplies (inpatient/one stop supplies). It is for this reason that the number of inpatient and one stop transactions increased in 2020/21.

Table of Pharmacy Stock and Dispensing Transactions for the period between 2018 and 2021

TRANSACTION TYPE	2018/19	2019/20	2020/21
Inpatient	27,999	29,837↑	38,258↑
Outpatient/ED	31,264	39,742↑	36,437↓
TTO	77,042	79,292↑	68,186↓
Clinic	134	11	17
Day case	5,041	6,633↑	5,903↓
One stop	52,176	57,863↑	62,749↑
Bulk issue	111,662	126,862↑	123,790↓
Credit	24,071	27,887↑	26,483↓
Other	938	1069↑	1310↑
Total	**330,327**	**369,196↑**	**363,133↓**

Table of Pharmacy Stock and Dispensing Expenditure for the period between 2018 and 2021

KPI	2018/19	2019/20	2020/21
Value of stock issued	£16,231,554	£15,851,356	£15,430,601
Value of stock returned	£ 787,477	£ 855,299↑	£ 892,566↑
Net value of stock issued	£15,440,077	£14,996,057↓	£14,538,035↓
Value of homecare products issued	£ 4,390,998	£ 3,304,591↓	£ 2,867,195↓

Overall expenditure was lower in 2020/21 compared with the two previous years. The reduction in emergency admissions and elective admissions resulted in a reduction in expenditure on some medicines. The increase in expenditure on cardiovascular, central nervous system, nutrition and blood, musculoskeletal and joint disease, water for nebulisation/humidification and haemo-filtration fluids and the lack of a reduction in expenditure on anaesthetic agents can be accounted for by the increased need for medicines required to support the treatment and palliation of COVID patients, the procurement of ready to use agents from around the country to

reduce the pressure on nursing staff and the need to switch to different, often more expensive alternative agents when supplies of our preferred options were exhausted. Some of the medicines used as part of the Recovery Trial such as remdesivir and tocilizumab are also high cost drugs.

Table of the Percentage Change in Expenditure within different BNF Drug Categories comparing 2020/21 expenditure with 2019/20 expenditure

BNF Code & description	% Change in spend (20/21 vs 19/20)
01 Gastrointestinal	-40%
02 Cardiovascular	8%
03 Respiratory	-1%
04 Central nervous system	9%
05 Infection	-44%
06 Endocrine	-10%
07 Obstetrics & Gynaecology & Urinary	-32%
08 Malignant Disease	20%
09 Nutrition and blood	5%
10 Musculoskeletal & Joint Disease	4%
11 Eye	-8%
12 Ear Nose & Oropharynx	-23%
13 Skin	-6%
14 Immunology & Vaccines	-23%
15 Anaesthetics	-1%
Water for nebulisation/humidifcation	46%
Haemofiltration fluids	98%
Enteral nutrition	-35%

Ward Pharmacy Services

Three events impacted on Ward Pharmacy in 2020/21:

1. EPMA: the embedding of electronic prescribing and medicines administration following the roll out to Medical and Surgical Wards/Departments (November 2019), the implementation of EPMA in Maternity (October, 2020) and the inability to implement EPMA in intensive care,
2. The provision of an extended and weekend Ward Pharmacy Service to patients being admitted to hospital (commenced in November 2019) and
3. The COVID-19 pandemic and the need to respond to this by changing ways of working.

The implementation of EPMA required the scheduling and provision of intensive support from senior Pharmacy staff members to aid the rapid acquisition of skills by ward-based staff and minimise risks to patient safety during and then after the change.

The implementation of EPMA radically altered the way that Pharmacy staff work at ward level and this required thought as to how to optimally use the different parts of the EPR when reviewing patients who are newly admitted or being discharged. Refining the approach is ongoing. Time was dedicated to reviewing the use of the system by staff in the early part of the COVID-19 pandemic to ensure that staff time was being used effectively. The redeployment of Trust staff and arrival of clinical staff who were new to the Trust created an additional need for support with using the EPR/EPMA/IT systems and much of this was provided by the ward-based Pharmacy staff.

The introduction of a Pharmacy admissions service within the emergency department was undertaken as a result of a three phase business case approved by the Trust Executive Team (Phase One) intended to support patient medication safety improvements through timely medicines reconciliation, reduction in omitted and delayed medicines and also to optimise the use of medicines. Phase One of the ED admissions service was rolled out in stages between November 2019 and January 2020. This provided a 9am to 5:30pm Dispensary service at weekends and bank holidays, one ITU shift across 7 days, two ED shifts at weekends and a late ED shift on Fridays and Mondays.

In April, 2020, with rising numbers of patients affected by COVID-19 attending ED, it became necessary to re-think how best to deploy the Pharmacy team to support clinical teams and maintain medicines safety. As we were unable to work in ED due to PPE constraints and the rapid transfer of patients between ED and wards and having identified a need to support patients and newly deployed clinical staff on wards, we changed our ED shifts to ward shifts and deployed these staff to review admitted patients across medical and surgical wards. With rising numbers of intensive care patients, three areas to cover, no EPMA but a need to closely monitor stock holding of critical medicines, Pharmacy staffing within intensive care was increased to two pharmacists and one pharmacy technician daily across the 7 day period and this was maintained whilst these areas were escalated.

Medicines Governance Services

Medicines Governance activities were scaled down during the COVID-19 escalation periods. Publication of NICE Guidance and the introduction of new medicines were much reduced, the Area Prescribing Committee meetings were suspended. Review / Approval of Guidelines and clinical trial documentation (RECOVERY trial) was undertaken via email to Committee members as needed. The Medicines Governance Committee meetings resumed briefly between waves one and two and re-commenced in February 2021. Two senior pharmacist were appointed in December to the vacant Deputy Chief Pharmacist/Medicine Management posts and Medicines Governance will form part of their portfolios.

Medicines Governance activities:

1. New product review and introduction (non-NICE & NICE)
2. Published NICE Guidelines/Technology Appraisals assessment and review
3. Review & internal communication of monthly NHSE Communications with actions as appropriate
4. Area Prescribing Committee and Trust Formulary reviews
5. Trust Guidelines/Patient Information Leaflets/Templates containing medication information assessment and review
6. Patient Group Directions-assessment & review
7. Unlicensed medicines risk assessments and assurance
8. Antimicrobial stewardship
9. VTE chemical prophylaxis
10. Risk register: Risks relevant to Medicines Governance
11. Controlled drug & Local Intelligence Network (CD LIN) input and quarterly reports
12. Medicines Safety
    a. Quarterly Incident Reports
    b. MHRA Monthly Drug Safety Update: impact assessment
    c. NHSI Patient Safety Alerts involving medicines: relevance/impact assessment and
    d. Nurse/Pharmacist medicines safety activities
        i. Staff education and training
        ii. Support for staff who have made a medication error
        iii. Review of medication incidents
        iv. Partnership for Patient Protection work
        v. Audits

MEDICINES OPTIMISATION

Medicines related audits were completed during the 2020/21. This included Audits relating to Safe and Secure Handling of Medicines, Controlled Drugs, Antibiotic Point Prevalence and Pharmacist Interventions.

Other notable Medicines Optimisation activities:

1. The increased presence of pharmacists and pharmacy technicians on wards particularly at weekends has increased the opportunity to intervene and make recommendations promptly. (Extrapolating from Pharmacist Intervention Audits, around 30,000 patient safety interventions are undertaken by clinical pharmacy teams mainly in relation to inpatient activities).
2. Embedding the training program for ward pharmacy technicians to undertake drug histories

3. Use of the electronic transfer of discharge information to Community Pharmacy (the ETCP System that has been linked to the EPR and the TIE) - identification of patients on admission and during their inpatient stay who may benefit from support from their Community Pharmacist when discharged
4. Implementing electronic prescribing and medicines administration in Maternity (October 2020) and more recently in Paediatrics (May 2021).
5. Strong focus on the use of cost-effective medicines preparations (NHSI – Use of Resources Data – Model Hospital). The Trust performed well against the majority of Model Hospital parameters (see Appendix 1).

As part of the 2021/22 action plan there will be continued effort with the following areas of work:

a. completion of the EPMA roll out to all wards,
b. implementation of GP Connect (if current problems with the system are resolved),
c. implementation of electronic outpatient prescribing,
d. implementation of EPMA Parts 3 & 4: dose range checking, dose calculator, integration of Lorenzo with the JAC Pharmacy System,
e. re-submission of the pharmacy transformation business case for phases two and three,
f. review of aseptic services and submission of an Options Paper,
g. improvements in the use of antibiotics/antifungals through effective antimicrobial stewardship strategies,
h. improvements in Trust performance against the medication questions in the National Inpatient Survey
i. the cross-sector polypharmacy-deprescribing project
j. activities to reduce harm arising from omitting critical medicines

MEDICINES/CONTROLLED DRUGS/SAFETY

Medicines Reconciliation

Medicines reconciliation (MR) figures include adult, children and maternity admissions and are generated from Lorenzo **discharge** data. National Guidance only applies to adult services however the Trust also monitoring medicines reconciliation data for children.

The medicines reconciliation data for December 2019 to March 2020 reflects the impact of introducing a medicines reconciliation service in ED. The improvements in medicines reconciliation figures was deemed pleasing and there was evidence it benefited patients by ensuring they had rapid access to essential medicines

Table of Medicines Reconciliation Data for all inpatients (adults and children) with a length of stay greater than 24 hours showing the impact of introducing weekend / extended ED admission services and of service changes and activity changes during COVID-19

	No. of patients with medicines reconciled within 24hr of admission	%	No. of patients with medicines reconciled	%	No. of patients with Medicines not reconciled	%	Total No. of inpatients with a LOS>24hr
Month	Activity	%	Activity	%	Activity	%	
Apr-19	530	29%	1282	**71%**	515	29%	1747
May-19	433	22%	1247	64%	691	36%	1797
Jun-19	462	25%	1280	68%	592	32%	1938
Jul-19	525	26%	1401	70%	589	30%	1872
Aug-19	513	29%	1280	73%	483	27%	1990
Sep-19	517	29%	1277	71%	523	29%	1763
Oct-19	557	30%	1345	72%	525	28%	1800
Nov-19	741	39%	1513	81%	363	19%	1870
Dec-19	979	51%	1559	81%	375	19%	1876
Jan-20	1075	56%	1611	84%	317	16%	**1934**
Feb-20	1014	56%	1488	82%	328	18%	1928
Mar-20	1045	60%	1511	80%	236	14%	1816
Apr-20	958	79%	1132	94%	74	6%	1206
May-20	1128	84%	1255	93%	90	7%	1345
Jun-20	1252	83%	1420	**95%**	81	5%	1501
Jul-20	1420	84%	1620	**95%**	85	5%	1686
Aug-20	1292	80%	1498	93%	120	7%	1618
Sep-20	1278	78%	1508	92%	132	8%	1640
Oct-20	1296	79%	1522	93%	123	7%	1645
Nov-20	1302	82%	1485	93%	109	7%	1594
Dec-20	1376	**85%**	1531	**95%**	88	5%	1619
Jan-21	1352	**86%**	1502	**95%**	79	5%	1581
Feb-21	1324	82%	1506	94%	101	6%	1607
Mar-21	1430	78%	1678	91%	160	9%	1838

The data from April 20 onwards shows the additional improvement in figures arising as a result of moving out of ED and deploying the staff instead to undertake medicines reconciliation activities across all medical and surgical wards. This resulted in a more equitable service provision that had the added benefit of improving both the medicines reconciliation numbers and percentages within 24 hours and overall and provided wards with an enhanced Pharmacy service that is now relied upon by ward staff. With additional medical still deployed on wards, it has proven difficult to

move the Pharmacy staff back into ED with the knowledge that this will impact upon medicines reconciliation figures and will result in some patients not being seen for several days. Currently the staff are continuing to review admitted patients on wards but will when possible visit ED to review/supply medicines for patients.

Whilst undertaking MRs is a vital patient safety initiative in relation to patients receiving their correct regular medication on admission, medication review is not a process unique to admission. All Pharmacy interventions and clinical advice provided from admission to discharge drive medication/patient safety and timely intervention by Pharmacy staff provides the Trust with greater assurance that medicines will not harm patients during their inpatient stay.

Medication Safety Officer and Medication Incidents

The MSO completes and presents a quarterly report of Medication and Controlled Drug incidents at the Medicines Governance Committee. This report includes a summary of agreed actions/progress.

Topics/areas being monitored include:

1. Safe and secure handling of medicines, in particular controlled drugs
2. Omitted and delayed medicines
3. Critical medicines
4. Medicines frequently occurring in medication related incidents:
    a. Anticoagulants
    b. Diabetic medication
    c. Opiates
    d. Antimicrobials

Partnership for Patient Protection analyses have been used to support the development of medication safety improvement approaches within these areas.

A task and finish group called the Medicines Improvement Group was also established last year to monitor and progress medication safety initiatives.

Pharmacy provides regular communications on medication safety at Safety Huddles and at Medical/Surgical Handover and provision of Safety Alerts where appropriate is an embedded process. Pharmacy has delivered several Topic of the Week sessions to communicate medication safety messages.

Following the reporting of incidents involving medicines in Datix, the Medication Safety Officer or another senior pharmacist attends the 72 hour review, takes part in serious incident investigations and the production of reports/approval/delivery of agreed actions.

Table showing Quarterly Medication Incident Data for 2018 to 2021

		Number of incidents by harm classification					
Year	Quarter	Total	Level 1 (No harm)	Level 2 (Minor harm)	Level 3 (Moderate harm)	Level 4 (Major harm)	Level 5 (Catastrophic)
18/19	Q1	194	174 (90%)	19 (10%)	1 (0.5%)	0	0
18/19	Q2	301	286 (95%)	14 (5%)	1 (0.3%)	0	0
18/19	Q3	268	268 (93%)	18 (7%)	0	0	1* (0.4%)
18/19	Q4	302	283 (94%)	20 (7%)	3 (1.0%)	0	0
19/20	Q1	268	240 (90%)	25 (9%)	3 (1.1%)	0	0
19/20	Q2	323	299 (93%)	24 (7%)	0	0	0
19/20	Q3	319	302 (95%)	17 (5%)	0	0	0
19/20	Q4	276	245 (89%)	30 (11%)	1 (0.4%)	0	0
20/21	Q1	203	186 (92%)	17 (8%)	0	0	0
20/21	Q2	358	336 (94%)	19 (5%)	1 (0.3%)	2 (0.6%)	0
20/21	Q3	278	251 (90%)	27 (10%)	0	0	0
20/21	Q4	268	245 (91%)	23 (9%)	0	0	0

*Patient death not deemed to be associated with the medication issue

Table Showing a Snapshot of Learning from incidents in Quarters 1 and 2 2020/21

We found…..	We acted…..
An inpatient was prescribed and administered the incorrect frequency of phenytoin 30mg/5ml suspension leading to double the intended daily dose for 11 days, causing phenytoin toxicity.	• A Rapid Incident Review was held to identify contributory • factors, learning and actions from the incident. • A Safety Alert to raise awareness of the correct process for prescribing and checking phenytoin safely, with recommendations for prescribers, pharmacists and pharmacy technicians, was taken to the Trust Safety Huddle and Medical Handover and sent across the Trust.
A patient was discharged home with a box of olanzapine tablets which was not on his discharge prescription and was labelled with the name of another patient. He took two of the tablets and became weak and tired which are side effects of olanzapine before the incident was identified.	Learning and actions from the Rapid Incident Review included: • The incident was shared at the Pharmacy Huddle to raise the importance of a complete check of all the medicines in the patient's POD locker when completing medicine reconciliation. • The incident was shared at the Trust Safety Huddle with learning: o To ensure all medicines in the POD locker belong to the current patient. o To ensure after a patient is discharged, the patient's POD locker is cleared of any remaining medication. • The implementation of green bags to transfer patient's medicines in throughout the patient's stay.
An inpatient was prescribed and administered 480mg of gentamicin, when the correct dose should have been 330mg for the patient's age, ideal body weight and renal function. The day after the patient was diagnosed with acute kidney injury (AKI).	A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident. • Learning from the incident was shared at the Trust Safety Huddle and Medical/Surgical Handover. • A gentamicin calculator has now been launched across the Trust to help prescribe the most appropriate dose of gentamicin for the patient and when levels need to be taken.
A patient was treated on ICU for diabetic ketoacidosis (DKA). When they were stepped down from ICU, their insulin was not prescribed on EPMA. The patient had a low threshold to ketosis and developed a further episode of DKA, which delayed their discharge.	• A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident. • Incident shared at ICU safety brief and the importance of prescribing all the patient's medicines on EPMA from the ICU prescription chart and other charts they may have in use (E.g. Diabetes chart, Anticoagulation chart etc.) when patients are stepped down from ICU. • An SOP for patients being stepped down from ICU is being completed. • A concise root cause analysis was completed for the incident to identify further learning and actions.
A patient in pain due to an injury sustained from a fall from a height was given morphine by the paramedics and then repeated doses of morphine in ED went into respiratory arrest	Serious incident review was undertaken and an action plan prepared to improve processes in ED

Medicines Safety Actions:

Education and training related initiatives involving a combination of collaborative working between the MSO, the Clinical Education Pharmacist and activities undertaken by members of the Pharmacy team include:

1. Encouraging use of EPMA intravenous fluid Sequences
2. Walkabouts and regular attendance at medical/surgical handovers for communication of medication matters
3. Presentation at meetings where CBU specific errors/EPMA updates/Critical medicines are discussed
4. FY1 training includes:
   - critical and omitted medicines training
   - Introduction to anticoagulation and discussion of incidents
5. FY2 training includes:
   - Refresh of anticoagulation knowledge and discussion of incidents
6. Resources to support safe practice of rotating medical staff
7. Support with reflection on medication related practice / incidents for the foundation programme
8. Provision of IV training and EPMA training to support redeployment of nursing staff
9. Safer Times newsletters to highlight impact of recent incidents
10. Prescriber Medicines Handbook, Physician Associate Handbook in development
11. Supporting timely completion of VTE risk assessments by providing a daily report for the Safety Briefing and highlighting missing risk assessments to the medical teams.

COVID 19 Vaccination Service

Working closely with the Vaccination Service Managers, Pharmacy has endeavoured to ensure strong Governance within the Vaccination Service with involvement in procurement, cold chain management, control of the supply from Pharmacy into the Clinics including preparation of diluted products as appropriate.

1. Governance considerations for the Vaccination Service:
   - Provision of Clinical Leadership
   - Adherence to the legal framework
   - Staff training completion
   - Procurement and Supply management
   - Consenting processes
   - Safeguarding
   - Safe and secure storage, preparation, administration
   - Infection prevention and control
   - Waste management
   - Record keeping

- Implementation/dissemination of National Protocol and procedural updates
- Provision of expert advice to vaccinators

The Vaccination Service is deemed to be safe and effective and supportive of the Vaccination program within the wider Health Economy (supporting training, Mutual Aid, assisting with the vaccination of high risk individuals.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

1. Continue to improve against Model Hospital parameters
   Areas for improvement and continued effort include:
   a. completion of the EPMA roll out to all wards,
   b. implementation of GP Connect,
   c. implementation of electronic outpatient prescribing,
   d. implementation of EPMA Parts 3 & 4: dose range checking, dose calculator, integration of Lorenzo with the JAC Pharmacy System,
   e. re-submission of the pharmacy transformation business case for phases two and three,
   f. review of aseptic services and submission of an Options Paper,
   g. improvements in the use of antibiotics/antifungals through effective antimicrobial stewardship strategies,
   h. improvements in Trust performance against the medication questions in the National Inpatient Survey
   i. the cross-sector polypharmacy-deprescribing project
   j. activities to reduce harm arising from omitting critical medicines

2. Continue to monitor medication safety and implement safety measures where needed including actions arising from 72 hour reviews/serious incident reviews
3. Continue the work of the Medicines Improvement Group and implement the action plan

4. IMPACT ON QPS?

Provide assurance in relation to actions to maintain/improve medicines safety

5. MEASUREMENTS/EVALUATIONS

- Medicines Information KPIs
- Transaction data providing evidence of the actions taken to maintain safe supply of medicines during the COVID-19 pandemic
- Medicines reconciliation data providing evidence of the impact of changes made to delivery of ward pharmacy during the COVID-19 pandemic
- Medication incident data showing patterns of incident reporting and level of harm to no harm incidents from 2018 to 2021 and learning from incidents

6. TRAJECTORIES/OBJECTIVES AGREED

a) Work with IT on the EPMA and IT developments in accordance with the work program (2021/22 program)
b) Prepare the Pharmacy Transformation Phase 2 and 3 business case (31st July, 2021)
c) Prepare the Aseptic Services Options Paper (31st August, 2021)
d) Antimicrobial Stewardship Strategy and Workstream development with Microbiology 30th September, 2021
e) Deliver the Medicines Improvement Group Actions as part of the Moving to Outstanding agenda including reducing harm from omitting critical medicines
f) Support the deliver the cross-sector polypharmacy de-prescribing work plan in accordance with the Working Group timescales

7. MONITORING/REPORTING ROUTES

Medicines Governance Committee
Patient Safety and Clinical Effectiveness Committee
Controlled Drug Local Intelligence Network
Moving to Outstanding Meetings

8. TIMELINES

See objectives and trajectory above

9. ASSURANCE COMMITTEE

Patient Safety and Clinical Effectiveness Committee

10. RECOMMENDATIONS

Note the contents of the Report and approve the actions.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/110**	
SUBJECT:	**Risk Management Annual Report**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	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.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1207** Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component. **#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	

	#1274 Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has in place a planned and systematic approach to the identification, evaluation and control of risks. This process has remained the same during the past 12 months throughout the pandemic, with risk assessments and risk registers being developed and maintained accordingly, to ensure staff can work in a safe environment and patients can be cared for in a safe environment. The annual report describes the management of risk throughout the Trust over the last 12 months.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	**To note**	Decision
RECOMMENDATION:	The Board of Directors is asked to review and note the findings within the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/21/05/144**		
	Date of meeting	4th May 2021		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Risk Management Annual Report 2020/21	AGENDA REF:	BM/21/07/110

1. BACKGROUND/CONTEXT

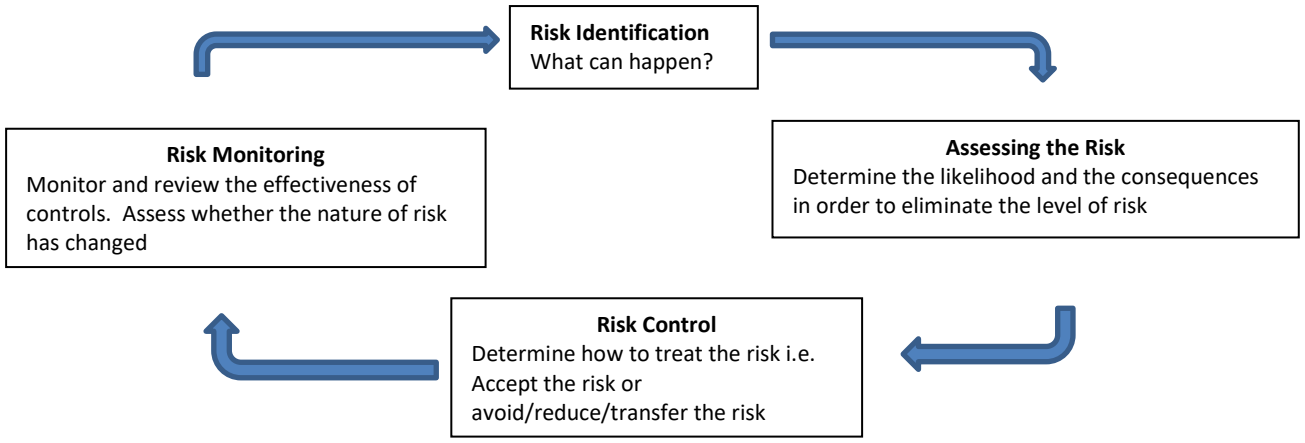
The annual report describes the management of risk throughout the Trust over the last 12 months.

New challenges have arisen within the past 12 months with the COVID19 global pandemic. Throughout the pandemic the risk management process has remained the same with risk assessments and risk registers being developed accordingly, to ensure staff can work in a safe environment and patients can be cared for in a safe environment. The monthly risk review group chaired by the Chief Nurse has continued.

2. KEY ELEMENTS

2. Risk Management Process

There is a clear risk management process embedded across the Trust. The process involves identifying possible risks or problems before they happen. This allows for the development of procedures and process to avoid the risk, minimise its impact, or at the very least help cope with its impact.



2.1 Assurance

The risk management process has been successfully embedded across the Trust which was identified in the 2019 CQC inspection report as “Good”.
Various levels of risk registers have been developed and are actively managed and reviewed by identified Leads and Clinical Business Units. There is also a monthly Risk Review Group chaired by the Chief Nurse. This has continued throughout the pandemic. Corporate and Strategic risks are updated monthly via the Patient Safety and Clinical Effectiveness Subcommittee and bimonthly via the Quality Assurance Committee.

2.2 Risk Management Strategy

The aim of the Risk Management Strategy is to ensure the Trust has effective processes to support better decision making through good understanding of risk and their likely impact with appropriate oversight, escalation and de-escalation.

2.2.1 Assurance

Through the risk management process, the Trust can identify significant risks and ensure appropriate oversight, escalation and de-escalation to enable the achievement of the organisation’s strategic and operational objectives. The potential consequence and impact of risk is evaluated ensuring all appropriate controls are in place.

A full review of the Strategy will take place in May 2021 which will outline the Trust risk objectives for the next two years (May 2021/May 2023). The revised strategy will provide an understanding of risk appetite and tolerances, outline training arrangements and set out the aims to continuously improve the risk management arrangements throughout the Trust.

2.3 Risk Management Training Needs Analysis

The requirement for risk management training within the Trust is outlined below. The table covers the training needs for all levels of staff throughout the organisation.

Topic	Training Requirements
Risk Management for Senior Managers	One off training programme
Risk Management for Managers	One off training programme
Risk Assessment Training	For all staff who are required to complete risk assessments as part of their role
DATIX Training	On request

2.3.1 Assurance

The training is mandatory to ensure all levels of staff have an understanding of the various aspects of risk management relating to their role.

A new programme of Risk Assessment training will be implemented throughout 2021/2022 by the Head of Health and Safety.

2.4 Risk Registers

Board Assurance Framework The Board Assurance Framework (BAF) has developed over the past two years and is now fully embedded within the Trust. This assurance framework records the principal risks that could impact on the Trust achieving its strategic objectives. The key information reported to the Board includes: • Identifying controls in place to manager strategic objectives • Provide assurance about the effectiveness of the controls in place • Identify those objectives at risk because there are gaps in the assurance.
Corporate Risk Register The Corporate has been developed over the past 18 months and is now fully embedded within the Trust. The risk register comprises of all risks which may potentially prevent the Trust from carrying out daily operations. The Corporate Risk Register now effectively links with the BAF. Risks from the Corporate Risk Register are escalated/de-escalated to and from the BAF as appropriate.
Clinical Business Unit (CBU) and Corporate Services Risk Registers All CBU''s and Corporate Services have fully developed risk registers in place. There is a consistent and standardised approach to the reporting and managing of risk registers.
Local Risk Registers Local risk registers are in place and are managed at Ward level. There is an escalation process in place should the risks need to be added to the CBU risk register for more stringent review.
Additional Risk Registers Throughout the global pandemic over the past 12 months, the Trust has developed a COVID19 Risk Register to ensure all risks related to the virus are recorded. This risk register is sighted at appropriate Sub-Committees and the Quality Assurance Committee.

2.4.1 Assurance

The Trust is able to track Trust Wide risks to assure both operational and strategic objectives are being met.
The Trust can be assured that risks are being mitigated and/or escalated when required.
The Trust has full sight of all levels of risk which are monitored and reviewed from CBU level up to Board.
There is a clear escalation and de-escalation process in place to ensure risks are sited on the most appropriate risk register. Any risks escalated or de-escalated from the BAF or Corporate Risk Register is done so via the recommendation of the appropriate Committee meeting.

2.5 Risk Review Group

The Risk Review Group was established in 2017 to oversee the recording and monitoring of risk registers within the Trust, reporting to the Quality Assurance Committee.
Monthly meetings take place to review the effectiveness of controls in place, following actions being taken. All Clinical Business Units (CBU's) attend the meeting on a 12-month rolling programme with each of them expected to attend at least 3 times. Corporate Services will attend at least each quarter.
Risks of 9 and above are scrutinised by the Group to ensure there is assurance that each risk is being effectively managed.
Both the Strategic Risk Register and Corporate Risk Register reports are presented at each meeting and the group will make recommendations to the Quality Assurance Committee to the amendment of risks on both the Strategic and Corporate Risk Registers.

2.6 Risk Register Annual Position Statement

	No. of Risks	No. of Risks 15 +	No. of Risks 12	No. of Risks of 9 and 10	No. of Local Level Risks
Surgical Specialities	20	1	4	6	9
Urgent and Emergency Care	13	1	9	1	2
Digestive Diseases	19	0	2	4	13
Medical Care	19	3	2	6	8
Women's and Children's	21	5	4	8	4
Clinical Support Services (including Pharmacy)	22	1	7	4	10
Integrated Medicine and Community	9	1	1	4	3
Human Resources	11	4	2	1	4
Estates and Facilities	46	3	4	11	28
Finance, Procurement & Commercial Development	13	2	4	1	6
Digital Services	11	1	5	4	1

2.7 Corporate Risk Register

The Corporate Risk Register comprises of all risks which may potentially prevent the Trust from carrying out daily operations. This links into the Strategic Risk Register which is managed by the Trust Secretary. Risks on the Corporate Risk Register may be escalated or de-escalated to or from the Strategic Risk Register as appropriate.

Currently there are 22 risks on the Corporate Risk Register.

A Corporate Risk Register Report is presented at the Risk Review Group on a monthly basis. The report makes the necessary proposals to amend/close any risks on the Corporate Risk Register. This includes proposals for change of risk rating, amendment of risk title, escalate to the Strategic Risk Register or closing of any risks etc.

Overview of changes to the Corporate Risk Register from April 2020 to March 2021

Activity	Number of Risks
Risks added to the Corporate Risk Register	14
Risks closed from the Corporate Risk Register	17
Risk escalated from the Corporate Risk Register to the Strategic Risk Register	2
Risks de-escalated from the Strategic Risk Register to the Corporate Risk Register	7
Changes to Risk Descriptions	1
Changes to Risk Ratings	4

2.8 Board Assurance Framework.

The Board Assurance Framework (BAF) records the principal risks that could impact on the Trust achieving its strategic objectives.
In February 2021, the BAF was audited by MIAA. The overall objective was to assess the approach to which the Trust maintains and uses the BAF to support the overall assessment of governance, risk management and internal control.

2.8.1 Assurance

- The objectives within the BAF align with those in the strategic plan.
- The organisation's BAF includes reference to the movement of risks/ risk profile.
- The BAF was regularly presented to the Board and Board minutes clearly demonstrate discussion and updates of the BAF.
- The BAF was visible on the Board agenda.
- Risks identified by the Board were reflected on the BAF.
- Assurances were clearly identified and mitigating actions were in place.
- The BAF was regularly presented to committees and the minutes of these committees clearly demonstrate the use of the BAF.

2.9 Management of Risk throughout the Pandemic

The process for managing risk has remained the same throughout the pandemic.

2.9.1 Assurance

- Risk assessments and risk registers have continued to be developed accordingly to optimise both staff and patient safety. The Risk review Group whilst intermittently has been stood down due to operational pressures work undertaken by the Clinical Business Units has continued with the support of the Head of Health and Safety.
- A COVID19 Risk Register was established at the start of the pandemic to ensure these risks could be managed and monitored effectively.
- The Covid-19 risk register, Corporate risk register and Board Assurance Framework have been continually updated and reported via the Quality Assurance Committee which has continued to function throughout the pandemic. This meeting was initially bi-monthly but for increased oversight has taken place monthly during the pandemic. This information is also presented at the Patient Safety and Clinical Effectiveness Sub-Committee which has run intermittently during the pandemic. Risk is also discussed as required during the tactical, recovery meetings with escalation to the Strategic Oversight Group in accordance with the Trust Decision Making Framework.
- During the pandemic a log of service change and recovery proformas was initiated. This was to ensure clear oversight of the decisions made by all necessary parties, avoiding decisions being made in isolation, thus reducing risk. This log is held by the Clinical Governance team. A standard Operating Procedure is in place.
- There have been a variety of risk assessments undertaken by WHH and this continues, to optimise safety for all. This includes assessment of clinical risk, service risk, environmental risk, equipment risk and risk to social distancing amongst others. These are held centrally by the Health and Safety Team and are supported by an environmental plan which is reported through the daily tactical meeting and Patient Safety and Clinical Effectiveness Sub- Committee. Standard Operating Procedures are also in place.

3. MEASUREMENTS/EVALUATIONS

The Trust has maintained the risk management process throughout the pandemic ensuring there is still appropriate scrutiny and assurance for the management of risk.

The Risk Management Strategy will be reviewed and updated by August 2021 to outline the Trust risk objectives for the next two years (August 2021/August 2023). The revised strategy will provide an understanding of risk appetite and tolerances, outline training arrangements and set out the aims to continuously improve the risk management arrangements throughout the Trust.

4. MONITORING/REPORTING ROUTES

All risks are monitored on a 12 month rolling programme via the Risk Review Group. The terms of reference are updated annually.
The Risk Review Group has continued to meet throughout the pandemic and when necessary risk were discussed at the Tactical Group meeting.

5. RECOMMENDATIONS

The Board of Directors is asked to note the information within the annual report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/111**	
SUBJECT:	**Emergency Preparedness Resilience and Response (EPRR) Annual Report 20/21**	
DATE OF MEETING:	28 July 2021	
AUTHOR(S):	Rachel Clint, Acting EPRR Manager (2020-2021)	
EXECUTIVE DIRECTOR SPONSOR:	Dan Moore, Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. #224 Failure to meet the emergency access standard. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets #1290 Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices, technology products and services, clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report will:- • Provide an overview of the emergency preparedness arrangements within Warrington and Halton Hospitals NHS Foundation Trust. • Outline the work that has been undertaken in the area during the past 12 months. • Describe the trust response to incidents which have occurred during 2020-21.	

	• Describe the response to COVID-19 and highlight the associated work to be prioritised in 2021-22. • Summarise the planned work streams and priorities for the year ahead.			
PURPOSE: ***(please select as appropriate)***	Information √	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the work and achievements undertaken during 2020-21 and the planned work programme for 2021-22 in support of the Trust's objectives.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2020/21	AGENDA REF:	BM/21/07/111

1. BACKGROUND/CONTEXT

All NHS organisations are required to deliver their legal duties and responsibilities for Emergency Preparedness, Resilience and Response (EPRR) set out in The Civil Contingencies Act 2004. As a Category 1 responder under the Act, the trust has a duty to develop robust plans to prepare and respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of our services in the event of a disruption.

Like most NHS organisations WHH has had our resilience tested on several occasions over the last year, most notably in the form of the COVID-19 pandemic, notwithstanding other pressures including outbreaks of infection, IT and telecommunication failures and demand management pressures. The trust plans and procedures and the commitment of trust staff have enabled us to manage such incidents in a professional manner which has helped to minimise disruption to patient care.

2. KEY ELEMENTS

Purpose

The purpose of the annual report is to:-

- Provide an overview of the emergency preparedness arrangements within Warrington and Halton Hospitals NHS Foundation Trust.
- Outline the work that has been undertaken in the area during the past 12 months.
- Describe the trust response to incidents which have occurred during 2020-21.
- Summarise the planned work streams and priorities for the year ahead.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Emergency Preparedness Structure

The Trust has a Major Incident Plan in place which is built on the principles of risk assessment, multi-agency co-operation, emergency planning, sharing information and communicating with public. This plan is underpinned by a number of associated business continuity plans which outline how our critical services will continue to be provided in the event of a disruptive incident.

Lead Officers

- Dan Moore- Chief Operating Officer is the designated Lead Executive Director with responsibility for Emergency Planning within the Trust.

- Terry Atherton is the Non-Executive Director nominated to support the Chief Operating Officer in this role.
- The Lead Director is currently supported by Rachel Clint, Acting EPRR Manager.

Committee Structure

In order to discharge our responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the trust's Committee structure.

The Event Planning Group (EPG), chaired by the Chief Operating Officer, is charged with the responsibility of overseeing the development of emergency preparedness arrangements within the Trust. The group meets on a monthly basis and its membership includes senior managers from all Clinical Business Units, clinical representation and corporate services. Because of the pressures associated with COVID-19 in 2020-21, the EPG group has met less frequently, however Tactical Board has been utilised as the appropriate group to oversee any updates to trust policies or national guidance.

In addition to Emergency Preparedness matters the role of the EPG is to anticipate and plan for forthcoming events which are likely to prevent a challenge to our services and resources and to develop co-ordinated plans in advance. Minutes of the Group's meetings are produced, and high-level briefing reports are provided to the Tactical Board.

The monthly Event Planning Group was paused between October 2020 and February 2021 following the increased pressures relating to COVID-19, with Tactical Board acting as the management board throughout the duration of the Level 4 and subsequently Level 3 incident.

Appendix 1a, 1b and 1c demonstrate the Tactical and Recovery structure through phases 1, 2 and 3 of the response to the pandemic.

EPRR External Structure:

NHS England Area Team has lead responsibility for co-ordinating a local health response to an emergency. A Cheshire, Halton and Warrington Local Health Resilience Partnerships (LHRP) exist to deliver National EPRR strategy in the context of local risks. The LHRP brings together the health sector organisations involved in emergency preparedness and strengthen cross-agency working. The quarterly Strategic LHRP meetings are attended by The Chief Operating Officer or Deputy. The Trust Resilience Manager attends the Practitioner and task group meetings.

4. IMPACT ON QPS?

Training

The Trust has an ongoing programme of exercises and training events to test and validate emergency plans. Details of all of the training events are reported in Appendix 3.

Assurance Process

The Trust is required to undertake an annual self-assessment against the 65 NHS England Core Standards for EPRR. The full assurance exercise was last undertaken in August 2019. Because of the role of the EPRR function in the pandemic, in September the 2020 annual self-assessment provided by NHSE instead included a review of the management of COVID-19 and preparation for winter pressures. The Trust self-assessment was submitted as 'substantial compliance' with three areas being rated as 'partially compliant'; Data Protection and Security Toolkit, Mass Casualty and Patient Identification and Decontamination Capability available 24/7. Measures to progress against these standards have been picked up through Event Planning Group. Formal outcomes of the 2019/2020 compliance are shared prior to the 2020-2021 process.

It is not clear whether the annual self-assessment will take place in its previous format in 2021, the trust awaits further instruction from NHSE and internal plans are in place to support the achievement of full compliance.

5. MEASUREMENTS/EVALUATIONS

Incidents & Exercises

During 2020-21 the following significant incidents and exercises are of note:

14th August 2020 - COVID-19: Debrief

Operational, clinical, nursing and corporate staff attended a debrief to capture the learning experienced during the first wave of the COVID-19 pandemic. This was an opportunity for staff to share their learning, comment on best practice and evaluate the decision making between January and July.

14th August 2020 – COVID:19: Desktop activity

This was a desktop exercise with scenarios presented to consider the required steps in planning for a potential second wave of COVID-19. This exercise also took winter planning into account and the challenges associated with capacity and demand alongside COVID-19.

11th September 2020 – Cheshire and Merseyside System Resilience Planning Workshop

This was a whole system exercise to plan for resilience ahead of predicted winter pressures alongside COVID-19.

30th June – present- COVID-19: Phases 2 and 3 of the pandemic

Phase 2 of the response was followed by the Recovery period (Phase 3) after the first national wave of COVID-19. The responses were managed through Tactical Board (June2020-July 2020 and September 2020- present) and Recovery Board between May and September 2020. When community prevalence and admissions started to increase in the late summer, Tactical Board was stepped up and the command and control function escalated with the need for surge planning and a revision of the management of COVID-19 in collaboration with clinical, nursing and operational teams.

The trust experienced a second and third wave of COVID-19, with increased admissions and escalation occurring from September – December 2020 and December 2020 – February 2021. During these months the trust responded to the Level 3 and Level 4 incident escalation by sustaining the Control Room function; acting as the single point of contact (SPOC), providing sitreps as per the requirement and actioning national guidance in accordance to NHSE and NHSI directives.

Unplanned Lorenzo downtime

The Trust has been affected by three notable Lorenzo downtime incidents. No patient harm was identified in any of these incidents and the debrief from the first experience on 1st September 2020 provided the opportunity to capture lessons learned and embed best practice. Subsequent incidents of unplanned downtime have been managed effectively with business continuity plans enacted at the earliest opportunities and the incidents were managed without fault.

31st December 2020 – End of the EU transition period

The Trust Board was kept regularly updated 2020/21 of the preparation for a no deal EU Exit. An EU Exit Team was re-established led by the Chief Finance Officer and EPRR Manager, with participation from subject matter experts for all critical areas including Procurement, Pharmacy, Workforce, Overseas Visitors, Communications and IT. The EU Exit operational response included:-

- Monthly/ bi-weekly Brexit Group meetings in the lead up to the end of the EU transition period and the months following.
- Overseas chargeable patients process developed for the management of chargeable patients. Details shared with operational teams, finance and through external communications.
- Assurance exercises to ensure critical medical supplies, PPE and consumables were not impacted upon by potential border issues.
- The Procurement department continue to monitor the impact of price changes as a consequence of the end of the transition period.
- Communication of EU Settlement process.
- Assurance work around data flows within and beyond the EU.
- Front line communication to Trust staff.

- Monitoring national guidance using an EU Exit operational readiness tracker and monitoring of actions in Brexit Group meetings.
- Service level business continuity plans in place across all CBUs.
- One single point of contact for escalating any potential EU exit issues in line with COVID incident management and winter planning– whh.controlroom@nhs.net
- Completion of daily SitRep reporting to NHSE.

Appendix 2 gives a summary of the training and events occurring in 2020/21.

6. TRAJECTORIES/OBJECTIVES AGREED

Work undertaken in 2020/21

The following work streams were completed during 2020-2021:

- The Major Incident Plan, Trust Escalation Plan, Full Capacity Plan, Pandemic Influenza Plan and Severe Weather Plans (including Cold Weather Plans and Heatwave Plans) were all reviewed and updated to reflect local and national developments. All were approved by the Event Planning Group and subsequently through Tactical Board.
- COVID-19 Ward escalation plans, ED escalation plans and Critical Care escalation plans.
- In accordance with the national framework, preparation for a no deal European Union exit was managed via the EPRR lead within the Trust. Work was undertaken which involved stepping up a Brexit Working Group, completing actions given by the DHSC on the EU Exit Readiness Guidance and Supplies Self-Assessment tools. The Board was regularly updated of the Trusts preparedness and situation reports were also submitted to DHSC daily between December 2020 and June 2021.
- The Trust participated and contributed fully in all Local Health Resilience Partnership meetings and work streams.
- System winter planning in collaboration with system partners.
- Close liaison has been maintained with partner agencies in planning for local mass gathering events i.e. Creamfields festival.
- Robust planning for holiday periods and school holidays.
- Coordination of national guidance, reporting changes and acting as the single point of contact for the COVID-19 response, operational guidance and wider national/regional guidelines.

Work programme for 2021/22

In 2020-21 the focus has primarily been on supporting the trust response to the COVID-19 pandemic. This has included phases of command and control tactical management, surge management and recovery.

NHS Operational Planning Guidance for 2021/22 includes the requirement for a maintained Control Room and SPOC function. This remains in place and is managed by the EPRR Manager.

For 2021-22 the focus will include reviewing all EPRR Plans in line with the Core Assurance Framework and testing a number of these plans. EPRR in an ongoing cycle of planning, training, testing and improving. Although debrief activities have been carried out, it is prudent to continue to capture the learning through response and recovery. Part of this will also incorporate preparation for a potential fourth wave or impacts of variants of concern. This will include collaboration with key stakeholders involved in the responses, raising staff awareness, testing plans and identifying any areas for improvement.

In support of and in addition to the above, the following work plans will be undertaken:

- Deliver training to key staff in Emergency Preparedness and Incident Management.
- Update and test the Trust Evacuation plan. There is a requirement to test this plan
- Procure a sustainable decontamination shelter.
- Develop specific plans for COVID-19 surges anticipating the potential demand pressures in the health care system.
- Develop specific plans for managing winter pressures.
- Review the Trust On-Call documentation for Senior Managers and Executives.
- Continue as a full and active member of the Local Health Resilience Planning Group.
- Update plans and procedures in line with any new National guidance.
- EPRR education of CBUs and workforce to support the embedding of lessons learned during the experiences of the pandemic.
- Monitor the lessons learned from other local, regional and national incidents.
- Support the trust response to the Public Inquiry into COVID-19 as appropriate.

7. MONITORING/REPORTING ROUTES

The NHS England led LHRP meets bi- monthly externally and is attended by the Trust Emergency Planning Lead; the outcomes are fed into the Trusts Event planning meeting / Tactical group meeting.

The 2021 NHS EPRR Core Standards Audit is yet to be confirmed by NHSE.

Reviewing and implementation of the latest NHSE and PHE guidance occurs through Tactical meetings. The Tactical Board function remains in place to oversee the management of incidents and escalation planning. Appropriate items are escalated to the Strategic Executive Oversight Group (SEOG).

8. TIMELINES

This report is presented annually to the board.

9. ASSURANCE COMMITTEE

The EPRR Manager escalates issues to the Tactical Board. The Event Planning Group continues to escalate changes through Tactical Board and SEOG.

10. RECOMMENDATIONS

The Board is asked to note the significant work and achievements undertaken during 2020-21 and the planned work programme for 2021-22 in support of the Trust's objectives.

Appendix 1-

1a Coronavirus Management Structure

Appendix 1
COVID-19 Managem

1b Recovery Structure

Appendix 2
COVID-19 and Reco

1c Phase 3 response

COVID-19 Tactical
Structure phase 3.p

Appendix 2 – Training and events in 2020-2021

Event	Organiser	Date	Staff Involved		Purpose
COVID-19 debrief	**EPRR Manager**	**3/8/22020**	Alex Crowe	Medical Director	To highlight the potential scale and range of impacts arising during a second wave of COVID-19. To identify the likely type and range of decisions that would need to be made by senior leaders at key points during a second wave of a novel coronavirus outbreak.
			Ali Kennah	Deputy Chief Nurse	
			Alison Aspinall	Communications Manager	
			Alison Coackley	Consultant in Palliative Medicine / Director of Medical Education	
			Alison Parker	Associate Director of Procurement	
			Chris Evans	Chief Operating Officer	

			Daniel Moore — Director of Operations and Performance Debs Smith — Deputy Director of HR and OD Diane Matthew — Head of Pharmacy Gina Coldrick — Communications and Engagement Specialist Guy Hanson — CBU Manager Hilary Stennings — Associate Director of Clinical Support Services Janet Purcell — Consultant Microbiologist Joanne Oldfield — Infection Control Nurse Katherine Summers — Infection Control Nurse Krissy Sta Maria — Infection Control Nurse Lesley McKay — Associate Director of Infection Control Mark Rigby — Head of Theatres Michelle Cloney — Chief People Officer Mithun Murthy — Respiratory Consultant Natalie Crosby — Associate Chief Nurse Rachel Clint — EPRR Manager (facilitator and note taker) Sheila Fields Delaney — CBU Manager UEC Toong Chin — Consultant Microbiologist Yvonne Mahambrey — Patient Safety Nurse Zaman Qazzafi — Consultant Microbiologist	To explore the interdependencies of mutual aid support from LRF partners, in order to identify potential areas for further development. To identify options for the cohorting of large numbers of confirmed cases. To expose the need for continued response arrangements and decision making out of hours, including weekends. To identify the increased demand on oxygen therapy delivery, clinical consumables and medical devices and associated procurement arrangements. To explore business continuity arrangements in relation to depleted staffing numbers as a direct result of the pandemic.
COVID-19 second wave planning desktop exercise	**EPRR Manager**	**3/8/2020**	Alex Crowe — Medical Director Ali Kennah — Deputy Chief Nurse Alison Aspinall — Communications Manager Alison Coackley — Consultant in Palliative Medicine / Director of Medical Education Alison Parker — Associate Director of Procurement Chris Evans — Chief Operating Officer Daniel Moore — Director of Operations and Performance Debs Smith — Deputy Director of HR and OD Diane Matthew — Head of Pharmacy Gina Coldrick — Communications and Engagement Specialist	A desktop / discussion-based exercise on preparation for the response to a second wave of COVID-19

			Guy Hanson – CBU Manager Hilary Stennings – Associate Director of Clinical Support Services Janet Purcell – Consultant Microbiologist Joanne Oldfield – Infection Control Nurse Katherine Summers – Infection Control Nurse Krissy Sta Maria – Infection Control Nurse Lesley McKay – Associate Director of Infection Control Mark Rigby – Head of Theatres Michelle Cloney – Chief People Officer Mithun Murthy – Respiratory Consultant Natalie Crosby – Associate Chief Nurse Rachel Clint – EPRR Manager (facilitator and note taker) Sheila Fields Delaney – CBU Manager UEC Toong Chin – Consultant Microbiologist Yvonne Mahambrey – Patient Safety Nurse Zaman Qazzafi – Consultant Microbiologist	
Cheshire and Merseyside System Resilience Planning Workshop: resilience planning for winter	**LHRP**	**11/09/2020**	Alex Crowe – Medical Director Ali Kennah – Deputy Chief Nurse Allen Hornby – Lead Nurse – Medical Care Daniel Moore – Director of Operations and Performance Debs Smith – Deputy Director of HR and OD Diane Matthew – Head of Pharmacy Guy Hanson – CBU Manager Hilary Stennings – Associate Director of Clinical Support Services Lesley McKay – Associate Director of Infection Control Mithun Murthy – Respiratory Consultant Natalie Crosby – Associate Chief Nurse Rachel Clint – EPRR Manager (facilitator and note taker) Sharon Kilkenny – Associate Director of Unplanned Care Sheila Fields Delaney – CBU Manager UEC Zaman Qazzafi – Consultant Microbiologist	Preparing for the delivery of health services over the winter months and systemwide resilience planning.

Lorenzo unplanned downtime - Debrief	**EPRR Manager**	**01/09/2020** **11/09/2020** **29/096/2020**	Ali Kennah – Deputy Chief Nurse Dan Moore – Director of Operations and Performance Diane Matthew – Chief Pharmacist Emma O'Brien – EPR Manager Matthew Gardner – Deputy Chief Information Officer Rachel Clint – EPRR Manager Roy Bhati – Consultant Sharon Kilkenny – Associate Director of Unplanned Care	Debrief and lessons learned following Lorenzo downtime lasting 7 hours on the day of 1st September 2020. (National Lorenzo incident which affected WHH, along with other Trusts who use the platform. Issues with Lorenzo were noted at approximately 10am, when it was reported that Lorenzo was running slow and freezing, before becoming inaccessible to many. This presented issues on the wards and in the Emergency Department and created some significant challenges to pharmacy).
Lorenzo unplanned downtime - Debrief	**EPRR Manager**	**15/01/2021**	Ali Kennah – Deputy Chief Nurse – Patient Safety Diane Matthew – Chief Pharmacist Phill James – Chief Information Officer Rachel Clint – EPRR Manager Roy Bhati – Consultant Sharon Kilkenny – Associate Director of Unplanned Care and Halton	Debrief and lessons learned following Lorenzo downtime lasting 6 hours through the night of 14th January 2021. (Access to the Lorenzo digital platform failed between approximately 11pm and 5am. This meant that staff were unable to access the platform and carry out business as usual).

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/112**	
SUBJECT:	**Guardian of Safe Working for Junior Doctors** **Combined report for Q4 2020-21**	
DATE OF MEETING:	28 July 2021	
AUTHOR(S):	Mark Tighe, Guardian of Safe Working	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	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.	 X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#224** Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The 2016 Junior Doctor Contract is fully established at WHH for all our Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of Exception Reporting via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 4 2020-21, 51 Exception Reports (ERs) were submitted – this represents a 50% rise since Q3, and approaches the average numbers seen pre-COVID. Over 90% of ERs relate to excess hours worked.	

	Four ERs were submitted as a result of missed educational opportunities. One Immediate Safety Concern was reported by a medical F1 due to a perceived lack of cover whilst on-call. Since the last report, it can be confirmed that rotas remain compliant, and the majority of Junior Doctors are happy with their allocations.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	The Board are requested to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients. Any concerns that the Board have should be reported back to the Guardian of Safe Working for his attention, consideration and actions accordingly.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.			
	Date of meeting	June 2021		
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***				

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Guardian of Safe Working for Junior Doctors Combined report for Q4 2020-21**	**AGENDA REF:**	**BM/21/02/112**

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most medical trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues and the Guardian of Safe Working (GSW).

The GSW attends the Regional Guardian Forum to ensure the Trust is performing in-line with its peers.

It is important to remember that most of the Junior Doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relate to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. KEY ELEMENTS

During Quarter 4 2020-21, 51 Exception Reports were submitted, which represents an average number for a 3-month period over winter. A reduction in ERs was noted during the acute pressures of Covid but have now returned back to pre-Covid numbers.

The majority of the ERs still relate to Foundation Doctors working past their allocated time (90%), usually on an ad-hoc basis. There were more in surgical specialties (60%) than medicine, probably due to the fluctuating nature of the workload. Four ERs related to missed educational opportunities, which is an increase on Q3, and will need to be monitored. There was one immediate safety concern, (ISC) submitted in this quarter, but the doctor has not reported any subsequent issues.

Assurance can be provided that all Foundation Programme Doctors employed during this period were well on track to progress through their current year of training.

Historically, there have been significant delays in the review meetings between the ES and Junior Doctor, once an ER has been submitted. At the end of Q3, there were 47 ERs outstanding (down from 56 at the end of Q2). However, as a result of excellent input from the Medical Clerical Officer supporting this process, the numbers are now the lowest on record – only 5 ERs are outstanding at time of writing. Junior Doctors are now receiving an email reminder to have their ER signed off within 2 weeks, if they want to receive compensatory payment or time off in lieu (TOIL). Any difficulties with the sign-off process are be escalated to the Medical Education Service and / or the Guardian of Safe Working.

Exception Reporting – Q4

Quarter	Reporting Period	Deadline for Data Provided by the Host
Q4 Report	**1st January 2021**	**31st March 2021**

Exception Reports (ER) over past quarter	
Reference period of report	01/01/21 - 01/04/21
Total number of exception reports received	51
Number relating to immediate patient safety issues	1
Number relating to hours of working	46
Number relating to pattern of work	1
Number relating to educational opportunities	4
Number relating to service support available to the doctor	0

***Note** : Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*

Summary

- number of exception reports raised = 51
- number of work schedule reviews that have taken place = 0
- immediate safety concerns = 1
- fines that were levied by the Guardian = NIL
- The majority of ERs have been submitted by FY1 doctors (80%) reflecting the busy workload of medical trainees on the wards. Higher numbers have been reported from Surgery Specialties than Medicine (60:40). Although the general workload in medicine is undoubtedly higher, our juniors encounter variable work patterns in the surgical specialties.

Over 90% of ERs relate to excess hours worked. Trainees comment that they stay late to complete ward duties or for review and management of sick inpatients, which they feel they cannot handover to the on-call teams. This is entirely understandable and predictable, although routine duties should not need to be done out of hours generally.

4 ERs was submitted as missed educational opportunities

An Immediate Safety Concern (ISC) was reported from a medical F1. The junior reported understaffing due to gaps on the on-call rota on an evening shift. He has not discussed further with his ES, nor responded to email requests from the Guardian for clarification.

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	36
Total number of overtime payments	7
Total number of work schedule reviews	2
Total number of reports resulting in no action	11
Total number of organisation changes	0
Compensation	0
Unresolved	10
Total number of resolutions	**56**
Total resolved exceptions	**56**

***Note** :*
** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*

** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*

** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

Reasons for ER over last quarter by specialty & grade

ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate patient safety	Gastroenterology	FY1	0	1	1	0
	Urology	FY1	1	0	0	0
Total			**1**	**1**	**1**	**0**
No. relating to hours/pattern	Acute Medicine	FY1	7	13	17	2
	Acute Medicine	FY1 *	2	0	0	0
	Cardiology	FY1	0	2	2	0
	Diabetes & endocrinology	FY1	0	1	0	1
	Gastroenterology	Foundation house officer 1	2	0	0	0
	Gastroenterology	FY1	0	7	7	0
	Gastroenterology	FY2	1	0	0	0
	General surgery	Foundation house officer 1	11	0	0	0
	General surgery	FY1	5	10	12	0
	General surgery	FY1 *	5	0	0	0
	General surgery	FY2	3	3	5	0
	Geriatric medicine	CT1	0	1	1	0
	Geriatric medicine	FY1	1	3	2	3
	Ophthalmology	ST3	0	1	1	0
	Otolaryngology (ENT)	FY2	0	6	4	2
	Psychiatry	FY1	1	0	1	0
	Trauma & Orthopaedic Surgery	Foundation house officer 1	1	0	1	0
	Trauma & Orthopaedic Surgery	FY2 *	3	0	0	0
	Urology	Foundation house officer 1	1	0	0	0
	Urology	FY1	2	0	0	0
Total			**45**	**47**	**53**	**8**
No. relating to educational opportunities	Acute Medicine	FY1	0	2	1	1
	Anaesthetics	CT2	1	0	1	0
	Diabetes & endocrinology	FY1	0	1	0	1
	Gastroenterology	CT1	1	0	0	0
	General surgery	Foundation house officer 1	1	0	0	0
	Otolaryngology (ENT)	FY2	0	1	1	0
	Trauma & Orthopaedic Surgery	FY2 *	1	0	0	0
	Urology	FY1	1	0	0	0
Total			**5**	**4**	**3**	**2**
No. relating to	Urology	FY1	1	0	0	0
Total			**1**	**0**	**0**	**0**

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The rotas at WHH are all compliant – the ophthalmology middle grade on-call rota was recently adjusted to account for increased weekend workload.

Longstanding issues with the delay in sign-off of Exception Reports has improved dramatically in Q4, and we hope to see this continue.

The issue of Foundation Year 1 Doctors having adequate time off for mandatory training has been addressed and as with compliance rates for completion, this too has been evidenced in the ER's submitted. The Medical Trainees' Workforce Administrator has formulated a Standard Operating Procedure for completion of mandatory training, which has been disseminated to junior doctor representatives and CBU Rota Managers for comment.

No further issues have been raised related to break times in AED (previously a fine was issued in 2019).

4. IMPACT ON QPS?

N/A

5. MEASUREMENTS/EVALUATIONS

Q3 2020-2

Quarterly Report on Safe Working Hours Data	
Reporting Time Period:	**1st January to 31st March 2021**
Trust Name:	**Warrington & Halton Teaching Hospitals NHS Foundation Trust**
Guardian of Safe Working Hours Name:	**Mr Mark Tighe**
GOSW Email Address:	**mark.tighe@nhs.net**
No.of doctors/dentists in training (total)	**197**
No.of doctors/dentists in training on the 2016 contract TCS (total)	**197**
No. of lead employer trainees on the 2016 contract at your Trust	**125**
Amount of time available in job plan for Guardian to do the role	**1.5 PA's**
Admin support provided to the Guardian (if any)	**Under review**
Amount of job-planned time for educational supervisors	**0.25 PA's per trainee**

Exception Report submitted by Lead Employer doctors – Q4 2020-21

Only 5 ERs were submitted by trainees with central contracts from the Lead Employer 2019/20. No significant events or issues related to these ERs

6. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed as soon as possible, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For EVERY Exception Report submitted, ether for payment or TOIL; it is the Educational Supervisor who is required to respond to the Exception Report within 7 days.
4. The Trainees need to indicate 'acceptance' or 'escalate' to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the Exception Report can be closed.
5. If an ER is not actioned within 7 days, the GSW will issue an email to expedite sign-off.

The GSW will be provided with timely data reports to support his role in the coming year, with particular reference to improvement in response times for ERs.

7. MONITORING/REPORTING ROUTES

Quarterly and Annual Guardian of Safe Working Hours' Reports should be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in the Trust's Annual Quality Account and signed off by the Chief Executive; the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

It is also normal practice for the Trust's Executive Committee (Strategic People Committee) to have sight of the Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

It might also be good practice to share a copy of the report with the Junior Doctors Forum of the employing/host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

8. TIMELINES

SPC – Strategic People Committee
Guardian of Safe Working - Quarterly Reports, Safe Working Hours Junior Doctors in Training:
Reports will be submitted to each Strategic Peoples Committee Meeting retrospectively for the previous reporting quarter.

9. ASSURANCE COMMITTEE

N/A

10. RECOMMENDATIONS

This Report covers Q4 of the 2020-21 the financial year. 51 ERs were received during this quarter (average 20-25 per month, total 984 since introduction of New Contract in October 2016). There was only one immediate safety concern raised in March 2021 within medicine but does not reflect a recurring concern. The work schedule review has been completed for Ophthalmology ST3+ trainees. No fines were submitted by the Guardian in Q4.

To conclude, The Trust will continue to monitor ERs and sign-offs, to ensure any persistent issues in departments are addressed. To date, the trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in-line with safe working hours. Persistent issues are dealt with in a timely manner.

Please note the findings of the report and consider the assurances made accordingly. The GSW can attend subsequent board meetings if any queries or concerns are raised.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/113**	
SUBJECT:	**Report from Digital Board**	
DATE OF MEETING:	28/07/2021	
AUTHOR(S):	Jason Bradley, Interim Chief Information Officer	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	X
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1372** FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Digital Board met on 12/07/2021, and the following assurance status for key delivery areas was noted: - **Digital Programme**. **Good assurance**. Progress is being made with recruitment for programme resources which are vital for delivering the next phase of the programme. Successful deployments in June included Paediatric iGrow and ECG monitor integration. Both deployments providing full digital processes. - **Dedalus (formerly DXC) Vendor management**. **Limited assurance**. Ongoing performance issues were discussed, with Dedalus asked to provide information on the process for prioritising updates to Lorenzo. Plans are in place to support the proposed move to Cloud with a tentative date of July 31st / August 1st2021. This continues to be monitored for operational impact of system downtime during current service pressures. - **Information and business intelligence**. **Good assurance**. Statutory reporting remains a challenge due to frequent new and changing requirements from external agencies. Recruitment to fill vacancies is progressing positively. Deployments in June included RTT waiting lists and priority codes, bed data reporting, and Phase 1 ED data. Some delayed reports have been escalated to operational colleagues where stakeholder input is required to complete the work.	

The priorities for Digital Analytics for 2021/21 include plans to automate more of the tasks undertaken by analysts to free up more resource to develop.

- **IT services update.**
  Moderate assurance. Issues with a backlog of device deployments are being resolved with a 45% reduction in June. Service desk arrangements have been reviewed following lessons learned from Operation Reset, with additional EPR resource being allocated to support the service desk. The roll out of Office 365 has been completed, and the service will now explore optimising the O365 suite of products to realise the benefits of cloud storage and have data readily accessible anywhere, anytime, any device.
- **Digital Compliance and Risk.**
  Good assurance. Routine monitoring showing continued good progress in managing risk of cyber-attacks. Work is ongoing with suppliers to review alert reporting to provide assurance that data received is accurate. Work on accreditation of digital and analytical services to start in July 2021 looking at requirements and defining an action plan.
- **Strategic Electronic Patient Record (including tactical solution).**
  Moderate assurance. Discussions continue on the tactical contract for Lorenzo, with further meetings being arranged with Dedalus and NHS Digital. An issue with the renewal of the contract for the ORMIS theatre system is also being pursued, related to termination clauses.
  Development of the strategic business case continues with stakeholder engagement sessions held in June and early July 2021 ahead of business case review at July 2021 FSC and Trust Board. A risk on the funding gap in the OBC is being reduced following discussion with the Executive Team on realisation of cash releasing benefits.
- **Clinical safety and risk review.**
  Good assurance (for Lorenzo). One Customer Safety Notice in month with no patient safety concern. A review of other core systems alerting processes to be scheduled.
  Digital Maternity.
  Good assurance. The first Digital Maternity Project Group meeting was held 28 June. Go live options are being considered with pros and cons between a phased approach and a “big bang”. The target for go-live is March 2022

A review of the papers presented to the board has now completed, with changes made to all routine papers for this meeting, with the EPR project board being the final paper that required a review. The quality of updates was noted at the meeting.

The start date for the permanent CIO has been confirmed for mid-August 2021 and the recruitment process has started for the Deputy CIO role. Once this is completed the remaining interim / acting up roles will go through recruitment.

	The main concern remains the ongoing negotiations with Dedalus on the cost and scope of the contract for Lorenzo from November 2021. The Outline Business Case for the EPCMS (Electronic Patient Care Management System) is presented separately for review.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of the report, the ongoing work to resolve the contractual challenges with Dedalus, including progress on migration to the Cloud, with further information on the tactical EPR project reported separately.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	**FSC/21/07/113**		
	Date of meeting	21/07/2021		
	Summary of Outcome	Assurance position was noted. Further information was requested on the contract position for ORMIS, the system used by Theatres.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Digital Board update– June 2021	AGENDA REF:	BM/21/03/113

1. BACKGROUND/CONTEXT

This report provides an update on the programmes of work in Digital Services and Digital Analytics, with the latest assurance assessment, and includes the minutes of the latest meeting (July 2021).

2. KEY ELEMENTS

2.1 Digital Programme
Good Assurance.

An update on the prioritisation for the Paperless Care Programme for 2021/22 was presented. The initial projects for the first half of the year continue on track, with detailed planning starting for the second half of the year. Progress is being made with recruitment for programme resources which are vital for delivering the next wave of projects. One appointee has now started, with a second post to be re-advertised. There are ongoing discussions with the Patient Flow Operational Group to confirm digital support required to underpin this new programme

Successful deployments in June included Paediatric iGrow charts and ECG digital charts:

- iGrow is a fully digital process that allows clinicians to plot child's growth on a chart without having to manually go through history of weight, height, head circumference. Other benefits include:
    - Reduction in incorrect plotting due to human error
    - Audit trail of historic metrics
    - Charts available as a document via the eOutcome system

- ECG Monitor Integration is a fully digital process, Trust wide, to view ECGs taken in the hospital or at GP Practices. Benefits include:
    - Prevention of ECGs being printed on paper Responsible Consultant can review at a convenient time electronically
    - The electronic ECG is stored and retrievable in eOutcome
    - All ECGs* are sent to the GP electronically

*other those taken on mobile devices (carts)

2.2 Dedalus (formerly DXC) Vendor management
Limited Assurance.
The vendor management group met on 07/07/2021 and considered six focus areas as outlined below.

The scope of the next Lorenzo release, 2.21, has been confirmed with seven Trust change requests included. One outstanding request for ED senior review was escalated to Dedalus. It was not clear why this had not been prioritised for the 2.21 version.

A project initiation document for the new OneED tool is being reviewed and is expected to be presented at Digital Board in August 2021 for approval.

The projects to migrate both Lorenzo and ORMIS (theatre system) to the Cloud continue to progress with a tentative date of the weekend 31st July / 1st August now scheduled.

The work on the Lorenzo Digital Exemplar programme is now moving to closure, with a national Blueprint for the Trust work on eTriage submitted to NHSX.

Performance issues continue to be reviewed, with one issue resolved by Dedalus, but two other issues not yet in scope for future release. Dedalus were asked to provide additional information on the prioritisation process. The system performance post migration to the Cloud will be closely monitored.

It was also noted that an issue for alerting for COVID vaccines had been resolved following changes in national data standards.

2.3 Information and business intelligence.
Good assurance.
Statutory reporting remains a challenge due to frequent new and changing requirements from NHS Digital, CIPHA and other external agencies. A reduction in weekend reporting has been achieved via intervention with NHSE representatives reducing seven day working demand.

Progress is being made with recruitment to vacancies in the team.

Key deployments reported include:

- Equality Dataset – Phase 1 ED
- RTT Waiting List and additions by priority code
- Paediatric Cardiology Waiting List Management report
- Bed Data Reporting -
- Phase 1 ED data
- Fracture Clinic Dashboard
- Pharmacy Anticholinergic Report
- Pharmacy Omitted Medications Reports
- Maternity DQ - Fetal Loss
- MESH - Future Outpatients
- Post Anaesthetic Care Dashboard
- PBR Process 2021/22 – Exclusion re-write
- COVID Reporting re-write

The priorities for Digital Analytics for 2021/21 include plans to automate more of the tasks undertaken by analysts to free up more resource to develop. A Digital Analytics PMO is now in place and they will be developing a capacity v demand to accompany the delivery of 2021/22 priorities as well as ensuring BAU continues and demands required for Digital Services tranche two priorities can also be serviced.

2.4 IT services update.
Moderate assurance.
A slight backlog of Technical calls, as reported at last Digital board, has now been recovered. A backlog of Telephony calls in the Network Team was reported, and IT are working with Estates to identify the resources needed to address the backlog.

Issues with a backlog of device deployments are being addressed, with an action plan and additional resources now in place. The backlog has been reduced by 45% during June 2021. The key measure to monitor success is the current number of items in the procurement queue with a target of circa 100 items at any given point. The current total is at 175, reduced from over 300.

Service desk arrangements have been reviewed following lessons learned from Operation Reset. Additional resources from the EPR team were added to the service desk during Operation Reset, and the percentage of dropped calls reduced. A temporary arrangement to allocate EPR resources to the service desk will be put in place, and an upgrade to the service desk system, allowing better reporting, will be deployed by September 2021.

The roll out of Office 365 has been completed, and the service will now explore optimising the O365 suite of products to realise the benefits of cloud storage and have data readily accessible anywhere, anytime, any device. This will have a longer term impact of reducing onsite storage capacity, with associated reduction in costs and risks.

2.5 Digital Compliance and Risk.
Good assurance
Routine monitoring showing continued good progress in managing risk of cyber-attacks.

Work is continuing with the suppliers of our alert monitoring tools to provide assurance that data received is accurate, in particular to ensure that the remaining devices outstanding for the CareCERTS are reporting accurately and not “old replaced” devices no longer in use.

External benchmarked security score remains in top 10% of the Healthcare / Wellness sector, with an advanced score of 780. IT Services continue to improve processes and configurations to improve the score further.

In 2018, Digital Services achieved level 1 (of 3) Excellence in Informatics external accreditation. Work is now being scheduled in July 2021 to set out the requirements and action plan needed to regain accreditation and seek to achieve higher level accreditation in future years.

Digital risks continue to be reviewed on a monthly basis, with Digital Services due to report at the Trust Risk Review Group on 2nd August 2021. A new risk noted this month is on legacy data from retired clinical / operational systems that are retained on legacy hardware. An options reviews is underway, with longer term options to consider moving to a vendor neutral storage solution.

2.6 Strategic Electronic Patient Care Management System (including tactical solution).
Moderate assurance

The strategic case for EPR has now been renamed the Electronic Patient Care Management System (EPCMS) to reflect the move from a records based system to one that more directly supports the clinical and operational workflows.

Discussions continue on the tactical contract for Lorenzo, but with gaps remaining in either cost or scope compared to the original approved business case. Negotiations continue with Dedalus and a separate paper is supplied to provide more detail on the current position and the next steps.

A further issue has been identified with the contract for ORMIS, our theatre system, that is also supplied through Dedalus, with regards to termination clauses. This is being reviewed with Dedalus.

Development of the outline business case for the EPCMS continues with stakeholder engagement sessions held in June and early July 2021 ahead of the business case review at July 2021 FSC and Trust Board (see separate papers).

Engagement timeline:

- Project Team – 16 June COMPLETED
- Finance Review – 17 June COMPLETED
- Exec team workshop 18 June COMPLETED
- Exec Lead – 22 June COMPLETED
- Execs – 6th July COMPLETED
- NEDs – 7 July COMPLETED
- Informal NHSE/I – 12 July COMPLETED
- FSC Papers – 14 July COMPLETED
- FSC – 21 July COMPLETED
- Trust Board Papers – 20 July COMPLETED
- Trust Board – 27 July

The key risk reported from the EPR Project Board is a funding gap between the estimated costs of a new system, compared to the cash releasing benefits that are being forecast. This was reviewed with the Executive Team during June and further opportunities identified in reducing bed days / length of stay through more effective decision and workflow support. These, and additional benefits, have been added to the updated OBC for presentation at July 2021 Trust Board.

2.7 Clinical safety and risk review.
Good assurance (for Lorenzo).
One Customer Safety Notice in month. Discussions held between WHH and Dedalus regarding the impact, possibly only an issue with reporting and no patient safety concern.

The focus on reporting has been on Lorenzo, and Digital Services will review the alerting process for other core systems.

2.8 Digital Maternity.
Good assurance.
The first Digital Maternity Project Group meeting was held 28/06/2021 to review the Project Initiation Document. The joint SROs are Rita Arya (clinical) and Deborah Carter (operations). Go live options are being considered with pros and cons between a phased approach and a “big bang”. This is key for how patient pathways are managed during the migration from Lorenzo to the new system. The target go live is for March 2022

2.9 Governance.
A review of the papers presented to the board has now completed, with changes made to all routine papers for this meeting, with the EPR project board being the final paper reviewed. The quality of the updates was noted by group members.

The start date for the permanent CIO has been confirmed for mid-August 2021 and the recruitment process has started for the Deputy CIO role. Once this is completed the remaining interim / acting up roles will go through the recruitment processes.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Items escalated to FSC.

The main concern remains the ongoing negotiations with Dedalus on the cost and scope of the contract for Lorenzo from November 2021.

The OBC for the EPCMS is presented separately for Trust Board consideration.

4. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report, the ongoing work to resolve the contractual challenges with Dedalus, including progress on migration to the Cloud, with further information on the tactical EPR project included in a separate paper.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/114**	
SUBJECT:	**WHH CHARITY – Trustee Checklist**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):	Michelle Cloney, Chief People Officer	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	X
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust Board is the Corporate Trustee of Warrington and Halton Teaching Hospitals' Charity. In June 2016 the Charities Commission (the regulator) issued new guidance for Charity Trustees. This checklist is designed to help the Corporate Trustee (delegated authority to the Charitable Funds Committee) evaluate the Charity's performance at suitable intervals against the legal requirements and good practice recommendations set out in the Charities Commission guidance: 1. Planning effectively 2. Supervising fundraisers 3. Protecting charity's reputation, money and other assets 4. Identifying and ensuring compliance with the laws or regulations that apply specifically to charity's fundraising 5. Identifying and following any recognised standards that apply to charity's fundraising 6. Being open and accountable The Corporate Trustee is requested to note that there is one update to item 4.2 where the Charity adopts the values of the Corporate Trustee.	

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision

RECOMMENDATION:	That the Trust Board note the responsibilities of the Corporate Trustee (delegated to CFC) and the change to the item 4.2.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee
	Agenda Ref.	CFC 21/06/65
	Date of meeting	10th June 2021
	Summary	Submit to Trust Board as per cycle
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

June 2021

Guidance	Current status	Mitigations/actions/notes
Section 4: Planning effectively	RAG	
4.1 We have set out our fundraising plan		• Our refreshed fundraising strategy was approved at the April 2017 committee meeting and KPIs are monitored at each CFC. The new strategy for 2020-23 has been deferred in light of unknown impact of Covid-19, a refreshed interim strategy is being presented to CFC in September 2021 • The accompanying annual plan is reviewed at each CFC meeting • We continue to review our Strategy periodically in line with changing trends in charitable giving.
4.2 It reflects our charity's values		WHH Charity's values are: Ethical, Transparent, Accountable, Compassionate, Creative and the Charity also adopts the values of the Corporate Trustee of Working Together, Excellent, Inclusive, Kind and Embracing Change.
4.3 The resources we use and the costs we incur in our fundraising		• Our overheads are subject to scrutiny at each CFC meeting as part of the Finance Report • The refreshed FR Strategy has identified limits to overhead expenditure based on income growth with the intention of reducing cost/income ratios to ensure that donated funds are used in majority for patient benefit • Income and expenditure (actual and forecast) are scrutinised and challenged at each CFC • A revised reserves policy was adopted in June 2019.
4.4 The key financial and reputational risks we may face		This has been identified in the Risk Strategy developed in Feb 2016. All WHH Charity risks are now managed through the Trust's DATIX system and reported to each CFC
4.5 We monitor progress		A fundraising activity and financial report is reviewed by the CFC at each meeting
4.6 We manage key risks		The key risks are reviewed at each meeting
Section 5: Supervising our Fundraisers		
5.1 We have considered and decided which fundraising issues we will not delegate		Our Fundraising team is directly accountable to and line-managed by a member of the executive team
5.2 Our fundraising staff have job descriptions		Current and in place
5.3 Our fundraising staff are doing the job successfully		PDR planned for September 2021, Income objectives subject to approval of WHH Charity refresh forecast Monthly 1:1s with Director and informal catch ups in between meetings
5.4 Our volunteers know who they report to and who to approach with problems or concerns		WHH Volunteers assumed responsibility for all volunteers in September 2016, those on placement with WHH Charity report to and are supervised by the Fundraising Manager
5.5 Our volunteers understand the boundaries within which they must work when representing the charity		They receive Trust induction from WHH Volunteers and local induction from the Fundraising Manager and are supervised at all times

5.6 Our subsidiary trading company is monitored for effectiveness and only enters into commercial partners in the charity's best interest	N/A	
5.7 Our arrangements with commercial providers fully comply with relevant legal requirements		We undertake all procurement through the Corporate Trustee and ensure through contract that all legal requirements are met and maintained
5.8 Are in our charity's best interest because appropriate due diligence is undertaken		We procure using the Corporate Trustee's procurement team
5.9 Our fundraising values and expectations are communicated		These are agreed upon contract
5.10 The costs are justifiable and can be explained		All expenditure is reviewed by the Budget Holder and reported through the Finance Report
5.11 Proper control is kept of the money raised		• All monies are routed into the WHH Charity bank account, no other methodology is permitted. • Staff training and awareness on the correct processing of charitable donations is continuous and written into the WHH Staff Handbook
5.12 Fundraising communications used are reviewed		All communications are approved by the Fundraising Manager and/or Director
5.13 Compliance with the agreement is monitored		Compliance is monitored following contract
5.14 Any conflicts of interest are recognised and dealt with		The Corporate Trustee has a Managing Conflicts of Interest Policy which has been adopted by WHH Charity
Section 6: Protecting our charity's reputation, money and other assets		
6.1 The reputational risks our charity may face are identified, assessed and managed		Reputational risks have been identified in our Risk Strategy
6.2 Likely donor, supporter and public perception is considered when income expectations and other goals are considered		Our bid application process includes this to ensure compliance of all parties via capital campaigns
6.3 The legal rules and recognised standards which apply to our fundraising are followed		We follow the Code of Fundraising Practice, the Institute of Fundraising and the Association of NHS Charities guidance. We are registered with and regulated by the Charities Commission
6.4 Our values are communicated to the people who work on our fundraising		All WHH staff adopt and practice the values of the Corporate Trustee, they and the public are further briefed on the aims and objectives of WHH Charity and are guided on how to proceed with fundraising initiatives on a personal/team/company level.
6.5 The costs of our fundraising are managed and explained		We control our costs through a bid application process We review our costs at each CFC meeting
6.6 Our fundraising finance is planned and monitored		We have an annual plan in place, the KPIs of which are reviewed at each CFC meeting.
6.7 Effective financial controls are in place and followed		The Corporate Trustee's Finance Team monitor all expenditure
6.8 Risks of financial crime and fraud are reduced		WHH Charity provides a letter of authorisation to every fundraiser who is requested to sign acceptance of the 'contract' between us.
6.9 Our charity is alerted to any suspicious donations		• Our Finance Team review all bank statements and incoming direct funds

		• Provenance of all cheque and cash donations is tracked through the donor journey and recorded via Harlequin, with a receipt and thank you letter posted out to the donor.
6.10 our charity can stop or authorise any unauthorised fundraising activity using its name		• We use a letter of authorisation to authorise fundraisers to raise funds on our behalf. • We would alert the police to any suspicious activity undertaken in our name.
6.11 Serious incidents are reported to the Commission, police and other agencies		• NHS Protect may also be contacted where NHS Employees or their families are involved.
6.12 Our data, name, image, logo and IP are protected		• We do not issue our logo independently for 3rd party use • We use letters of authorisation for 3rd party fundraisers • We provide our own branded materials for support • Our intellectual property is protected to the best of our ability and knowledge
Sections 7 and 8 Following the Law and recognised standards		
7.1 the Code of Fundraising Practice and other resources are used to find out about the legal rules and recognised standards which apply to our fundraising		We follow the Code of Fundraising Practice, Institute of Fundraising and the Association of NHS Charities guidance
7.2 These rules and standards are followed		We follow the Code of Fundraising Practice, Institute of Fundraising and the NHS Charities guidance
Section 9: Be Open and Accountable		
9.1 Any legal rules and requirements that apply to how our charity reports and accounts for its fundraising are complied with		We are audited periodically and produce an annual report and accounts each autumn.
9.2 Our open and accessible complaints procedures are followed if concerns are raised		• In the first instance complaints should be raised to the Fundraising Manager or Director • The Charity uses the resources of the Corporate Trustee ie PALS and Complaints procedure. • The Charity will make this process clear via its website
9.3 Our fundraising aims and achievements are clearly communicated to the public and donors/supporters		Our website is maintained and updated regularly, Our social media platforms are updated regularly.

MC Last updated 2.6.2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT		AGENDA REF:	

1. BACKGROUND/CONTEXT

2. KEY ELEMENTS

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

4. IMPACT ON QPS?

5. MEASUREMENTS/EVALUATIONS

6. TRAJECTORIES/OBJECTIVES AGREED

7. MONITORING/REPORTING ROUTES

8. TIMELINES

9. ASSURANCE COMMITTEE

10. RECOMMENDATIONS

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/115**			
SUBJECT:	**Outcome of formal public consultation to relocate Breast Assessment and Symptomatic services to CSTM**			
DATE OF MEETING:	28 July 2021			
AUTHOR(S):	Pat McLaren, Director of Communications & Engagement Stephen Bennett, Head of Strategy & Partnerships			
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement Lucy Gardner, Director of Strategy & Partnerships			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	X		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	X		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	X		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability, #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper summarises the outcome of the recent formal public consultation to relocate some elements of the Breast service from Kendrick Wing at Warrington to CSTM.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	It is recommended that the Board note the outcomes of the recent public consultation.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Outcome of formal public consultation to relocate Breast Assessment and Symptomatic services to CSTM	AGENDA REF:	BM/21/07/115

1. BACKGROUND/CONTEXT

The Trust currently provides Breast Screening Services (Mammography), Breast Assessment and Symptomatic Breast Services across Warrington, Halton, St Helens and Knowsley in partnership with St Helens and Knowsley Teaching Hospital NHS Trust (STHK),

A 6 week period of formal consultation commenced on the 28th May 2021 seeking the views of the public on some proposed changes to the service. The formal consultation followed a period of pre-consultation engagement.

The period of formal consultation ended on Thursday 8th July 2021.

2. KEY ELEMENTS

The proposed changes to the service are as follows:

1) Relocation of the Assessment Service from Kendrick Wing on the Warrington Hospital site to the Captain Sir Tom Moore building on the Halton site to create a single assessment/results and rapid access symptomatic service for Warrington and Halton. The assessment service at St Helens Hospital will remain unchanged.

2) Relocation of the rapid access Outpatient Symptomatic clinics, currently provided at Warrington Hospital and Halton Hospital Delamere Centre into the new location at CSTM on the Halton site alongside a screening service and the relocated assessment service.

3) Retention of Breast screening services in Warrington to ensure all Warrington residents are able to continue to access screening in Warrington. Screening services will continue unchanged at St Helens Hospital and the mobile screening units.

Consultation and engagement with the public around the proposals has taken place using the following four methods:

- Electronic online questionnaire advertised via Trust channels incl. social media.
- Hard copy paper questionnaire sent to a large sample of patients from the current caseload.
- Face to face consultation at several current screening locations (adhering to current social distancing requirements).
- MS Teams Live sessions with an open invite to all interested parties.

3. EVALUATION & MONITORING

404 responses to the questionnaire were received in total - 252 during the formal consultation period and a further 152 during the period of pre-consultation engagement.

208 of the responses were received via the online survey (166 during consultation and 42 during pre-consultation) and the remaining 196 were received via paper forms returned to Trust (86 during consultation and 110 during pre-consultation).

60% of respondents during the consultation period said they were aware of the proposed changes to the Breast Services at Warrington & Halton.

68% said they had been given enough information to form an opinion on the proposed changes.

In total, **63%** of all respondents during the consultation period said they would be either "Very Satisfied" or "Satisfied" to access Breast Assessment and Outpatient Symptomatic rapid access breast clinics at the Captain Sir Tom Moore Building.

The factors that respondents felt were most important for them with regards attending a Screening or Assessment location were ranked as follows:

1) Waiting time to access the service
2) Outcome of treatment
3) Staff expertise
4) The location of the service
5) Car parking
6) The environment and facilities

The common themes/questions emerging from the public feedback was as follows:

Theme	Detail	Response during consultation
Car parking/accessibility	A number of people highlighted the difficulties in obtaining a car parking space when accessing services in Kendrick Wing.	The Halton site is generally viewed more positively than the current Warrington site with regards car parking so this was a positive.
Availability of screening services	A number of people raised concerns about the possibility of having to travel across to Halton in order to access screening services. Screening services are by far the highest volume service within the overall Breast care offer.	Significant emphasis has been given throughout the consultation period to the fact that **screening services will remain available in Warrington for Warrington patients**.
Travelling time	Some issues were raised regarding increased travel times for some Warrington patients.	Equivalent number of Halton patients will benefit from reduced travel time. Overall net increase in travel time for all assessment patients in 19/20 would have been less than 1

		minute extra. Important to note that the screening and assessment service is not specific to Warrington but also covers Halton, St Helens & Knowsley.
Travel costs	Some issues were raised regarding the increased costs of travelling across to Halton for Warrington patients.	Significant emphasis has been given throughout the consultation period to the fact that the Trust operates a free shuttle bus service between the Warrington and Halton sites for those patients with concerns about having to pay for bridge tolls as a result of the proposed changes.
Design of the new spaces in the CSTM building	Some comments were received relating to the design of the new space at CSTM, in particular for people with disabilities and around waiting areas for male patients.	These comments and suggestions were fed back to the estates project team and the outcomes communicated during the consultation period.

The outcomes from the formal consultation were shared with the members of Halton's Health & Wellbeing Board virtually on 12th July 2021.

The outcomes from the formal consultation were shared with the members of Warrington's Health & Wellbeing Board on 15th July 2021.

The WHH Executive Team confirmed the decision to proceed with the proposed changes on 16th July 2021.

The report detailing the outcomes of the consultation was shared with Commissioners and NHSE on 20th July 2021 and will also be published on the Trust website.

The relocation of the elements of the Breast Service as described in section 2 commenced w/c 19th July 2021.

Letters will also be sent to all patients on the active WHH caseload informing them of the outcome of the consultation and thanking them for their participation.

4. RECOMMENDATIONS

It is recommended that the Trust Board note the outcomes of the recent public consultation and the decision to commence relocation of Breast Assessment and Symptomatic services.

5. APPENDIX – REPORT DETAILING OUTCOMES OF FORMAL CONSULTATION

Reconfiguration of Breast Screening, Assessment and Symptomatic Services across Warrington & Halton

Public Consultation Outcomes Report 15th July 2021



CONTENT

1. INTRODUCTION

1.0 The Breast Screening and Assessment Service

Warrington and Halton Teaching Hospitals (WHHNHS) is the lead provider for the Warrington, Halton, St. Helens and Knowsley Breast Screening and Assessment Service (WHSKBSS) which is commissioned by NHS England Specialist Commissioning and the symptomatic service is commissioned by the relevant borough commissioners.

For clarity, **Breast Screening service** refers to the periodic mammograms offered as part of the national programme to identify and treat breast cancers earlier. **Breast Assessment/Symptomatic service** refers to the diagnostic phase following a mammogram where any patients requiring further investigation are brought back to clinic for additional imaging and possibly a needle biopsy to obtain a timely diagnosis of any abnormalities detected during screening.

1.1 Breast Screening

WHSKBSS provides routine **breast screening, diagnostic and onward referral services** to a population of approximately 92,000 from across the four boroughs. Breast Screening is offered to all women aged 50 - 70 (up to their 71st birthday), in line with national programme/guidance where screening is conducted once every three years. Patients over the age of 70 able to self-refer for screening.

In 2019/20 the service invited over 28,000 people for screening and performed a mammogram on around 22,000. The WHSKBSS service is currently provided from the following locations:

- Warrington (Kendrick Wing Warrington Hospital and Bath St. Health & Wellbeing Centre (c.33k patients per annum)
- Halton Hospital (c.20k patients per annum)
- St Helens Hospital (c.29k patients per annum)
- Knowsley Whiston Hospital (c.9k per annum)
- Mobile Units (numbers counted in locations above)

1.2 Breast Assessment Service

Breast Assessment Clinics run twice weekly at Warrington and once per week at St Helens to ensure results are provided rapidly. Current Assessment Services are provided at Kendrick Wing Warrington Hospital and Burney Breast Unit, St Helens Hospital.

Assessment clinics are designed to enable patients to undergo additional more detailed mammogram views, an ultrasound scan and a needle biopsy (if appropriate) in a single attendance. Assessment clinics use a triple assessment:

- mammography/ultrasound scans
- clinical examination
- image-guided needle biopsy, if required

Approximately 50% of patients brought back (from routine screening) for assessment will require a biopsy and these patients are provided with the outcome of the biopsy at a results clinic approximately 1 week later. Those patients who will require treatment are seen by a breast surgeon and breast care nurse within
that clinic.

In 2019/20 approximately 900 people were referred into the assessment service following routine screening. Around 200 of these patients per year are subsequently referred into the Breast Symptomatic treatment service following a positive cancer diagnosis from the assessment/results clinic.

1.3 Symptomatic Breast Services

The symptomatic services at WHH and STHK comprise outpatient rapid access breast clinics and inpatient surgical services. They do not currently form part of the Warrington, Halton, St Helens and Knowsley Breast Screening and Assessment Service.

These services are accessed by a direct referral, usually by a GP. All adults, regardless of age or gender can be referred to the Symptomatic Service. The first stage of the Symptomatic Service involves an outpatient meeting with a Consultant and undergoing similar investigations to the Screening pathway Assessment Clinics. Symptomatic service triple assessment comprises:

- mammography/ultrasound scans
- clinical examination
- Image-guided needle biopsy, if required

Treatment can include any combination of surgery, chemotherapy, radiotherapy and hormone tablet treatment.

1.4 Proposal for Model service change

1. There will be no change to the service offer for breast screening at this stage, however the Trust would, in future, like to consolidate the screening service offered at Bath St and Kendrick Wing to offer an expanded and more sustainable screening offer at Bath St. See below for more on this.
2. Assessment Clinics to relocate from Kendrick Wing to new Captain Sir Tom Moore Breast centre at Halton (Runcorn site)
3. Symptomatic Clinics to relocate from Kendrick Wing to new Captain Sir Tom Moore Breast centre at Halton (Runcorn site)
4. Patient choice for 1-3 will remain with patients able to choose one of four options for screening and one of two options for assessment/symptomatic service.

1.5 Case for Change

- The number of patients screened each year by the service has doubled over the last 20 years. However, the service provided from the base at Warrington Hospital's Kendrick Wing has retained the same basic estate footprint, which is no longer fit for purpose and has no opportunity for obvious expansion.

- There are real opportunities to create a significantly enhanced patient experience and improve access, create a more efficient service and support the longer-term sustainability of the service by relocating to an alternative, superior location.
- The service at Warrington has become inaccessible to some patients due to aged estate and persistent issues with elevator outage.
- The current multi-site nature of the screening service and split-site nature of the assessment service creates inefficiencies in use of estate, equipment and workforce.
- The workforce challenges are significant with a local and national shortage of Breast Radiologists and Mammographers making recruitment into crucial posts challenging.

1.6 Options Appraisal

Five options were explored and scoped out by a multi-disciplinary working group, involving wide representation from clinical staff, estates, service managers and Trust executives.

1. Relocate Warrington Hospital's screening and assessment service at Kendrick Wing elsewhere on the Warrington Hospital site
2. Relocate existing Warrington Hospital screening and assessment service into the Captain Sir Tom Moore building (CSTM) at Halton and retain existing service at Bath St. Warrington
3. Relocate existing Warrington Hospital screening service onto Captain Sir Tom Moore Building (CSTM) at Halton Hospital and relocate the assessment service at St Helens to CSTM to create a regional breast service 'centre of excellence'.
4. Relocate existing Warrington Hospital screening and assessment service to Captain Sir Tom Moore Building at Halton Hospital while retaining current services at St Helens and increasing service provision at Warrington Bath Street.
5. Do nothing.

The options were extensively explored by the working group and the most viable option, delivering the most patient benefit, was option 4. This option enables:

- Significantly enhanced patient experience for those using Warrington Hospital – Kendrick Wing is over 100 years old, has significant maintenance issues associated with an aged building (location of serious fire in 2018) and expansion/reconfiguration of this estate is prohibitive. There are no alternative, suitable locations elsewhere on the Warrington Hospital site
- Significantly enhanced accessibility to a ground floor service at Captain Sir Tom Moore building. Accessibility at the current service at Kendrick Wing has deteriorated over the years as it is a first-floor service requiring movements through multiple doors, steep stair access and a small lift which has multiple service issues.
- Service and operational efficiencies ensuring the service is future-proofed, especially when both population growth and the change in population demographics (including ageing population) are factored into the service delivery.
- Provision of both screening and assessment clinics simultaneously - critical for patients experiencing anxiety following their breast screening where there are anomalies.

2. APPROACH TO LOCAL INVOLVEMENT, ENGAGEMENT AND CONSULTATION

2.1 Requirement for Consultation

NHS commissioning organisations have a legal duty under the National Health Service Act 2006 (as amended) to 'make arrangements' to involve the public in the commissioning of services for NHS patients ('the public involvement duty'). For CCGs this duty is outlined in Section 14Z2 (and Section 13Q for primary care services) of the Act to fulfil the public involvement duty, the arrangements must provide for the public to be involved in (a) the planning of services, (b) the development and consideration of proposals for changes which, if implemented, would have an impact on services and (c) decisions which, when implemented, would have an impact on services.

Further to this the Consultation Institute states "…there are many statutory requirements for consultation, but the truth is that ALL significant changes to long-standing services need consultation.

The Courts provide their own incentive to engage. It's called the '*doctrine of legitimate expectation*'. If the public has a sound basis for expecting to be consulted, then failure to do so can lead to losing a Judicial Review. And Judges have ruled that if people have been accustomed to the benefit of a service, then its withdrawal without consultation can in many circumstances, be unlawful".

2.2 Local involvement, engagement and consultation plans

Working with NHS Halton and NHS Warrington CCGs, the Trust undertook a period of pre-consultation engagement prior to full public consultation on the proposed model. The process for this was as follows:

Defined objectives of pre-engagement and formal consultation

1. To ensure the local population is made aware of the proposals and provided with a number of platforms to engage and participate
2. To ensure the local population are able to make alternative recommendations and suggestions relating to the proposed development and relocation of the breast screening service at WHHNHS
3. To ensure any emerging issues and themes are taken into account and any potential mitigating actions are considered
4. To inform the Public Consultation documentation, questions and answers using initial feedback from the first round of engagement
5. To prepare engagement reports for the appropriate stakeholder and advisory groups.

Methodology

The methodology for the pre-engagement and consultation exercises was designed based on the Gunning Principles (see appendix 1) and comprised:

Pre-consultation engagement (1 April – 15 May 2021) 6 weeks

- Drafting of comprehensive communications plan, an information and engagement document, FAQs and questionnaire
- Development of Easy Read, Additional Language and other format materials
- Local engagement with patients attending Warrington and Halton breast screening and assessment sessions (Bath St, Warrington Hospital Kendrick Wing, Halton Hospital) and staff
- Patient panel workshop service design and wayfinding 9 April 2021
- Promotion of the proposed plans for initial input
- Media release
- Briefing to MPs and other key stakeholders
- Collation of feedback, analysis to inform public consultation
- Collection of respondent data for Equality Impact Assessment
- Report on the pre-engagement exercise to relevant governance bodies

The aims of the pre-consultation engagement were to ensure the local population were aware of the proposed model and service change, to ensure the local population were able to be involved in the development of the local model, to give an opportunity for the public to share their initial views of the proposals to relocate the breast assessment and symptomatic clinics to Halton and to feed into the formal consultation process. Please see appendix 6 for a summary of pre-consultation outcomes.

Formal Public Consultation 28 May 2021 – 8 July 2021 (6 weeks)

- Engagement at breast clinics with current patients across all sites
- Promotion of the proposed plans for initial input
- Media release
- Delivery of a number of virtual presentations (day/evening time and weekend) by the service on their plans with a Q&A session
- Briefing to MPs and other key stakeholders
- Collation of feedback, analysis to inform public consultation
- Collection of respondent data for Equality Impact Assessment
- Report on the outcomes of the consultation to relevant governance bodies

The aims of the formal consultation were:

- To inform and involve all current and new patients of the various elements of the Breast services of the proposals and seek their input and views
- To ensure the local population was made aware of the proposals and provided with multiple platforms to engage and participate by sharing their views and opinions
- To ensure the local population (including those people that were harder to reach) were able to make alternative recommendations and suggestions relating to the proposed changes to the services
- To ensure any emerging issues and themes were taken into account by the project team and any potential mitigating actions were considered
- To inform a final decision about the proposed changes following the conclusion of the consultation period.

Engagement

The formal public consultation took place over eight weeks (see timeline above). The methods of engagement and communications for the consultation were diverse, please see Appendix 2 for the completed log of engagement activity, key points:

- Comprehensive and inclusive communications plan
- Summary Document and on-line/paper survey
- Attendance at events and meetings
- Holding public drop-in sessions on Zoom and 'pop ups' at various breast clinics
- Stakeholder briefings
- Attendance at wellbeing boards and health scrutiny fora

Respondents

Details of respondents can be found at appendix 5

MAIN FINDINGS

The following section highlights the main findings from all the engagement activity. The information is from the survey results, attending various groups and meetings and the public engagement events and have been themed to form the findings.

There was some confusion about which services were relocating, despite attempts to resolve this in the consultation. This appeared to be as a result of people clicking straight on the survey link without reading the summary booklet, attending a meeting for more information or speaking with staff.

Responses

404 responses were received in total. 252 during the formal consultation period and a further 152 during the period of pre-consultation engagement:

- 208 from online survey (166 during consultation and 42 during pre-consultation).
- 196 from paper forms returned to Trust (86 during consultation and 110 during pre-consultation).

	Location accessed:					
Service accessed:	**Warrington**	**Bath St**	**Halton**	**St Helens**	**Mobile**	**No Answer**
Breast Screening	131	27	40	18	25	11
Breast Assessment	77			26		
Outpatient Symptomatic Breast Services	33			12		

- 83% of all respondents that provided an answer have accessed services in Warrington.
- 60% of respondents during the consultation period said they were aware of the proposed changes to the Breast Services at Warrington & Halton
- 68% said they had been given enough information to form an opinion on the proposed changes
- There was a range of responses to the question of where people would prefer to access Screening services. For clarity, screening will continue to be provided in Warrington, Halton, St Helens and via the mobile unit.

Preferred Location for Screening Services	Total Respondents	% of total
Warrington Hospital	78	40.4%
Warrington, Bath Street	46	23.8%
Captain Sir Tom Moore Building, Halton Site	105	54.4%
St Helens Hospital	27	14.0%
Mobile Breast Screening Unit	13	6.7%
None of these	6	3.1%
	275	

- 63% of all respondents during the consultation period said they would be either “Very Satisfied” or “Satisfied” to access Breast Assessment and Outpatient Symptomatic rapid access breast clinics at the Captain Sir Tom Moore Building.

- On average across all consultation respondents, the factors that people felt were most important for them with regards attending a Screening or Assessment location are ranked in order below:

  Most important

  1. Waiting time to access the service
  2. Outcome of treatment
  3. Staff expertise
  4. The location of the service
  5. Car parking
  6. The environment and facilities

  Least important

Key Themes from Public Comments – see next page

Themed Feedback

COMMON THEMES	*REPRESENTATIVE FEEDBACK*	*PROPOSED SOLUTIONS/ACTION*
TRANSPORT AND COSTS	1. *Getting to Halton is very difficult in the first place when living in Warrington. I would struggle getting there. Bath Street is much nearer and a great service.* 2. *Ensure there is free transport service from Warrington to Halton hospital for breast screening patients.* 3. *Unfair there will be no service at Bath street and have to travel to Halton or St Helens as they are not easy places to get to from Warrington.* 4. *Bath Street and Warrington Hospital are easy to get to when living in the Warrington Area.* 5. *It would be either having to go on the bus or in the case of treatment a taxi each way which in total would cost £40.* 6. *Expand the parking spaces as an increase in number of clinics on site would make parking more difficult though the shopping facilities locally do provide some alternatives for those without mobility issues*	1, On publication of the consultation outcomes direct patients to map showing two routes from Warrington to the Runcorn Site with Captain Sir Tom Moore (CSTM) building postcode (one toll, one Daresbury) plus estimated travel time 2, Ensure that information relating to the free shuttle bus between Warrington and Runcorn site is included in patient appointment letters and on website 3, Reiterate the locations that breast screening is available 4, Patient parking and congestion is carefully monitored, a new staff permit system being introduced in August should ensure patient spaces are kept solely for patient use.
ACCESSIBILITY	1. *The age group of people who mostly have screening is usually mature and aren't always able to drive so moving this service would cause many problems* 2. *I do not drive and it would make access very difficult to get to. My X had breast cancer treatment and has her symptoms progressively got worse she couldn't drive and it proved to be a nightmare to get over to Halton for treatment* 3. *Signage at Halton hospital is poor and I have found myself wandering around trying to find the department I am looking for.* 4. *It would make it more difficult for me as I am a carer for my son and mum and its difficult to get to appointments as it is so if it is further away this will make it more difficult for me*	1, Ensure that information relating to the free shuttle bus between Warrington and Runcorn site is included in patient appointment letters and on website 2, Continue to collect feedback from patients in the first year of operation of the service with particular reference to ease of access 3, Ensure patients are aware of Clatterbridge patient transport offer for those undergoing treatment and unable to get themselves to CanTreat 4, Audit of signage at both the Nightingale Building and CSTM has been undertaken, additional external signage being procured for Breast Centre 5, Reiterate concessions for carers and reiterate continuation of breast screening services at Warrington

PATIENT CHOICE	5. *Continuity of care, is important. St Helens has a breast unit and chemotherapy unit together along with Macmillan* 6. *Removal of choice as would be unable to choose between attending Warrington & Halton NHS Trust and St Helens & Knowsley NHS trust*	1, On publication of the consultation outcomes ensure that information about the Macmillan Delamere Centre is included and describe its proximity to the new breast centre at CSTM 2, At time of booking ensure that patients are aware that they can choose to have their assessment/symptomatic appointment at either CSTM Halton or St Helen's Burney unit
TREATMENT AND CARE	1. *As someone who has had breast cancer and a mastectomy any improvement to the current services in both Halton and Warrington hospitals is very much necessary. The services I received were appalling and need vast improvement in treatment times, communication and staff - particularly Macmillan support* 2. *It's unclear how the treatment services i receive currently for my secondary breast cancer will be impacted* 3. *What's happening to the current can treat and can support building? Are other cancers going to be supported at the Tom building?* 4. *I have had breast cancer and I would prefer women who are diagnosed not to have to walk through a corridor where everyone is sat because you are very aware people are looking at you* 5. *A written outcome of results of tests as people with disabilities like myself find it hard to remember information and things that were discussed during the apt. Even if nothing is found it would be good to get it in writing*	1, Ensure that all patient feedback such as this is followed up by service manager and fed to the Head of Patient Experience who will invite patient to join the Breast Service 'Experts by Experience' panel 2, On publication of the consultation outcomes ensure that information about the Macmillan Delamere Centre is included and describe its proximity to the new breast centre at CSTM 3, On publication of the consultation, clearly describe how current treatments will be impacted 4, On publication of the consultation describe how the CanTreat facility, operated by Clatterbridge at Halton, remains unaffected and describe any other cancers that are now being treated at the CSTM 5, Highlight design of new unit and enhanced privacy and dignity arrangements 6, Discuss with service and Head of Patient Experience and Inclusion ways in which patients can be supported
COMMUNICATIONS	1. *As treasurer of CANsupport and a volunteer, i feel annoyed that there isn't enough time for the consultation. More information should be given and relevant people notified as to the proposed changes.*	1, Service Manager to make contact with CanSupport to share outcomes of the Consultation report and the timelines and communications plans therein.
TOLL COSTS	1. *Traveling to Halton would incur two charges I can't afford to go over & return via the Runcorn Widnes Bridge.* 2. *No charge to cross and return on the Runcorn Bridge.* 3. *Widnes Bridge also incurs a charge to go over and come back that I currently don't have to pay going to Bath Street.*	1, On publication of the consultation outcomes direct patients to map showing two routes from Warrington to the Runcorn Site with Captain Sir Tom Moore (CSTM) building postcode – describe routes in terms of South Warrington (via Walton/Daresbury) North Warrington (via new Slutchers Lane bypass) OR toll bridge options with estimated travel times.

4. NEXT STEPS

The consultation outcomes have been shared with Health and Wellbeing Board, Health Scrutiny Committee and with a multi-agency group comprising commissioners, specialist commissioners and the acute Trust.

- Share outcomes from formal consultation with Halton HWBB virtually – 13th July 2021 - model and the approach to consultation were endorsed by the Board
- Share outcomes from formal consultation with Warrington HWBB – 15th July 2021 - model and the approach to consultation were endorsed by the Board
- Final decision on proposed changes by WHH Executive Team – 16th July 2021 decision based on close scrutiny of public feedback throughout pre-consultation and consultation and feedback from HWWB, Scrutiny and the multi-agency interest group
- Full consultation report shared with CCG and Trust governance committees for assurance and completion
- Letters to all patients on active WHH caseload informing them of the outcome – week commencing 19th July 2021.

The main findings and appropriate mitigations will be shared as part of the publication and service change process to ensure that actions required are achieved.

APPENDIX 1. ADHERENCE TO THE GUNNING PRINCIPLES

When undertaking any public consultation in the UK the Gunning Principles must be applied. This has been confirmed by the Court of Appeal in 2001 (Coughlan case).

When assessing this consultation the four principles will be applied as below.

1. When proposals are still at a formative stage - ***Public bodies need to have an open mind during a consultation and not already made the decision, but have some ideas about the proposals.***

The model proposed was developed following NHS England's quality assessment of Breast Screening and Assessment services in the Halton, Knowsley, St Helen's and Warrington boroughs and was in response to the need to consolidate and build on scarce resources across the areas.

During the pre-consultation engagement general questions were asked to gather views and experiences that the Trust used to refine and develop the proposals. During the pre-consultation stage it became clear that people were unclear about the differences between screening, assessment and symptomatic services and we went to lengths to make this clearer. A service user joined the Trust's working group in 2018 and staff from a wide range of disciplines and services were involved in developing proposals.

The consultation questions enabled people to give their opinions on the proposals and discuss any potential impact.

The Trust was clear from the outset that development of the Captain Sir Tom Moore estate could proceed at pace since capital was available, on the premise that NO services would be relocated until conclusion of a public consultation.

2. Sufficient reasons for proposals to permit 'intelligent consideration' - ***People involved in the consultation need to have enough information to make an intelligent choice and input in the process. Equality Assessments should take place at the beginning of the consultation and published alongside the document.***

The consultation documents made the reasons for the proposals clear, as below:

- The case for change
- Full description of what services were available and where
- Data on usage of the services that were proposed to change

Throughout the consultation a Frequently Asked Questions document was produced and added to, to ensure that any additional questions or concerns were addressed.

An Equality Impact Assessment was undertaken to determine where specific engagement should be undertaken and to consider any potential impact to protected characteristics. As well as general engagement and communications focused work was undertaken. This included:

- Attending a wide range of meetings, holding pop up and drop in sessions (Covid-19 restrictions were in place hence many virtual attendances)
- Targeted engagement at Third Sector Organisations who represent the wider community
- Targeted communications (paper copy) at service users on the Trust's current case load
- Electronic online questionnaire advertised via Trust channels incl. social media.
  Face to face consultation at several current screening locations (adhering to current social distancing requirements) inc MS Teams Live sessions with an open invite to all interested parties.

3. Adequate time for consideration and response - ***Timing is crucial – is it an appropriate time and environment, was enough time given for people to make an informed decision and then provide that feedback, and is there enough time to analyse those results and make the final decision?***

There was a planned period of pre-consultation followed by an eight-week consultation. Halton's Health Policy and Performance Board and Warrington Health Scrutiny Committees were briefed on the pre-consultation and consultation plans.

The engagement and communications methods used were wide and varied. The full communications activity log can be seen in Appendix 2.

Full analysis of the outcomes of the consultation and the equality impact assessment informed a final decision ('go/no go') on proposed changes by WHH Executive Team. This followed close scrutiny of public feedback throughout pre-consultation and consultation and feedback from HWWB, Scrutiny and the multi-agency interest group

4. Must be conscientiously taken into account - ***Think about how to prove decision-makers have taken consultation responses into account.***

Full analysis of the outcomes of the consultation and the equality impact assessment informed a final decision ('go/no go') on proposed changes by WHH Executive Team. This followed close scrutiny of public feedback throughout pre-consultation and consultation and feedback from HWWB, Scrutiny and the multi-agency interest group.

APPENDIX 2 ENGAGEMENT AND CONSULTATION – ACTIVITY LOG

Phase	Task	Date	Task lead	RAG
1	Warrington Health Scrutiny committee	23/03/21	Lucy Gardner	
1	Halton Health and Wellbeing Board	24/03/21	Lucy Gardner	
1	Warrington and Halton Joint PPGs/Engagement and Inclusion meetings presenting on	06/04/21	Lucy Gardner	
1	Service user group	09/04/21	Clare Boyd	
1	Stakeholder Brief	15/04/21	Comms	
1	Communications, Engagement and Involvement Plan	09/04/21	Comms	
1	Full suite of Engagement and Involvement materials	15/04/21	Comms	
1	Deploy Comms Plan	05/05/21	Comms	
1	Engagement commences (services, virtual)	05/05/21	Services/ Strategy team	
1	Mail out to 500 people – random sample of current caseload – including males – letters informing of engagement and engagement documents enclosed	05/05/21	Service/Comms	
1	Delivery of 2 x ZOOM presentations (weekday/weekend/am/pm/twilight) by each of three services with a Q&A session	11/05/21 @ 6.30pm 14/05/21 @ 10am	Services/ Strategy team	
1	Live engagement exercises (within social distancing/ (pop up/window posters)	04/05/21	Services/ Strategy team	
1	Evaluate feedback from qualitative and quantitative engagement	24/05/21	Strategy	
2	Share outputs from pre-consultation engagement shared with WHH Exec team and local CCGs	27/05/21	Strategy	
2	Approval of public consultation paper at WHH EXECS (SEOG) and partners	27/05/21	Lucy/Gardner/SEOG	
2	Public consultation commences	28/05/21		
2	Website updated with all consultation materials including consultation documentation and link to online questionnaire	28/05/21	Comms	
2	Email to CCG Engagement lead re start of public consultation – asking for suggestions of groups to contact to increase representation *(response*	28/05/21	Comms	

	received 8th June and all suggested contacts already on WHH stakeholder list and contacted) Followed up with email containing consultation resources			
2	Posters advertising consultation displayed in CSTM, Kendrick Wing, Bath Street, St Helens, Mobile Units	01/06/21	Comms/Strategy	
2	Stakeholder bulletin #1 announcing consultation starts – including to partners, advocacy groups, MPs	03/06/21	Comms	
2	Press release issued announcing start of consultation	03/06/21	Comms	
2	Attendance at GP forum for Warrington and Halton GPs to inform of proposals and consultation	04/06/21	Lucy Gardner	
2	Social media posts announcing consultation and inviting responses and also sharing details of the dates listed below where people can come and talk to us (see below)	28/05/21 to 07/07/21	Comms	
2	Face to face consultation (within social distancing) – Captain Sir Tom Moore Building, Halton	10/06/21	Strategy/Service	
2	Face to face consultation (within social distancing) – Breast clinic, Warrington Hospital	14/06/21	Strategy/Service	
2	Face to face consultation – Breast clinic, Bath Street HWB Centre	15/06/21	Strategy/Service	
2	Stakeholder bulletin #2 consultation reminder sharing details of virtual consultation event -to partners, advocacy groups, MPs.	16/06/21	Comms	
2	Face to face consultation – Breast clinic, Bath Street HWB Centre	22/06/21	Engagement	
2	Face to face consultation – Breast Clinic, St Helens Hospital	30/06/21	Engagement	
2	Promotion of virtual Consultation session scheduled for 24/06/21 via update message to Stakeholders on 21/06/21	21/06/21	Comms	
2	Promotion of virtual Consultation session scheduled for 24/06/21 on social media	15/06/21 onwards	Strategy/Service	
2	Follow up email to contacts suggested by CCG on 8th June to remind of the virtual consultation event and asking for suggestion of groups we could attend to ensure a representative response to consultation. Provided contact for responses - whh.communications@nhs.net	21/06/21	Comms	
2	Virtual Consultation session on MS Teams LIVE	24/06/21	Strategy/Service/Comms support	

2	Targeted emails and social media to directions4men and Wolves foundation – in response to feedback from virtual consultation event about how to increase male representation	24/06/21	Comms	
2	Email follow up to virtual consultation event attendee – thanking for input and offering the opportunity to visit current facility re accessibility provision	24/06/21	Comms	
2	Website updated with questions and responses from virtual consultation sessions	25/06/21	Comms	
2	Reminder – one week to go to have your say – to be updated on social media/press/stakeholders advocates	1/07/21	Comms	
2	Outputs from engagement - Warrington HWBB/Health Scrutiny – 29th June 2021.	29/06/21	Strategy	
2	(Interim) outputs from formal consultation shared with Halton HWBB	07/07/21	Strategy/Lucy Gardner	
2	Public consultation ends	08/07/21		
2	Write up consultation outcomes	08/07/21 - 10/07/21	Strategy/Comms	
2	Consultation outcomes for approval to proceed by WHH Executive Team	13/07/21	Strategy/Lucy Gardner	
2	Consultation outcomes to Warrington HWBB	15/07/21	Lucy Gardner	
2	Publish consultation outcomes	16/07/21	Strategy/Comms	
2	Issue letters to patients on current symptomatic case load informing of consultation outcome and changes to service with effect from… and links to further information. # letters required to be confirmed.	16/07/21	Comms/Strategy/Operations	
2	If supported, proceed with movement of services	19/07/21	Strategy/Operations	

Key:

1: Phase 1 – pre-consultation engagement

2: Phase 2 – public consultation

Appendix 3 – Stakeholders involved

ADVOCATES/THIRD SECTOR GROUPS
Red Cross
Halton Red Cross
Halton Carers
Wired Carers
Deafness Resource Centre
Warrington Disability partnership
Warrington Disability partnership
Speak Up, Warrington
Speak Up, Warrington
Wellbeing enterprise
Healthwatch Warrington
Healthwatch Halton
Council of Faiths
Age UK Mid Mersey
Warrington MENCAP
Warrington Voluntary Action
Halton and St Helen's VCA
Halton and St Helen's VCA
Halton Older People Empowerment Network (OPEN)
Warrington Deaf Centre
Warrington Lifetime (older people)
Bipolar Group
Alternative Futures
Deafness Support Network
Older Persons Forum
Warrington MS Society
Warrington Mencap Leisure
Cheshire Autism Practical Support ChAPS
Citizens Advice Warrington
Clair's Parents Meeting Parents ADHD Supp
Community Integrated Care
Healthwatch Warrington
MNDA South Lancs Branch
Muscular Dystrophy Lymm & Warrington
Room at the Inn
Spinal Injuries Association
SWAN uk syndromes with no name
Talking Matters Warrington
The Brain Charity
Torch Trust for the Blind
Warrington & Vale Royal College
Warrington BSL Signing Choir
Warrington Stroke Association
Warrington Wolves Charitable Foundation
Wired
Veterans Hearing Support
Autism Together

Young Disabled Persons Forum
Warrington Parents & Carers
Home Start Warrington
Families United
WYC - Warrington Youth Club
Arty Smarty
Accent Warrington & Halton Music Ed Hub
Young Carers Service
Warrington Speak Up
Warrington Armed Forces Community Support
WECA - Warrington Ethnicity Community Assoc
The Proud Trust Warrington
Conservative Cllr and Helping Hands
Directions for Men (male group)
Offload via Wolves Foundation
CAB Halton
CAB Warrington
Arthritis Action.

MEMBERS PARLIAMENT	Party	Constituency
Andy Carter	CON	Warr South
Charlotte Nichols	LAB	Warr North
Derek Twigg	LAB	Halton
Mike Amesbury	LAB	Weaver Vale

PARTNERS	ORGANISATION
Prof Steven Broomhead	Warrington Borough Council
Cllr Russ Bowden	Warrington Borough Council
David Parr	Halton Borough Council
Cllr Rob Polhill	Halton Borough Council
Dr Andy Davies	Warrington CCG and Halton CCG
Maria Austin	Warrington CCG and Halton CCG
Simon Kenton	Warrington Together
Colin Scales	Bridgewater Community Healthcare
Simon Barber	North West Boroughs/Merseycare
Jackie Bene	C&M Healthcare Partnership Chief Officer
Alan Yates	C&M Healthcare Partnership Chair
General	C&M Healthcare Partnership
Edna Boampong	C&M Healthcare Partnership
Enquiries Team	University of Chester

Appendix 4 Equality Impact Assessment

The law requires that any new service, significant change in service, reduction or removal of service has an equality impact assessment to see if there are negative impacts, i.e. direct or indirect discrimination on particular people because of their protected characteristic, relating to the action.

Any change to function, provision or policy that may have an effect on people would automatically be subject of the Equality Act 2010. The parts of the acts that are 'engaged' (i.e. that would be active in relation to this proposal) would be:

- Section 4 – protected characteristics
- Section 13 - direct discrimination
- Section19 – indirect discrimination
- Section 20 – duty to make adjustments
- Section 29 – provision of a service
- Section 149 – Public Sector Equality Duty

Equality Impact Assessment documents:

- Set out the detail of the change in relation to the equality legislation.
- Analyse the input from interested parties.
- Identify any concerns and worries related to equality issues.
- assess the impact of change against the health inequalities duty
- Propose recommendations for committees to consider.
- Determine if the Public Sector Equality Duty (PSED), section 149 Equality Act 2010 has been met.

Summary: Equality Assessment (EA)

- The majority of consultees supported the proposal and rich feedback provided relating to equality concerns
- Public Sector Equality Duty will be met subject to actions and mitigations being actioned.
- Consultation was conducted and responses were received across the demographic spectrum
- No appreciable discrimination was discerned although people who were unsure or disagreed with the proposal had legitimate concerns about accessibility – chiefly transport, and mitigations have been set out to resolve this, predominately awareness raising of the alternative methods available
- Further awareness raising relating to the continuation of breast screening services is required to reassure those who misconstrued that the entire service was relocating

Respondent data public consultation (for pre-consultation engagement data see appendix 5)

Equality Impact Assessment (EIA) Reconfiguration of Breast Services		
Initial assessment	**Yes/ No**	**Comments**
• Age	**Yes**	**Positive impact** - Predominantly the 50+ age group would be the main cohort of patients that would utilise this service, however the service is available to all adult (18+) patients and there is no specific negative or positive impact of the scheme from an age perspective. The new service will increase capacity for ultrasound examination, which is used heavily in the under 40 age group, rather than a mammogram. Therefore, there would be faster access to the diagnostic aspect of the service for patients under 40 as there will be double the ultrasound capacity that is currently available, there will not be any additional mammogram capacity available. **Neutral impact** – Both older and younger age groups are statistically more likely to rely on public transport. Therefore the relocation of some services to CSTM from Warrington may have a negative impact in terms of costs for people living in Warrington requiring public transport for travel. It is also important to note that there are a very similar number of people living in Halton who will benefit from the proposed relocation as they will see travel times reduced. The Trust can provide significant mitigation to anyone likely to see a negative impact through the provision of the **free** shuttle bus service which travels frequently between the Warrington and Halton sites.
• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	**Yes**	**Positive Impact** - The new department will be a significant environmental improvement to the current provision at Kendrick Building, Warrington, with HBN compliant disability access throughout the whole department. The unit will: • Be located on the ground floor, there will be no need for lift access, and there are no ramps required to access the main building or the unit itself. • Provide all rooms that meet the minimum HBN compliant sizes with door widths accommodation wheelchairs needs and transport trolleys if needed. • Include a main reception desk that has disabled access incorporated into its design and a hearing loop.

• Gender reassignment	**Yes**	• Provide a patient toilet that meets accessible toilet requirements. It should be noted that representatives from Warrington Disability Partnership were specifically invited to attend the virtual consultation session held via MS Teams during the consultation period and did join the call. They asked numerous questions relating to service provision for people living with disabilities during the consultation session, all of which were answered during the session. In addition, the representative was invited to come and tour the proposed new location for the services alongside the existing location to provide direct feedback on the facilities and improved environment. **Positive Impact** - Mental health support has been a significant focus of the scheme development and design with input from patient focus groups (previous patient users) and staff as well as incorporating lessons learnt from other schemes delivered by the design team, this has resulted in: • Inclusion of 2 counselling rooms ensuring optimum privacy and dignity provision and environmental factors that can create a calm and safe environment for 'breaking bad news' and difficult/upsetting discussions: ○ One that is to the back of the unit with no line of sight by the public or other patients ○ One that has direct access of the waiting room but also has a further exit from the room out of the unit and immediately through the front door, should patients wish to vacate the department without being seen ○ A dedicated patient beverage bay to enable the staff to provide hot drinks for patients • Consideration of artwork locations, colours and size throughout the department to create a calm, safe and welcoming environment • Introduction of wall lit pictures for patients undergoing mammography providing a light within the room when main lights are turned down, but also a distraction for what can be a distressing and uncomfortable experience • Inclusion of ceiling back lit picture tiles within waiting rooms space to give the appearance of outside light in areas where windows are not possible • Inclusion of the ceiling back lit picture tiles within the ultrasound room, again to provide a light

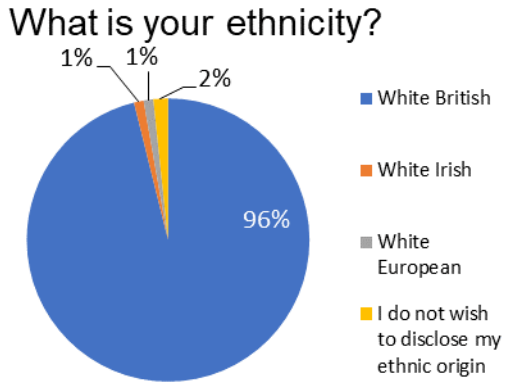
• Race	**No**	within the room when main lights are turned down, but also a distraction for what can be a distressing and uncomfortable experience for some pictures • Ease of wayfinding, to reduce stress and anxiety of trying to locate the unit: ○ The unit is located on the ground floor to the left of main reception, as part of the design the main receptionist will be located at the front desk to greet patients on arrival and direct them to the department door ○ The signage has been considered with the patient focus group and will be clear and visible from the main entrance ○ The CSTM building has adequate parking available for patients reducing anxiety of trying to find a parking space that is experienced at other Trust sites
• Religion or belief	**No**	**Positive Impact** – Transmen will access this service and all privacy and dignity aspects will be considered as they are for all patients, there will be no negative impact. Privacy and dignity for all patients has been a key focus of the design, this is reflected through: • The access to and from the counselling rooms without entering a waiting room directly • Location of the main clinic rooms down a corridor off the main wait area with no direct lines of site or acoustic issues identified • Dedicated accessible patient toilet provision without leaving the department
• Sex	**No**	**None** - No impact positive or negative has been identified for any patient on the basis of race. It is acknowledged that respondents to the public consultation were predominantly white, heterosexual females of Christian beliefs and this was also true of the responses received during the pre-consultation engagement. The Trust directly reached out to all known BAME community groups across Warrington and Halton during the consultation period to ensure they were aware of the proposals and the various ways through which they could get their views heard. The Trust also made the offer to come and consult directly with representatives from these communities separately if that was desirable.

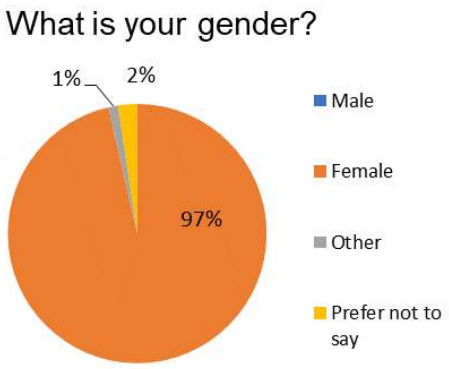
• Sexual orientation including lesbian, gay and bisexual people	**No**	All consultation materials were made available in alternative (non-English) languages. **None** - No impact positive or negative has been identified for any patient on the basis of religion or belief. It is acknowledged that respondents to the public consultation were predominantly white, heterosexual females of Christian beliefs and this was also true of the responses received during the pre-consultation engagement. The Trust directly reached out to all known community groups covering different religious beliefs across Warrington and Halton during the consultation period to ensure they were aware of the proposals and the various ways through which they could get their views heard. The Trust also made the offer to come and consult directly with representatives from these communities separately if that was desirable.
• Marriage and civil partnership	**No**	All consultation materials were made available in alternative (non-English) languages.
• Pregnancy and maternity	**No**	**Neutral impact** - Predominantly the female sex would be the main cohort of patients that would utilise this service (99%), however the service is available to all adult patients and there is no specific negative or positive impact of the scheme from a gender perspective. Privacy and dignity elements as explained above in 'gender reassignment' apply to all patient accessing the service. Feedback was received during the pre-consultation engagement around ensuring that male patients felt comfortable using the spaces and it was felt that the current location in Kendrick Wing felt quite "female orientated". This was discussed with the wider project team during the subsequent consultation period. The estates project team confirmed that the interior design of the new location was deliberately gender neutral and the operational team have identified alternative sub-waiting areas for male patients who perhaps feel less comfortable waiting in the main waiting areas with a number of female patients. **None** - No impact positive or negative has been identified for any patient on the basis of sexual orientation. It is acknowledged that respondents to the public consultation were predominantly white, heterosexual females of Christian beliefs and this was also true of the responses received during the pre-consultation engagement. The Trust directly reached out to all known

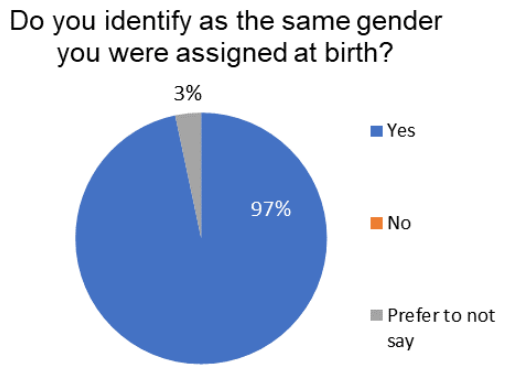
		community groups covering different sexual orientations across Warrington and Halton during the consultation period to ensure they were aware of the proposals and the various ways through which they could get their views heard. The Trust also made the offer to come and consult directly with representatives from these communities separately if that was desirable. **None** - No impact positive or negative has been identified for any patient due to marriage and civil partnership status. **Positive impact** – The new service will increase capacity for ultrasound examination, which is used heavily in the under 40 age group, rather than a mammogram. Therefore, there would be faster access to the service for patients under 40 as there will be double the ultrasound capacity that is currently available, there will not be any additional mammogram capacity provided as part of the scheme.
Is there any evidence that some groups are affected differently?	Yes	It has been identified that should patients from Warrington wish to access the CSTM site for their treatment there would be travel involved and this would potentially include toll charges on the Runcorn bridges. For those patients who have limited funds available this could be a barrier to choosing the new purpose designed facility. The Trust can provide significant mitigation to anyone likely to see a negative impact through the provision of the **free** shuttle bus service which travels frequently between the Warrington and Halton sites. No other groups have been identified that may be affected differently.
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	No	**None** – No potential discrimination has been identified
Is the impact of the document likely to be negative? • If so can the impact be avoided? • What alternatives are there to achieving the document without the impact?	No	Consultation to date with patients, staff and members of the public has been very positive and it is not anticipated that this document will affect that. Responses to both the pre-consultation engagement and the formal consultation have indicated that a good majority of people (>63%) are either “in favour” or “strongly in favour” of the proposals.

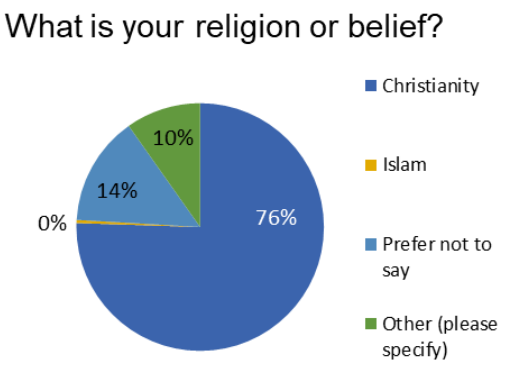
• Can we reduce the impact by taking different action?		
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the Human Resource Department together with any suggestions as to the action required to avoid /reduce this impact. For advice in respect of answering the above questions, please contact the Human Resource Department.		
Was a full impact assessment required?	**No**	It has been determined that a full impact assessment is not required at this stage. However, as part of the public consultation this EIA will be revisited and if any aspects are identified that require a full assessment that will be completed at that stage
What is the level of impact?	**Medium/High**	**Positive impact**

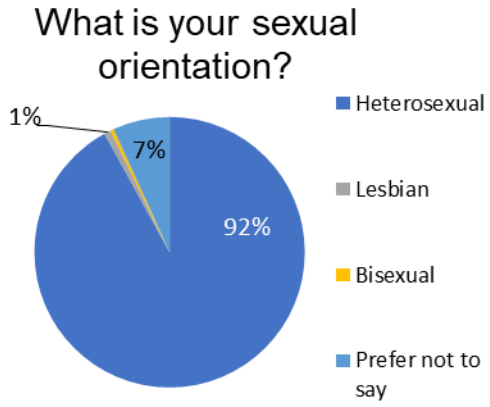
Respondent data

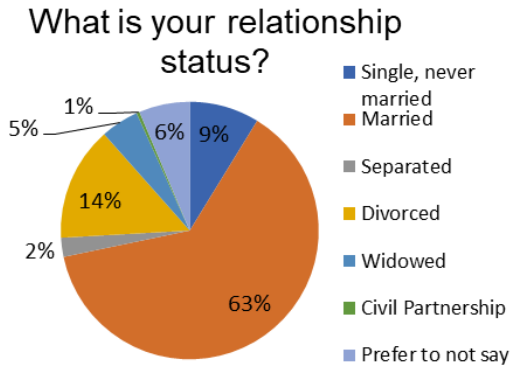


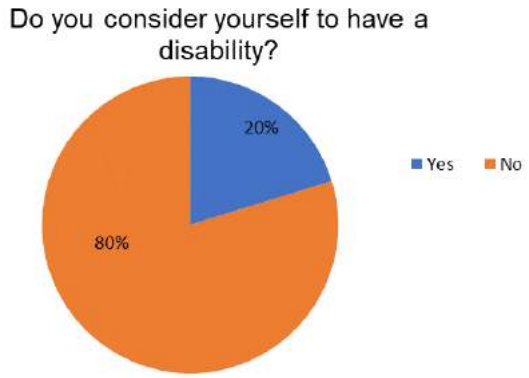


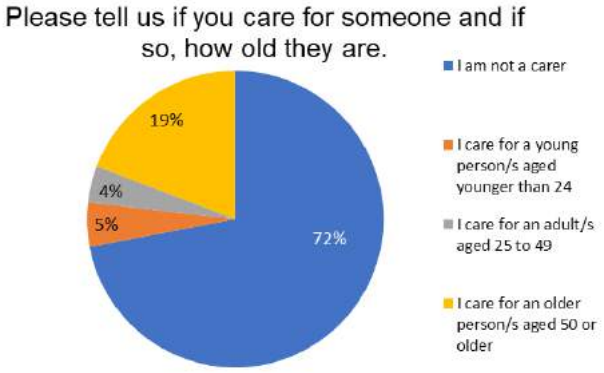

Do you identify as the same gender you were assigned at birth?
3%
97%
Yes
No
Prefer to not say


What is your religion or belief?
10%
14%
0%
76%
Christianity
Islam
Prefer not to say
Other (please specify)


What is your sexual orientation?
1%
7%
92%
Heterosexual
Lesbian
Bisexual
Prefer not to say


What is your relationship status?
1%
5%
6%
9%
14%
2%
63%
Single, never married
Married
Separated
Divorced
Widowed
Civil Partnership
Prefer to not say


Do you consider yourself to have a disability?
20%
80%
Yes
No


Please tell us if you care for someone and if so, how old they are.
19%
4%
5%
72%
I am not a carer
I care for a young person/s aged younger than 24
I care for an adult/s aged 25 to 49
I care for an older person/s aged 50 or older

APPENDIX 5 PRE-CONSULTATION ENGAGEMENT OUTCOMES

Pre-consultation engagement has taken place during April and May using the following three methods:

- Electronic online questionnaire advertised via Trust channels incl. social media.
- Hard copy paper questionnaire sent to a large sample of patients from the current caseload.
- MS Teams Live sessions with an open invite to all interested parties

Total Responses

152 responses were received
42 from online survey
110 from paper forms returned to Trust

82% of all respondents that provided an answer have accessed services in Warrington

	Location accessed:					
Service accessed:	**Warrington**	**Bath St**	**Halton**	**St Helens**	**Mobile**	**No Answer**
Breast Screening	70	22	21	18	7	15
Breast Assessment	42			12		
Outpatient Symptomaic Breast Services	12			6		

Awareness

- 55% of respondents said they were aware of the proposed changes to the Breast Services at Warrington & Halton
- 79% said they had been given enough information to form an opinion on the proposed changes.

Preferred Location

- There was a range of responses to the question of where people would prefer to access Screening services (the highest % chose the CSTM building)
- In total, 73% of all respondents said they would be either “Very Satisfied” or “Satisfied” to access Breast Assessment and Outpatient Symptomatic rapid access breast clinics at the Sir Captain Tom Moore Building

Preferred Location for Screening Services	Total Respondents	% of total
Warrington Hospital	54	28.0%
Warrington, Bath Street	40	20.7%
Captain Sir Tom Moore Building, Halton Site	56	29.0%
St Helens Hospital	22	11.4%
Mobile Breast Screening Unit	19	9.8%
None of these	2	1.0%
	193	

Critical Factors

On average across all respondents, the factors that people felt were most important for them with regards attending a Screening or Assessment location are ranked in order below:

Most important

Waiting time to access the service
Outcome of treatment
Staff expertise
The location of the service
The environment and facilities
Car parking

Least important

Most common themes from comments in response to question *'If we were to implement our proposals to relocate Breast Screening and Assessment and Symptomatic services, please could you tell us how this would affect you or your family/loved ones, or if there is anything else you would like us to consider?'*

- A number of comments regarding additional distance to travel but balanced out by the same volume commenting on improved travel times.
- A number of comments regarding car parking availability – need to emphasise that parking on the Halton site is much better than at Warrington in formal consultation.
- Some confusion around Screening availability in Warrington – need to clarify the point around screening remaining in Warrington as part of formal consultation.
- A couple of negative comments relating to accessing Halton from North Warrington (e.g. Birchwood) – deemed to be a significant journey. Balanced out by shorter travel times for those travelling from South Runcorn. Need to emphasise that patients will retain the ability to choose assessment/symptomatic sites in the formal consultation.
- A few comments around cost of travelling over to Halton – need to emphasise the availability of the shuttle bus service in the formal consultation.
- A few specific comments regarding accessing the Halton site for those with disabilities – need further exploration with the project team during the consultation period.

Most common themes in response to Q: Do you have any reasonable adjustments that you would like us to make if we were to relocate Breast Assessment and Symptomatic Services to The Captain Sir Tom Moore building?

- Signage on the CSTM site to ensure patients are able to navigate effectively.
- Mobility/wheelchair access on the Halton hospital site.
- Consideration around creating a separate waiting area for male patients.
- Consideration around communication methods and providing consultation documents in different languages.

General Response themes: In general, there appears to be a largely positive view from current patients around the proposed changes:

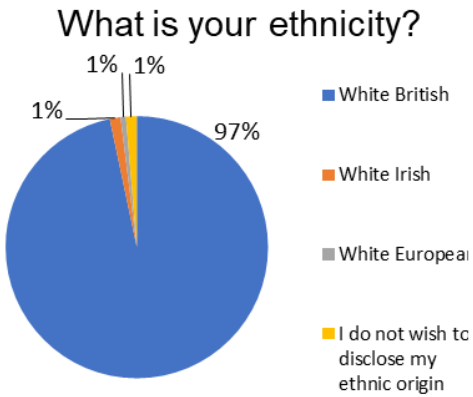
Issues for further consideration:

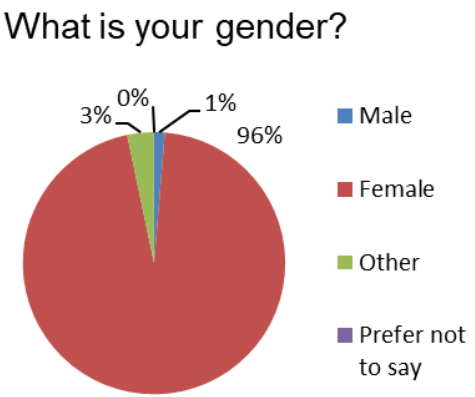
- Diversity of respondents – can we find a way to get views of minority ethnic groups/more men?
- Ensure good access for people living with disabilities.
- Need to emphasise and clarify access to shuttle bus service.
- Need to emphasise and clarify retention of screening services in Warrington.
- Need to emphasise and clarify patient choice for those unwilling/unable to travel to Halton site.
- Some useful feedback for consideration around CSTM set up and service offer.

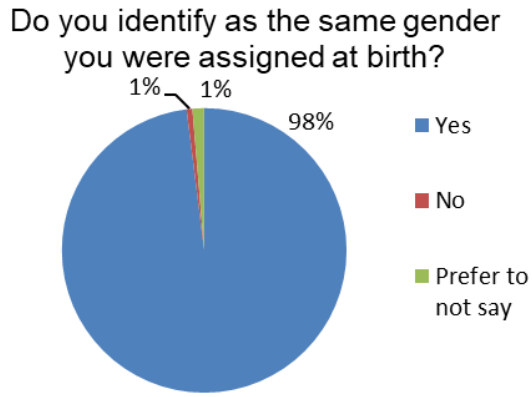
These areas will addressed through improvement of the consultation documents and FAQs.

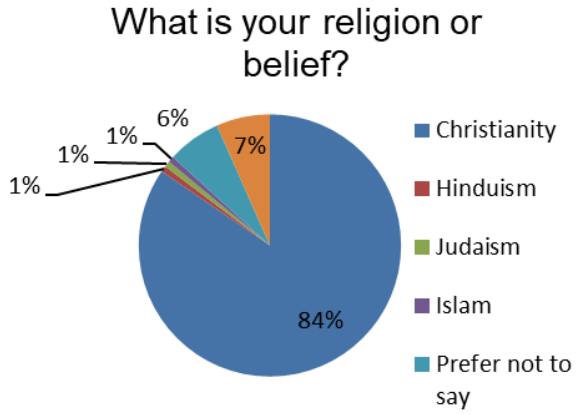
Respondent demographics

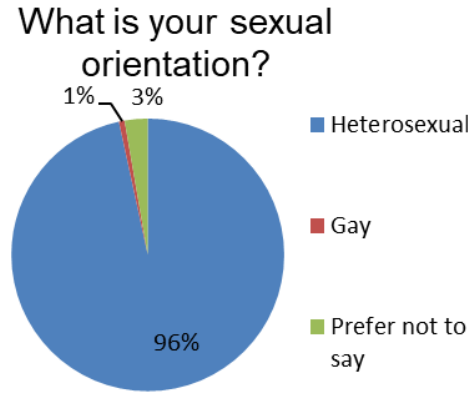
Respondent Demographics (1)

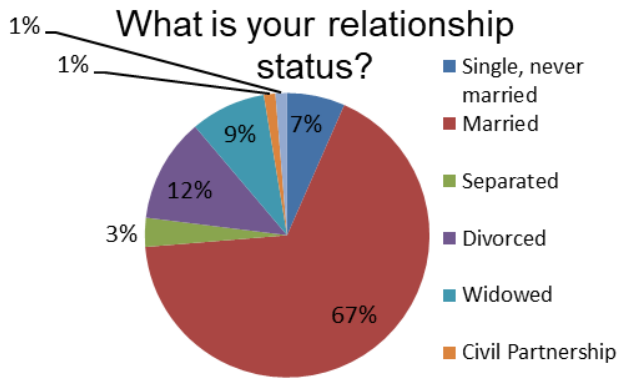




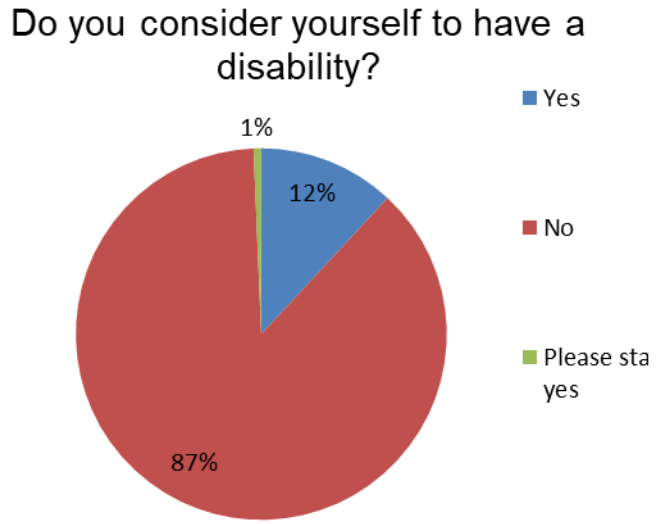


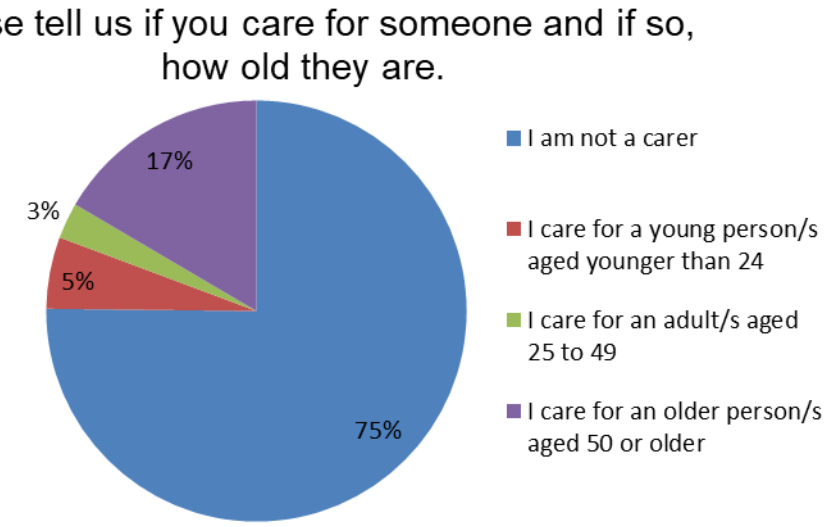






Respondent Demographics (2)





Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/116**				
SUBJECT:	**Outcome of formal public consultation to provide Outpatient Services from Runcorn Shopping City**				
DATE OF MEETING:	28 July 2021				
AUTHOR(S):	Viviane Risk, Strategy Programme Support Manager				
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships				
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	X			
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	X			
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	X			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability, #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision.				
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper summarises the outcome of the recent formal public consultation to provide Outpatient services from Runcorn Shopping City.				
PURPOSE: *(please select as appropriate)*	Information X	Approval	To note	Decision	
RECOMMENDATION:	It is recommended that the Board note the outcomes of the recent public consultation and the decision to progress the service development.				
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.			
	Agenda Ref.				
	Date of meeting				
	Summary of Outcome				
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full				
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Outcome of formal public consultation to provide Outpatient Services from Runcorn Shopping City**	**AGENDA REF:**	**BM/21/07/116**

1. BACKGROUND/CONTEXT

The Trust currently provides Outpatient services for Audiology, Ophthalmology and Dietetics from both the Warrington and Halton sites with Dietetics clinics also being provided from St Paul's Health Centre in Runcorn.

A 6 week period of formal consultation commenced on the 7th May 2021 seeking the views of the public on the proposal to provide these three services from a Health Hub in Runcorn Shopping City. The formal consultation followed a 3 week period of pre-consultation engagement.

The period of consultation ended on Friday 18th June 2021.

2. KEY ELEMENTS

The proposal is as follows:

Ophthalmology:

1) Relocation of Ophthalmology services currently delivered at Halton Hospital to Runcron Shopping City, including paediatric orthoptic and optometry clinics and paediatric visual processing clinics.
2) Replicating some services that are currently only delivered at Warrington Hospital in Runcorn Shopping City, including glaucoma assessment clinics, cataract pre- and post-operative clinics, ophthalmology primary care clinics for new patients, and neuro-ophthalmology clinics.
3) Plans are being developed to offer a new Hydroxychloroquine screening service, not currently provided by the Trust, at Runcorn Shopping City. This service would screen rheumatology patients to assess their suitability for Hydroxychloroquine treatment and provide routine monitoring.

Audiology:

1) An expansion of current services, delivered at Halton Hospital. Services would continue to be offered at Halton Hospital resulting in an increase of capacity and allowing more patients to be seen each week. Services include assessment, fitting and repair of hearing aids.

Dietetics:

1) Consolidation of clinics currently delivered at both Halton Hospital and St Paul's Health Centre and delivering these from Runcorn Shopping City. Clinics include two general paediatric clinics and five general adult clinics per week.

The above proposals will allow Halton residents to stay in Borough to receive care and will significantly increase capacity and therefore access to these services.

No services will be moving from Warrington Hospital and patients will still be able to decide where they attend their outpatient appointment.

Consultation Methods

Consultation and engagement with the public around the proposals has taken place using the following four methods:

- Electronic online questionnaire advertised via Trust channels incl. social media;
- Hard copy paper questionnaire circulated to each service;
- Face to face consultation sessions at Warrington Hospital, Halton Hospital and Runcorn Shopping City (adhereing to social distancing guidelines);
- Open invite MS Teams Live sessions presented by the Director of Strategy and Partnerships and the service leads with Q&A.

3. EVALUATION & MONITORING

569 responses to the questionnaire were received in total - 254 during the formal consultation period and a further 315 during the period of pre-consultation engagement.

507 of the responses were received via the online survey (221 during consultation and 286 during pre-consultation) and the remaining 62 were received via paper forms returned to Trust (33 during consultation and 29 during pre-consultation).

75% of respondents during the consultation period said they were aware of the proposals. 62% said they had been given enough information to form an opinion on the proposed changes.

In total, **51%** of all respondents during the consultation period supported the proposals. 11% somewhat supported the proposals.

58% of respondents during the consultation period would be happy to have their Ophthalmology appointment at Runcorn Shopping City. 58% would be happy to have their Audiology appointment at the new proposed location, and 55% would be happy to have their Dietetics appointment there.

The common questions emerging from the public feedback was as follows:

Theme	Detail	Response during consultation
Concerns over privacy	Concerns were raised over the privacy of patients attending medical appointments in a public setting.	The unit will have window films to provide privacy and ensure the waiting areas are not easily visible by those passing by. The reception desk is set back from the main entrance.
Concerns over use of tax payer funds	Specific concerns about the use of tax payer money, as the holding company of Shopping Ciy uses offshore banking and the estate at Halton is viewed as under utilised and investment should be made there instead.	The commercial sensitivity of negotiations was stressed, so figures were not shared. Confirmed that space at the Halton site will be reallocated as clinically appropriate and used effectively.
Concerns over the future of Halton Hospital	Moving services off the Halton Hospital site was seen as the start of 'dismantling' the hospital and closing it down. Questions were raised over why the money was not being used to invest in the hospital site instead, for example to demolish or refurbish 'the blocks'.	Significant emphasis has been placed on the plans to develop Halton as the Trust's elective site, and that we are fully engaged with the process to bid to secure funds to build a new hospital on the Halton site. It was explained that the money from Liverpool City region is from a pot specifically aimed at regeneration of town centre and retail spaces, and that the services has been selected as appropriate to be delivered from this space. The space the services vacate will be allocated to other appropriate services.
Concerns around public transport provision	Some respondents were concerned about needing to travel from Warrington to attend an appointment in Runcorn Shopping City, specifically those with mobility issues or those who rellied on a family member or friend for transport.	Assurance was provided that patients will still be able to access services in Warrington, and that this is an expansion only.

The outcomes from the formal consultation were presented to Halton's Health & Wellbeing Board on 7th July 2021. The presentation and proposals were met with widespread support.

The outcomes from the formal consultation were shared with the WHH Executive Team on Tuesday 13th July 2021. The Executive Team confirmed the decision to progress with the proposals.

The outcomes of the consultation will be shared with the public via our Trust website following the WHH Trust Board on 28th July 2021.

Tender submissions for the construction phase were received midday Monday 19th July and assessed by the panel on Friday 26th July. The contract will be awarded w/c 2nd August 2021. Construction is due to complete mid-November.

4. RECOMMENDATIONS

It is recommended that the Trust Board note the outcomes of the recent public consultation and the decision to proceed with the proposals to deliver outpatient services from Runcorn Shopping City.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/117**			
SUBJECT:	**Quality Strategy**			
DATE OF MEETING:	28th July 2021			
AUTHOR(S):	Layla Alani, Deputy Director Governance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Quality strategy describes: • Key achievements over the past three years that have impacted and influenced the quality of care and standard of services delivered at WHH. • Describes the Quality Priorities agreed over the coming year 2021/22. • Outlines areas of focus to optimise quality across the organisation over the next three years.			
PURPOSE: *(please select as appropriate)*	Information	Approval	**To note**	Decision
RECOMMENDATION:	The Quality Strategy has been approved by the Quality Assurance Committee. The Board of Directors are asked to note the Quality Strategy 2021-2024.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/06/157		
	Date of meeting	1 June 2021		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Quality

We will..... **Always put our patients first** through high quality, safe care and an excellent patient experience

WHH QUALITY STRATEGY 2021-2024

We are WHH & We are PROUD to make a difference

Foreword

Warrington and Halton Teaching Hospitals NHS Foundation Trust is dedicated to the provision of high-quality care and clinical excellence. Recognising that our patients and staff deserve nothing less than OUTSTANDING, we have embarked on an organisation-wide journey called 'Moving to Outstanding'.

Simon Constable

Chief Executive

We will... **Always put our patients first** delivering safe and effective care and an excellent patient experience.

We are proud to present our Quality Strategy 2021 - 2024 which is built upon the foundations of our Quality, People and Sustainability Framework (QPS).

Over the past three years we have achieved so much and have evidenced the delivery of high-quality care despite the challenges of the Covid-19 pandemic. The new three year Strategy will focus upon our continued commitment to deliver the highest quality of care to our patients and optimise health outcomes. This will be supported by our plans to become a recognised 'outstanding' organisation.

Having focussed on delivering continuous quality improvements over the past three years we are now seeking to deliver a more comprehensive strategic approach that embeds quality within the very fabric of everything we do, ensuring high quality safe care. This will be further enhanced by the exciting introduction of our newly established Halton Clinical Research Unit. We will continue to ensure that care is delivered in an open, transparent and compassionate way. We will continue to drive the Trust's Quality Strategy priorities as noted below. These will be refocused and agreed each year.

Priority 1 We will reduce avoidable harm and patient deterioration with focus on COVID-19 recovery by managing and reducing clinical and operational risks.

Priority 2 We will improve patient outcomes, based on evidence and deliver care in the right place, first time, and every time.

Priority 3 We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for.

The areas we have chosen to focus on as priority areas are:

- Gram Negative Bloodstream Infections (GNBI).
- Improvement in the communication process for DNACPR.
- COVID-19 Recovery.
- Embedding the Medical Examiner role, including community implementation.
- Ensure effective decisions about health care are based on the best available, current, valid and reliable evidence.
- Clinical Business Unit (CBU) governance to be strengthened further.
- Implementation of the End of Life Serious Illness Programme.
- Development and implementation of the Trust Learning Disability and Mental Health Strategies.

- Improve the standard and choice of food available to patients.

The priorities have been chosen based upon national and local drivers and our internal governance intelligence. Emphasis remains upon working across organisational boundaries in partnership with others and across the Integrated Care System (ICS), to ensure that we provide efficient and safe patient pathways to optimise health outcomes and improve the experience for our patients.

Welcome to Our Quality Strategy 2021- 2024

In 2018, we launched our first Quality Strategy which outlined our commitment to prioritise quality above all else. Our new three-year Strategy will build upon this commitment to support all staff in our aspiration to become an 'outstanding' organisation.

This Quality Strategy details our ambitious plans to deliver sustained, significant and continuous improvement to the quality and safety of the care that we provide for our patients. Quality Improvement (QI) will continue to be an integral part of everyone's daily work with learning shared effectively across the organisation.

We will continue to work towards a culture which encourages innovation, experimentation and change. This will be supported by the additional investment made in 2020 for Quality Improvement and the newly opened Halton Clinical Research Unit.

Covid-19 has brought a number of challenges over the past year, but staff have evidenced exemplary leadership capability, creativity and innovative ways of working to deliver high quality, safe care in the most challenging of times. The learning gained through this period will influence the way in which we deliver our services to ensure, safety, efficiency and a positive patient experience across all services.

Kimberley Salmon-Jamieson

Chief Nurse and Deputy Chief Executive

It is well recognised that all Trusts will be met with challenges as part of Covid-19 recovery and we are committed to ensure that all staff are supported and equipped to meet these challenges whilst driving the standard of care delivered to all of our patients. We remain committed to our aspiration of becoming an 'outstanding' Trust that delivers the highest standards of care to all patients, all the time, building upon our 2019 Care Quality Commission (CQC) inspection where the Trust was awarded a 'Good' rating.

We look forward to working with staff to support the implementation of this Strategy which will be monitored by our Board of Directors, Quality Assurance Committee and by our public and partners through the reporting of measurable success detailed within our Trust Annual Quality Account.

Thank you all for your continued hard work.

Alex Crowe

Executive Medical Director

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our Mission, Vision, Values, Aims and Objectives

Our Mission

We will be outstanding for our patients, our communities and each other

Our Vision

We will be a great place to receive healthcare, work and learn

Our Objectives

Quality

We will... **Always put our patients first** delivering safe and effective care and an excellent patient experience.

People

We will... **Be the best place to work** with a diverse and engaged workforce that is fit for now and the future.

Sustainability

We will... **Work in partnership** with others to achieve social and economic wellbeing in our communities.

We are WHH and together we make a difference

Our Values

Working Together | Excellence | Inclusive | Kind | Embracing Change

Introduction

Who We Are:

Warrington and Halton Hospitals NHS FT comprises of two acute (secondary) care hospitals across two sites in the Boroughs of Warrington and Halton, making us part of the mid-Mersey health economy. Warrington Hospital is the home of all our emergency and complex surgical care and maternity services while Halton General Hospital and the Captain Sir Tom Moore facility in Runcorn is a centre of excellence for planned routine surgery.

Although each hospital focuses on aspects of care, we provide outpatient clinics for all our specialties and diagnostic (scanning) services at both Warrington and Halton sites so patients can access their appointments closer to home wherever possible. We also provide some outpatient services in the local community.

In delivering the NHS Long term plan (2019) we are part of the Cheshire and Merseyside Health and Care Partnership, the second largest Integrated Care System in the country; integral in both One Halton and Warrington Together 'place based' health and social care systems. We serve a population of 330K across both boroughs and employ over 4,200 staff comprising 52 nationalities.

We became a Foundation Trust in 2008 and have over 15K 'members' across the boroughs of Warrington, Halton and surrounding areas and occasionally beyond. These members are represented by our Council of Governors comprising public (elected), staff and partner governors who are committed to representing the views of service users and public within their constituencies.

What Guides Us – Our WHH Values

Our work is underpinned by our values statement which sets out five value sets: These values and associated behaviours will support the creation of a compassionate, inclusive and high-quality care culture that enables excellence in quality and safety to flourish.

Embedding Our WHH Values into Our Quality Strategy

This Quality Strategy is an enabling Strategy that supports the delivery of our overall Strategy. This Quality Strategy sets out our plans and commitment for the next three years to put our patients and our communities at the heart of what we do. Work will continue building strong partnerships **Working Together,** to have an unrelenting focus on **Embracing Change** and improving the quality and safety of our services, to deliver our ambition to be as productive, **Inclusive** and efficient as we can be. The experiences of our colleagues and our patients will continue to be the most important measure of our progress. It is the delivery of this Strategy, together with the supporting strategies of patient experience, people and our sustainability plans that will ensure that we act with kindness as role models to deliver **Excellence** in quality, safe and sustainable health and care services for the local population of Warrington and Halton and beyond.

What Are We Trying to Accomplish?

Quality is our number one priority: 'We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority', it is the first strategic objective of the Trust under the Quality domain.

This Quality Strategy is a guide for all colleagues, patients and governors to ensure that we deliver excellent care, every time, to every patient. Our aim is to create a culture of continuous improvement and learning which are both patient-centered and safety- focused.

A national Patient Safety Strategy (NHS England 2019) focuses on three aims. Our Strategy for quality is based on the same three aims. These are:

1) To be world leading at drawing insight from multiple sources of information.
2) To give staff at all levels the skills and support they need to improve safety and quality so that they can be the infrastructure for improvement working with patients and partner organisations.
3) To decrease harm in key areas by 50% by 2023/24 and beyond through specific initiatives targeted at safety and improvement.

To do this, we must create the conditions where we:

- Listen to and include the views of our staff and key stakeholders.
- Have access to and actively use the comprehensive evidence base from the medical and nursing literature to ensure that we use the best interventions to improve the quality of care that we provide.
- Provide clinical staff with the data that they need to make the best decisions about clinical care.
- Fully embed the Trust Values in everything that we do in order to ensure the working environment is conducive to the enablement of continual improvement and innovation.
- Actively engage with and enable staff to lead and deliver measurable change for improvement.
- Focus on human factors and how we deliver care as teams.
- Are open and honest with people when things go wrong and make sure that we learn from errors.

We must ensure that we create the culture of learning, openness, transparency and candour consistent with the recommendations of national reports such as Learning not Blaming, the Francis Report, the Kirkup

Report, A Promise to learn, a commitment To Act, and the Public Administration Select Committee's report into Clinical Incidents.

The outcomes of this Strategy links closely to those described in the Trust's Quality Accounts and the Care Quality Commission's (CQC) domains of safe, effective, caring, responsive, and well-led. This Strategy will be delivered through the implementation of an annual Quality Plan and progress of each priority is monitored and reported on a quarterly basis to the Trust's Patient Safety and Clinical Effectiveness Sub Committee which reports into the Quality Assurance Committee. Where possible we include performance indicators to measure and benchmark our progress. This is reported on a monthly basis, via the Quality Dashboard to the Board of Directors.

The annual Quality Plan will contain specific priorities in addition to local quality indicators outlined in this document. Our current Quality Plan 2020/21 continued to run as planned until March 2021.

Our WHH Strategy

Our Mission is:

We will be OUTSTANDING for **our patients**, our communities and each other.

We are committed to achieving our mission together with our patients (our experts by experience), their carers and families; our staff and volunteers, our partners and members of the public - in fact everyone who uses or works within our services or may do so in the future.

This means a commitment to creating opportunities for the participation of all groups, ensuring that ways and means to engage are accessible to all and that all voices are heard, and views are considered and incorporated wherever possible in-service delivery, design and transformation.

We recognise the links between staff engagement and public engagement, and value of the contribution that our staff make. At the same time, we are committed to ensuring that when care is needed, that patients, their families and carers have the best possible experience. We have set out our goals in our Patient Experience Strategy.

1. *We believe every patient should have the opportunity to give feedback about their experience and we promise to use this to improve care and services.*
2. *We believe our patients should be first in everything we do, and we promise to communicate based on what matters most to you*
3. *We believe our patients should always experience care that is based on their specific needs and we promise to work in partnership with you and your carers to achieve best possible outcomes*
4. *We believe every patient should experience care and treatment in the right environment and we promise to continuously improve what you can see, do, hear and feel during your stay.*
5. *We believe that our processes should be designed to support our patients and we promise to develop these so that everything is simple, done in a timely manner and easy to understand.*

Our WHH Strategic Quality Objectives

At Warrington and Halton Teaching Hospital NHS Foundation Trust our strategic aim is to always put our patients first through high quality, safe care and an excellent patient experience. We will achieve this aim through our three strategic Quality objectives.

Our 3 strategic objectives under the **Quality domain** are:

Patient Safety - We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyones top priority.

Patient Experience - By focusing on patient experience we want to place the quality of patient experience at the heart of all we do where ''seeing the person in the patient''is the norm.

Clinical Effectiveness - Ensuring practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients.

Our Quality Strategy has been developed to ensure patients are safe in our care, to provide patients with the best possible clinical outcomes for their individual circumstances and to deliver an experience of hospital care which is as good as it possibly can be.

With this care model in mind we use the following three priority domains:

- **Patient Safety Domain**
- **Patient Experience Domain**
- **Clinical Effectiveness Domain**

Defining Quality?

The NHS Five Year Forward View (NHS England 2014) highlights that the definition of quality in health care is enshrined in law and includes three key aspects: patient safety, clinical effectiveness and patient experience. A high-quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients.

The *NHS next stage review* (Department of Health 2008) also defined quality based on the same three criteria which will shape the Trust's approach to quality and our quality governance framework:

- **Safety:** doing no harm to patients.
- **Effectiveness of care:** including preventing people from dying prematurely, enhancing quality of life and helping people to recover following episodes of ill health.
- **Experience of care:** this should be characterised by compassion, dignity and respect.

The NHS Outcomes Framework (Department of Health 2017) (Appendix 1) and the Care Quality Commission's Key Lines of Enquiry (CQC 2018) safe, effective, care and well led are also based around Lord Darzi's (2008) domains which cannot be viewed each in isolation but as interlinked, with equal importance being placed on each (Doyle, Lennox , Bell 2013). In addition, each of the domains is influenced by leadership (Well-led) or resources (Sustainable use of resources) as outlined in the diagram.


Well-led
Positive experience
(caring and responsive)
High-quality,
person-centred
care for all
Safe
Effective
Sustainable use of resources

Local Quality Indicators

Our current Quality Improvement Strategy has run as planned until the end of March 2021.

In **year one** of this Strategy 2021/22, there are three priorities and nine new local quality indicators, with new stretched local quality indicators to be identified commencing in **year two** and becoming fully embedded in **year three.**

Year one 2021/22 local quality indicators are listed below and detailed in the 'Plan on A Page' below.

Patient Safety Domain

- Gram Negative Bloodstream Infections – A 5% Reduction in Gram Negative Bloodstream Infections (GNBSI).
- Improvement in the communication process for DNACPR
- COVID-19 Recovery, waiting list management, appropriate clinical review oversight

Clinical Effectiveness Domain

- Embedding the Medical Examiner role across the Trust and Community Services.
- Ensure effective decisions about health care are based on the best available, current, valid reliable evidence.
- CBU Governance to be strengthened ensuring consistency across the organisation.

Patient Experience Domain

- Implementation of the End of Life Serious Illness Programme
- Development and implementation of the Trust Learning Disability and Mental Health Strategies.
- Nutrition- to ensure that patients have access to a choice of food and nutrition.

OUR 2021–22 QUALITY PRIORITIES

The improvement aims	The quality priorities	The outcome
IMPROVE PATIENT SAFETY 	1. DNACPR - improving communication with patients and families 2. COVID-19 recovery - robust waiting list management with senior clinical oversight 3. Gram-negative bloodstream infections - achieving a 5% reduction	A safety and learning culture where quality and safety are everyone's priority
IMPROVE CLINICAL EFFECTIVENESS 	4.Medical Examiner - embedding the service and piloting community roll out 5.Evidence based interventions - effective decisions based on the best evidence 6.CBU governance - strengthened and consistent across the organisation	Doing the right things, the right way, to achieve the right outcomes for our patients
IMPROVE PATIENT EXPERIENCE 	7.End of life Serious Illness Programme - improving care and communication 8.Learning disabilities and mental health - implementing and embedding our strategy 9.Nutrition - To ensure that patients have access to a choice of food and nutrition.	Patient experience at the heart of all we do, seeing the person in the patient

Quality Governance Framework - Assurance and Scrutiny

Quality Governance Framework

Quality Governance is the combination of structures and processes at and below Trust Board level to ensure and assure the quality of our services, together with systems to monitor and assure the Trust Board of Directors. These are listed below.

- ## Board of Directors

The Board of Directors has overall responsibility for the services that we deliver and is accountable for operational performance as well as the implementation of Strategy and policy. A quality dashboard is reported monthly to the Board of Directors. Where possible we include performance indicators to measure and benchmark our progress against each quality improvement priority and local quality indicators.

- ## Quality Assurance Committee

The Quality Assurance Committee provides assurance to the Trust Board of Directors in respect of clinical quality and patient safety, effectiveness and experience through robust reporting and performance monitoring.

- ## Patient Safety and Clinical Effectiveness Sub Committee

The progress of each priority is reported on a quarterly basis to the Trust's Patient Safety and Clinical Effectiveness Sub Committee which reports into the Quality Assurance Committee.

- ## Clinical Business Units

There are six Clinical Business Units within the Trust, who report into the Executive Directors and provide assurance on Strategy and risk management performance of the Clinical Business Units. The Clinical Business Units are supported by 'Clinical Support Services' as well as 'Corporate Support Services'.

- ## Commissioning for Quality and Innovation (CQUIN) Schemes

This is a programme of work focusing on delivering key quality outcomes for patients, rather than process outcomes. The delivery of schemes is via teams from across our clinical care groups supported by colleagues in information technology and governance so that improvements in quality in specified areas of care are fully embedded in a sustainable

- ## Clinical Audit

Clinical audit is designed to improve patient outcomes. Its purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care.

Clinical Safety Domain

Quality Governance and Shared Quality Improvement Learning

Established governance processes for the assurance of quality and safety across the Trust are in place. Regular Quality Assurance meetings also take place with Warrington and Halton Clinical Commissioning Groups aswell as monthly interface meetings.

Over the next year, we aim to establish a new collaborative assurance arrangement for quality issues which are jointly owned by the CCG and the Trust to ensure that we are exploiting every opportunity to improve quality across care pathways which span primary and secondary care.

- For example, WHH currently monitors *Clostridium difficile* infections within the Trust and is held to account for incidents where preventable infections occur. Some of these infections arise within community settings and are not attributed to the Trust, yet there may be opportunities for the Trust to share learning and expertise in order to prevent these community acquired infections. A joint governance arrangement may allow a population health-based approach to reduce the overall number of infections and reduce the overall impact of this infection.
- For 2021/22, we will focus on Increasing the improvement capability and capacity across the Integrated Care System through the sharing of training and learning opportunities from the Quality Improvement approaches undertaken by the Quality Academy.

In addition, in order to deliver this new Quality Strategy, these objectives will be extended to include assuring Warrington and Halton Partners of Health and Care of quality standards being met forming part of the newly emerging Integrated Care System. This integrated approach to health and care will be delivered through care bundles and care pathways to ensure that people are cared for as close to home as possible by the appropriate professional, and only admitted to hospital when they really need acute care. The Quality Strategy has the potential to greatly improve the health of people living within the Warrington and Halton locality and beyond.

Care Bundles

Care Bundles are ‘best practice’ clinical interventions, with an applied research base, that involve key clinical management steps that have been demonstrated to improve patient outcomes. The quality goals for 2021-24 will include achieving national benchmarks for implementation of the care bundles building on the work for stroke, frailty, Acute Kidney Injury (AKI), Venous Thromboembolism (VTE), Sepsis and the SAFER patient flow bundle.

GIRFT, Right Care and Model Hospital

The Trust acknowledges the value of utilising best practice evidence and benchmark data to improve outcomes. As such, the Clinical Business Units (CBU’s) are actively engaged in the GIRFT programme and utilising the Right Care and Model Hospital data. During 2019/20, the Trust reviewed the current systems and processes which support the engagement in these programmes with a more robust system being implemented in 2020/21 and embedded in 2021/22 and beyond. This is to ensure a consistent, coordinated and rigorous approach to analytical review and implementation of recommendations with an overall aim to reduce unwarranted variation; to improve care, outcomes and to reduce cost.

Care Pathways for long-term conditions

Clinical Safety Domain

The Trust acknowledges the value of a care pathway as a tool that enables practitioners to provide better health care and better patient outcomes at a lower cost. The Trust will continue to focus on implementing NHS Right Care Pathways which support local health systems to think strategically about designing optimal care for people (and their carers) with long term or high impact conditions. Right Care is a programme committed to reducing unwarranted variation to improve people's health and outcomes and reduce inequalities in health access, experience and outcomes. It makes sure that the right person has the right care, in the right place, at the right time, making the best use of available resources https://www.england.nhs.uk/rightcare/what-is-nhs-rightcare/

The quality goals for 2021-24 will include achieving implementation of the Right Care Pathways and building on the work for:

- **Cardiovascular and Respiratory conditions:** Embed the national priority initiatives for NHS Right Care Pathway for cardiovascular and respiratory conditions.

- **Frailty:** Embed the NHS Right Care Frailty Pathway and Toolkit which supports systems to understand the priorities in frailty identification and care, and key actions to take. It provides opportunity to assess and benchmark current systems to find opportunities for improvement.

- **Epilepsy:** Embed the NHS Right Care Pathway and toolkit for epilepsy, focusing on the key components for epilepsy care across the system and reducing unnecessary emergency care for people living with epilepsy.

Maternity Quality Indicators

This Quality Strategy is an important link to the WHH Maternity Services Strategy as it sets out additional measures to drive improvement further and faster.

We aim to put the family at the centre of decisions so that all women, babies and their families get the highest quality of care which meets their needs, and improves their overall physical, mental and emotional wellbeing.

To support this we will:

- Collect and share data on the quality and delivery of our maternity services as outlined in the Maternity Performance Indicators dataset.
- Support local teams in reviewing data and undertaking service improvement.
- Review the Ockenden report and implement the 7 immediate and 26 local safety actions; and benchmark ourselves against the actions until full compliance is achieved.
- Monitor ongoing compliance with the implementation of the NHS Litigation Authority (NHSLA) 10 safety standards for maternity services ready for submission on 15 July 2021.
- Analyse the summary of themes arising from the Healthcare Safety Investigation Branch (HSIB) maternity programme and implement the safety recommendations and learning to improve systems and processes in order to reduce risk and improve safety
- Undertake a gap analysis on all MBRRACE reports to inform maternity care from the UK.
- Review the report of the National Maternity Review Better Births: Improving outcomes of maternity services in England and implement the recommendations to improve outcomes of the maternity services.
- Undertake a gap analysis using the perinatal safety surveillance tool and taking timely and proportionate action to address any concerns identified.
- Utilise the maternity self-assessment tool to help maternity services achieve sustained improvement across the five CQC domains – i.e. are services safe, effective, caring, responsive to people's needs, and well-led.
- Develop Maternity Voices Partnerships (MVPs) to provide a mechanism for ongoing feedback and co-design of services and, at their best, enable co-production on maternity.
- Work in collaboration with other partners to promote overall population health including alongside Local Authorities and Public Health. This includes early years, 0-19 years, and speech and languages services to ensure the greatest start for families.

National Quality and Safety Indicators

As well as recognising well-led services, the Accountability Oversight Framework (Department of Health 2017) enables early identification and support if performance falls below the expected level. Safety measures are weighted and override all other measures, ensuring that safety is central to every Hospital, including WHH's Strategy and that leadership teams are held to account for the quality and safety of their services.

The detail of the metrics included in the Safety and Patient Experience domains of the Accountability Oversight Framework are provided below for information. The metrics within the Accountability and Oversight Framework demonstrates the important link with the local quality indicators within this Quality Strategy.

Accountability Oversight Framework Domain Key Performance Indicators	
Patient Safety	**Patient Experience**
Hospital Standardised Mortality Ratio (HSMR)	Friends and Family Test (FFT) % Extremely Likely
Summary Hospital-level Mortality Indicator (SHMI)	Complaint Volumes (trends)
Mortality outlier alert	Complaints not responded to by day 35
Never Events	PALS Concerns Volumes (trends)
Attributable/avoidable Infection Prevention &Control (IPC) indicators (MRSA, CPE, VRE, Clostridium Difficile)	Ward/department accreditation progress and outcomes (continuous improvement profile)
Trainees satisfaction score (Annual Rating Only)	Food and Nutrition Patient Experience Survey
Falls with harm (3-5) by patient bed day	Pain Management Patient Experience survey
Fairness and effectiveness s of reporting score (Annual Rating Only)	**Workforce and Leadership**
Pressure ulcers (Grade 3+ avoidable	Attendance
Confirmed level 5 harms	Turnover (Rolling 12m)
VTE Risk Assessment	Engagement Score (quarterly)
Delayed Transfers of Care	Appraisal - Medical
Clinical Operational Excellence	Appraisal - Non-Medical
Diagnostic Performance Confirmed level 5 harms A&E	Appraisal Quality (quarterly)
4 Hours Arrival to Departure	Trust Mandatory Training - Clinical
RTT - 18 Weeks (Incomplete Pathways)	Trust Mandatory Training - Corporate
Cancer Urgent 2 Week Wait Referral	Nurse Retention
Cancer 2 Week Wait breast Symptom	BME Staff Retention
Cancer 31 Days First Treatment	Band 5 Nursing & Midwifery Turnover (Rolling 12m)
Cancer 31 Days Sub Surgical Treatment	% Band 5 Nursing & Midwifery Vacancies vs Est (Rolling 12m)
Cancer 31 Days Sub Chemo Treatment	
Cancer 62 Days RTT	Medical Agency Spend (£k)
Cancer 62 Days Screening	Proportion of appointments that are internal

Clinical Safety Domain

Cancelled operations - rescheduled <= 28 days	Median time to complete ER Investigations
12 hour trolley waits	**Strategy**
Finance	Existence of a Strategy
Delivery of Financial Plan	Existence of annual plan
	Delivery against plan

Research and Innovation

At both Warrington and Halton Hospital sites we participate in studies to promote medical research and improve care in the future for certain conditions. These studies are large studies that often involve many patients in many different hospitals.

Our Research and Development (R&D) Department works closely with the clinical Business Units within the hospitals to ensure we can offer patients the opportunity to participate in high quality research that has been approved by an independent ethical body.

The Trust recognises that participation in clinical research demonstrates our commitment to improving the quality of care we offer both by helping ensure our clinical staff stay abreast of the latest possible treatment options and because active participation in research leads to successful patient outcomes.

The Research and Development department is funded by the National Institute for Health Research and takes part in nationally funded studies, and real life patient stories on these can be found here. In addition, WHH have recently opened the Halton Clinical Research Unit (HCRU) and are developing a partnership board with Liverpool University Hospitals NHS Foundation Trust (LUHFT). Our own dedicated research and clinical trials facility at our Halton Hospital site supports our research ambitions and aims to widen participation in research across Warrington, Halton and surrounding areas.

To support this, we will:

- Support our staff to develop skills in research and innovation.
- Routinely offer patients in all specialities the opportunity to participate in high quality research studies.
- Build research activity into our measures of performance and clinical quality.
- Strengthen research governance and expand the research and development support function.
- Increase the research activity of the Trust and the research income from national funding bodies.
- Develop strategic partnerships with neighbouring organisations to increase our research potential.
- Actively translate research into practice to improve clinical and quality outcomes
- Work closely with our commercial development team to identify opportunities to generate income, reinvest and drive quality of care through best evidence and innovation.

In order to support research, over the next three years we will:

- Maintain or improve the number of research trials available for patients to participate in and
- Improve the number of patients participating in clinical research trials.
- Maintain and improve performance in initiating clinical trials and studies.
- We will collect regular feedback from patients who have experienced care as part of a research study through:
    - patient satisfaction surveys,

Clinical Effectiveness Domain

- friends and family initiatives and
- regular public engagement events.

The Health Education England (HEE) Research & Innovation (R&I) Strategy identifies the importance of a workforce that embraces R&I as being central to improving the quality of care and patient experience. Historically, practice-based research has more commonly been developed by medical practitioners, with non-medical professionals predominantly supporting research delivery. We aim to redress this balance and over the next three years we aim to promote Nursing, Midwifery and Allied Health Professional (NMAHP) Research and a three year vision with the overarching aims of:

- Increasing research awareness amongst NMAHPs
- Increasing the use of research in practice by NMAHPs
- Increase the number of NMAHPs participating in research, and
- Increase the volume of research studies undertaken and led by NMAHPs.

The link between research active organisations and those that deliver the highest quality care is clear and so our commitment to research will be essential if we are to continually improve the quality of the services we deliver.

Identifying Quality Improvement Priorities

How we identify our improvement priorities – stakeholder engagement.

The Trust has a duty to fully engage with stakeholders and members to ensure that we are listening to their views on quality and Quality Priorities moving forward.

The Trust Quality Priorities have and will continue to be identified through receiving feedback and regular engagement with governors, staff, patients, the public, and commissioners of NHS services, overseeing scrutiny groups and other stakeholders. This will ensure that the quality of care delivered meets the needs of the population that we serve. Progress on the planned improvements will be reported through the Trust's Quality Assurance Committee and ultimately through to the Board of Director's.

Our staff, governors, members and patients are the eyes and ears of the organisation and their views are constantly sought to ensure that we are focussing on the things that will make the most difference. We surveyed staff, patients and visitors, through the Staff Survey and the Friends and Family Test and from those results we capture the views of the staff and wider public in relation to the range of priorities.

Quality Improvement Across the Integrated Care System (ICS)

Quality Improvement in Our Healthcare System

Our partnerships make us stronger; by investing in them, we will deliver the best possible care to our communities.

Working in partnership across the Integrated Care System has been a fundamental part of our improvement journey so far and we will continue to underpin all our work as we continue that journey.

Our drive to improve the quality of care delivered across our communities will see the Trust work increasingly though partnerships across our localities. We will develop our role as part of an integrated offer, working more closely with our Commissioners and with other local providers, including GPs, Community and Mental Health Trusts, and colleagues in Social Care. This drive to improve care through collaboration is reflected through the recent Integration and Innovation White Paper, which outlines the requirements for system working. We will work as part of a joined-up system across Cheshire and Merseyside, contributing to and learning from best practice across the region, and working to ensure equity of care for our communities.

We are already involved in several projects which achieve these aims and have more planned to deliver over the next 3 years. These include:

- Our New Hospitals Programme
- The creation of a Clinical Services Hub in Runcorn Shopping City
- Development of the Warrington Town Deal Health and Wellbeing Hub, and the Runcorn Town Deal and Education Hub
- Partnership with University of Chester
- Enhanced partnership working with St Rocco's Hospice
- Prevention Pledge and Social Value Award
- Supporting elective recovery
- Developing workforce models to support best patient care across our localities
- Developing a continuity of carer model across our midwifery services

In addition to measuring the quality improvement activity within our hospital, we are now looking to measure activity within the community and increasingly across care pathways which span the primary and secondary care divide. Quality issues that were formerly the province of one part of the healthcare system are now shared by the whole Integrated Care System. We are starting to look jointly with our partners at the opportunities for quality improvement.

Clinical Effectiveness Domain

To support this we will:

- Develop streamlined clinical pathways and delivery of seamless care with partner organisations.
- Ensure that service and care pathway design is informed by patients, families and carers.
- Develop a Communication and Engagement Strategy that has building partnerships at its core.
- Demonstrate the behaviours needed as an organisation to foster strong relationships – open, honest, committed to putting our patients, colleagues and communities first.
- Create opportunities to more effectively collect, evaluate and act on the opinions and ideas that are fed back through our partners.
- Engage with and empower our colleagues, encouraging them to innovate and use best practice by removing the barriers to progress. We will make it easier to turn good ideas into practice.
- Cement our partnerships and joint working arrangements through the use of patient enabled IT across health organisations and people's homes.
- Recognising that the local, neighbourhood needs of citizens will vary across Warrington and Halton and beyond; our partnerships must add personal value to the citizens and colleagues alike.
- To deliver outstanding care, both now and in the future. We will encourage academic and commercial partners to work with us and be innovative, bringing the very best health outcomes for our citizens.

Quality Improvement Priorities

The Board of Directors, in partnership with staff and Governors, has reviewed data relating to quality of care and agreed our quality improvement priorities for 2021/22 as outlined below:

Priority 1: We will reduce avoidable harm and deterioration and focus on COVID-19 recovery by managing and reducing clinical and operational risks.

Priority 2: We will improve outcomes, based on evidence and deliver care in the right place, first time, and every time.

Priority 3: We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for.

In order to embed the above three quality improvement priorities, we have established nine local quality indictors to support their implementation. The priorities have been chosen based upon national and local drivers and our internal governance intelligence, identifying areas for improvement. Emphasis remains upon working across organisational boundaries in partnership with others, to ensure that we provide the efficient and safe patient pathways to optimise health outcomes and experience for our patients.

Full details of the Patient Safety, Clinical Effectiveness and Patient Experience nine local quality indictors can be seen in the next section below.

The Way Forward - Our Approach to Quality Improvement

Achieving this vision will require us to build upon our experience using the Quality Improvement approach which has created an enthusiasm and a focal point for colleagues wanting to improve the services that they deliver. We need to go beyond this and equip our staff with the skills and capacity to systematically improve the quality of care.

To ensure continuous improvement across all aspects of our work, we will continue to support staff to lead improvements by providing education and training in skills and practices within quality, safety and effectiveness.

We will continue to work with the Innovation Agency and external partners to embed a culture of innovation within the Trust. Through working with the Innovation Agency, we will improve health and care and generate economic growth. This is a key aspect of both the Quality and Quality Academy Strategies.

We will connect with regional networks of the NHS and academic organisations, local authorities, the third sector and industry by responding to the diverse needs of our patients and populations through partnership and collaboration.

We will continue to provide Foundation Quality Improvement (QI) Practitioner level training sessions which provide staff with the foundation of quality improvement. The Kaiser Permanente dosing formula describes the numbers of staff that should have a certain level of quality improvement skills to build capability and capacity for improvement within an organisation. The Trust are working toward achieving 100% compliance and are on trajectory to achieve this by March 2021 in accordance with Kaiser Permanente recommendations.

The Quality Academy has created a bespoke improvement training programme for the Trainee Workforce (Foundation Year 1 to Specialist Trainee 8) which will continue to be delivered by the Quality Improvement Specialist and the Clinical Audit Manager for Foundation Year doctors. They will also be provided with a pick list of audits and improvement projects that relate to Trust priority audits and quality improvement work, enabling them to contribute to the Trust quality improvement work.

Improving quality requires leadership and expertise at all levels of service delivery. The step change in quality improvement in the next three years will come from a generation of quality improvement specialists, equipped with the knowledge and skills of improvement methodology which can be applied across the whole organisation and right down to the microenvironment of individual patient care. Our focus will be on training of this increasingly numerous groups of individuals and investing in them to provide the impetus for large scale quality improvement. Progress will be monitored, measured and reported quarterly through the Quality Academy Board, and a quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities.

Measuring, Monitoring and Publishing Quality Improvements & Performance

The Trust maintains its commitment to delivering high quality services by monitoring effectiveness and studying outcomes. The Quality Assurance Committee will oversee the implementation of this Strategy, holding Clinical Business Units (CBU) Clinical Directors and Senior Leadership Teams to account for local delivery of the Strategy.

We will continue to be open and transparent, publishing progress against our Quality Priorities at our Quality Assurance Committee and public Board meetings. We will do this by producing a monthly Integrated Performance Dashboard and Quality Dashboard Report outlining the Trust's performance against each of the quality domains.

Moving forwards, we want to continue to improve the way we present and share data by using sophisticated data analysis methods including statistical control charts. By continuing to improve the way we display data it will make it easier for staff, from the ward to the Board, to understand where we are making improvements and where we need to increase our efforts. Continual measurement will also help us ensure that any improvements we do see are sustainable in the long term.

The Care Quality Commission's (CQC) Insight reports will also play an important role in the way we measure the quality of our care. The Trust is now on a journey to achieve a CQC rating of 'Outstanding' and this document will assist us in monitoring our performance and detecting any deterioration that needs to be addressed. The CQC 'Insight' report is a data dashboard and is produced on a monthly basis. It provides an overview of the various indicators for risk and quality as monitored by the CQC and gives some indication of the level at which the CQC currently rates each provider. Each month an Integrated Performance Report Dashboard will be presented to the Board containing the salient sections of the CQC 'Insight' report focusing on any areas of change since the last update was received.

We look forward to assuring the Board of Directors and the Integrated Care Partnership over the coming years about how this new Strategy is being implemented and reporting the quality improvements that it will bring to the health and care of people who live across Warrington and Halton and beyond. Our aim is to ensure that all staff who work in our hospitals strives for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients. We will also continue to produce an annual Quality Account which will be our way of demonstrating to the public the progress we have made against our Quality Priorities each year and what we plan to improve in the succeeding year. This document will also demonstrate our delivery of CQUIN Schemes and our commitment to participating in all relevant national audits, and the outcomes of which provide another vital means of measuring the quality of our services.

Setting a Clear Direction and Priorities

Quality and Safety are routinely placed on the top of the Trust's agenda. Each Trust Board meeting starts with a patient story with a focus on quality and safety ensuring that the message is clear to all – this is our priority and we will ensure there is always time to discuss quality and safety issues.

This commitment to quality and safety has also been demonstrated by the Clinical Business Unit Clinical Directors who advocate, advise and steer the direction of the quality and safety agenda within the organisation. The Clinical Directors are highly motivated and clinically credible individuals who, by working closely alongside the Trust's senior nursing leadership, act as 'champions' for the quality and safety agenda, offering strategic leadership on key priority areas and helping to develop a culture for continuous improvement by role modelling within the organisation.

Successfully managing quality relies on commitment, consultation and co-operation with all staff from the ward to the Board. Each year discussions with the Board of Directors, the Council of Governors, patient representatives, staff and public will take place in order to ensure Quality Priorities are identified to focus efforts for the coming 12 months. We will ensure the Quality Priorities are appropriate, meaningful and resonate with all. Data and evidence will also play a vital role; each year we will ask where there is scope for improvement and in which areas is the quality gap the greatest?

The feedback from our front-line staff, Governors and patients will help set core Quality Priorities that have an overarching impact across the organisation. Whilst these will change year on year, it is likely that the following will always focus in some guise:

Patient Safety Domain:

- Reducing avoidable harm and deterioration
  - Reducing healthcare acquired infections
  - Reducing medication errors
  - Reducing Serious Harm Falls
  - Reducing Hospital Acquired Pressure Ulcers
  - Safe staffing levels.
- COVID-19 Recovery, waiting list management
- Focus on having no avoidable deaths by reducing clinical and operational risks
- Increasing incident reporting and learning from error; Implement the NHSE Patient Safety Response Framework (PSIRF) which will replace the current Serious Incident Framework when launched.

Clinical Effectiveness Domain:

- Ensuring mortality rates are at least within expected limits
- Participating in national and local audits
- Effective safe discharge.
- Improve outcomes, based on evidence: such as National Institute of Clinical Excellence (NICE) and
- Deliver care in the right place, first time, and every time. Getting It Right First Time (GIRFT)

Patient Experience Domain:

- Focus and acting on what patients tell us and co-creating solutions to challenges they face
- Involving patients in their care and embracing the 'no decision about me without me' philosophy.
- Ensuring nutrition and hydration for patients:
  - MUST risk assessments are completed daily.
  - Weekly re-screening of MUST and appropriate dietetic referral if MUST ≥2
- Get the basics right so our patients will be warm, clean, and well cared for.

Equality, Diversity and Inclusion Quality Indicators

Providing High Quality, Accessible and Responsive Services, With Focus Upon Population Health and Health Inequalities

As a Trust, we remain committed to promoting equality and diversity amongst our workforce, ensuring our services and employment practices are fair, accessible, and inclusive for the diverse communities we serve and the workforce we employ. This is reflected and reinforced in our 'vision and values', celebrating diversity and creating an inclusive culture for our patients and workforce.

We take steps to ensure that we are a great employer which values and welcomes the different ideas, skills, behaviours and experiences of our colleagues. We also aim to foster a culture that promotes wellbeing and mental health and provides support to enable all our colleagues to thrive.

For our patients, we pledge for 'Better Health Outcomes for All' and to 'Improve Patient Access and Experience'.

To support the achievement of this and 'Improving Our Quality' for patients we will:

- Ensure we provide a positive patient experience for all patients regardless of their identity and protected characteristics.
- Ensure accessible information and communication with patients.
- Ensure the recording of equality data so that reasonable adjustments are identified and provided.
- Aim to reduce health inequalities by advancing equality of opportunity for all patients.

In order to demonstrate that we are achieving this and 'Improving Our Quality' for staff we will:

- Ensure that WHH is a fair and inclusive employer of choice.
- Ensure equitable career progression for all staff groups and for staff of all protected characteristics.
- Foster talent which is fair and inclusive.
- Monitor staff experiences and respond appropriately.
- Ensure fair recruitment processes.
- Develop case studies to improve awareness and understanding of different protected characteristics amongst staff and patients.
- Ensure equality and diversity is championed and embedded at a local level across the trust.
- Seek assurance that services are delivered in a way that is consistent with the Public Sector Equality Duty

In addition, WHH will ensure that we will:

- Continue working towards meeting the requirements of the anticipatory duty to make reasonable adjustments on public functions in the Equality Act.

Patent Experience Domain

- Enhance the equality, diversity and inclusion workstream to focus on all protected characteristics for patients and workforce through engagement with community partners.

Conclusion

We are confident that by implementing this Strategy and continuing to **always put our patients first** and put patients at the heart of everything we do; we will continue to ensure that our services are safe, effective, caring, responsive and well-led.

By working hard to foster a culture of continuous improvement, by empowering staff and patients to make the changes they want to see, we will continue to deliver the best possible care to the people of Warrington and Halton and beyond.

We will monitor the implementation of this Strategy closely and look forward to working together to make the Warrington and Halton NHS Teaching Hospitals NHS Foundation Trust even better.

References

Care Quality Commission (2017). Key lines of enquiry prompts and ratings characteristics for healthcare services. Available at: https://www.cqc.org.uk/sites/default/files/20170609_Healthcare-services-KLOEs-prompts-and-characteristics-FINAL.pdf

Department of Health (2017). NHS Outcomes Framework. Available at: http://www.NHS Outcomes Framework.uk

Department of Health (2008). High quality care for all: NHS Next Stage Review final report. Department of Health; London.

Doyle C, Lennox L, Bell D (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open.

NHS England (2019). Patient Safety Strategy. Available at: https://www.england. patient-safety-Strategy/

NHS England (January 2019). NHS Operational Planning and Contracting 2019/20 which can be accessed via the following link: https://www.england.nhs.uk/rightcare/what-is-nhs-rightcare/

Additional Information

For more information about our Quality Strategy and programmes please contact:

Clinical governance and Quality Department Tel: 01925 662789

Warrington and Halton NHS Teaching Hospital NHS Trust

Lovely Lane, Warrington WA5 1QG

www.whh.nhs.uk

If you would like to receive this document in another format, please do not hesitate to contact us.

Cantonese:
如果你希望以另外一種格式接收該資訊，請和我們聯絡，不必猶豫。

Gujarati:
જો તમને આ માહિતી બીજી રચના કે ફોર્મેટમાં મેળવવાની ઇચ્છા હોય, તો કૃપા કરી અમારો સંપર્ક કરતા અચકાશો નહિ.

Hungarian:
Kérjük, vegye fel velünk a kapcsolatot, ha más formában kéri ezt az információt.

Polish:
Jeżeli chciał(a)by Pan/Pani otrzymać niniejsze informacje w innym formacie, prosimy o kontakt.

Punjabi:
ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿਚ ਇਹ ਜਾਣਕਾਰੀ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰਨ ਤੋਂ ਨਾ ਝਿਜਕੋ।

Urdu:
اگر آپ اس معلومات کو کسی اور صورت میں حاصل کرنا چاہتے ہیں تو برائے مہربانی ہم سے رابطہ کرنے میں ہچکچاہٹ محسوس نہ کریں۔

We will... **Always put our patients first** delivering safe and effective care and an excellent patient experience.

2021

—

2024

Three Year Plan

Contact us:

Warrington and Halton Teaching Hospitals
Lovely Lane,
Warrington,
WA5 1QG

01925 635911

www.whh.nhs.uk

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/07/118**	
SUBJECT:	**Health and Safety Annual Report**	
DATE OF MEETING:	28th July 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	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.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1207** Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The paper outlines the statutory requirement to report on the Health and Safety work undertaken throughout the 2020/2021. This has been impacted by the Covid-19 pandemic and the requirement for additional assurances with regard to both staff and patient health and safety are detailed within this paper. Work undertaken throughout 2020/21 has focus upon: • Ensuring health and safety measures have been put into place to ensure constantly changing legislation has been implemented throughout the COVID pandemic • Ensuing policies and procedures have been updated appropriately • Ensuring that the Trust meets its legal obligations on having health and safety statutory risk assessments in place • Ensuring incidents are reported and investigated appropriately • Ensuring action is taken appropriately to safeguard patients, public and staff safety. • Ensuring risks are escalated appropriately	

	The above actions have meant that the Trust has fully discharged its Health and Safety duties. **Assurance statement –** There is an established pro-active safety management system within the Trust with clear processes and procedures to ensure compliance with all relevant health and safety regulations. Due to the COVID pandemic, 2020 has seen a constant change to existing and new legislation, the Trust has met the requirements of this legislation and will continue to update systems and processes should any further future changes be applied.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	**To note**	Decision
RECOMMENDATION:	The Board of Directors is requested to note the Annual Report as a means of assurance that Health and Safety risks within Warrington and Halton Hospitals NHS Foundation Trust are being properly managed and controlled.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/07/193		
	Date of meeting	6th July 2021		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Health and Safety Annual Report 2020/21	AGENDA REF:	BM/21/07/118

1. BACKGROUND/CONTEXT

It's been a particular challenging year within Health and Safety ensuring that the Trust is keeping up to date with new legislation and guidance which has constantly changed and evolved throughout the pandemic, as well as ensuring that the Trust remains compliant with existing legislation.

The paper describes Health and Safety (H&S) activity across the Trust over the past 12 months including the assurance of systems and processes put in place for the management of Health and Safety throughout the pandemic.

The management of Health and Safety remains a critical component of the overall Governance agenda, with the safety of patients and staff being a core value. This will form part of a Trust look back exersize to support a national enquiry expected to take place next year.

2. KEY ELEMENTS

2.1 Health and Safety Training

The following health and safety training is in place. A large number of the training sessions available are mandatory and this is recorded on the Trust central system – ESR. Monthly compliance reports are sent out via the Organisational Development Team.

Topic	Training Requirements
Health and Safety Training for Senior Managers	Booklet to be read and signed 3 yearly
Health and Safety Training	E-learning to be completed 3 yearly
Non-Clinical Manual Handling	Classroom or e-learning to be completed 3 yearly
Clinical Manual Handling	Classroom training to be repeated every 2 years
Working at Height	Departmental based annually

The programme consists of:

- Health and Safety Awareness Training for all Staff – This is a general awareness of health and safety law and how it is managed throughout the Trust. The training can be accessed via e-learning or a Health and Safety Awareness Booklet

- Health and Safety Awareness for Senior Managers and Doctors – This is a training booklet which provides up to date information on current legislation and corporate manslaughter

2.1.1 Communication and Training throughout the Pandemic

Throughout the pandemic, the provision of information, instruction and training has been essential in ensuring a safe working environment.

2.1.2 Assurance

- The Trust have maintained robust communication methods throughout the pandemic with a robust governance structure in place comprising of a number of cells:
    - Medical
    - Nursing
    - Operational Management
    - Infection prevention and microbiology
    - Governance. Legal and statutory
    - Procurement
- This has been supported via an overarching Tactical Meeting and Recovery Board as appropriate. This structure has enabled timely escalation to the Strategic Executive Oversight Group chaired by the Chief Executive. This has been held daily throughout the pandemic.
- Communication from ward to Board and vice versa has been supported through modalities such as the daily safety brief and the Chief Executives daily message. Team Brief has run intermittently. All information from the daily safety brief is disseminated to all staff across the Trust. This includes, items discussed, risk assessments and any safety alerts raised.
- A daily COVID19 staff bulletin was developed and disseminated to all staff across the Trust. This has provided detail on training such as fit testing and statistical information.
- Relevant information has also been provided Via Trust Extranet Site.
- The Extranet Site has a dedicated page for Covid-19; to provide advice and information to all staff.
- The Health and Safety Newsletter provides information on hot topics, incident data and lessons learnt from incidents. This is produced bi-monthly.
- All existing Health and Safety training packages have been reviewed throughout 2020 to ensure all instruction, guidance and information is fully up to date with current health and safety legislation.

2.2 Health and Safety Policies

There are a wide range of policies and guidance documents developed and now embedded across the organisation relating to existing legislation and legislation that has occurred as part of the Covid-19 pandemic.

This includes:

- Health and Safety at Work etc. Act 1974
- Management of Health and Safety at Work Regulations 1999
- The Workplace (Health, Safety and Welfare) Regulations 1992
- Manual Handling Operations Regulations 1992
- Control of Substances Hazardous to Health 2002

- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
- The Health and Safety (Display Screen Equipment) Regulations 1992
- The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- Access to Work – Information for Managers and Employees
- Alcohol at Work Guidance
- Blood Borne Viruses in the Workplace
- Colour Vision Examination Guidance
- Confined Spaces – A Brief Guide to Working Safely
- COSHH – Working with Hazardous Substances
- Catering – High Risk Guidance
- Working with Display Screen Equipment – A Brief Guide
- Electrical Safety and You – A Brief Guide
- Understanding Ergonomics at Work
- Examination and Testing of Lifts Guidance
- Work at Height – A Brief Guide
- Basic Advice on First Aid
- Home Working Guidance
- Trust Health and Safety Inspection Guide
- Legionella Guidance
- Lifting Operations Guidance
- Machinery – Using Work Equipment Safely
- Manual Handling Guidance – Making the Use of Lifting Aids
- Manual Handling Guidance – Getting to Grips with Manual Handling
- Trust Noise at Work Guidance
- Aide Memoire – New and Expectant Mothers
- Occupational Health – Working to Prevent Sickness Absence
- Trust Personal Protective Equipment Guidance
- Risk Grading Tool
- Skin at Work Guidance

The Workplace (Health, Safety and welfare) Regulations place a statutory duty on all Trusts to undertake risk assessments. This was significantly impacted by Covid19 to ensure staff safety and welfare with clear mitigation of risk and appropriate control measures. These risk assessments covered the following areas:

- Environmental assessments and inspections
- Equipment assessments
- COVID secure risk assessments
- Clinical risk assessments
- Observation assessments

During the past 12 months the following policies and guidance documents have been reviewed and approved at the Health and Safety Sub Committee meeting:

- Lifting Operations and Lifting Equipment Regulations (LOLER)
- Management of Smoke Free Policy
- Manual Handling of Plus Sized Patients Policy
- Asbestos Policy
- Ventilation Systems Policy

- Lifts Policy
- Safe Operating Procedure for the Monitoring of Oxygen
- Safe Operating Procedure for Oxygen Concentrators
- CCTV/ANPR Policy

2.2.1 Assurance:

All Health and Safety Policies and Guidance documents are fully up to date and the Trust is complaint with all relevant legislation.

2.3 Guidance, Information and Advice

The Health and Safety team, over the past two years, have developed a number of pages on the Trust HUB (now the Extranet) to provide support and advice to Wards and Departments on a wide range of Health and Safety topics. Information includes:

- A Health and Safety Library Page – which provides an A-Z list of all Health and Safety guidance documents, templates and checklists.
- Example risk assessments – this provides an example of risk assessment for each standard within the risk management framework.
- Advice pages on specific topics which include, Slips, Trips and Falls, Stress, COSHH, Display Screen Equipment, Housekeeping, Good Practice, Working at Height.
- Copy of safety alerts developed for any particular issue that may need immediate attention.
- Statistics received from the Health and Safety Executive have been renewed on the appropriate pages.

2.3.1 Health and Safety Newsletter

The Health and Safety Newsletter is produced on a bi-monthly basis and is disseminated to all wards and departments.

The newsletters keep staff informed of “hot topics” as well as raising awareness of safety issues across the Trust. The aim is to provide staff with up to date information on Health and Safety topics throughout the Trust.

Topics covered in the health and safety newsletter over the past 12 months include:

Display Screen Equipment	Hand Hygiene	Sharps Safety
RIDDOR Regulations	COVID Risk Assessments	Environmental Risk Assessments
Working at Height	Fit Testing	Staff Welfare Facilities
Smoke Free Site	Lessons Learnt	Social Distancing
Workstations	Testing Nurse Call Alarms	Non-Patient Manual Handling
Winter Weather Guidance	Top Tips for staying COVID Safe	Quit Smoking
Musculoskeletal Disorders	Driving on Site	Barriers and Segregation
Incident Reporting	Inspections	New RIDDOR Guidance for COVID
Personal Protective Equipment	Face Masks	Respiratory Masks

2.3.2 Assurance:

All guidance, training and information are updated regularly throughout the year.

All information is up to date in accordance with current legislation and can be found on the Trust extranet site.

There is a suggestion section on the Health and Safety newsletter to encourage staff to actively be involved in their health and safety at work with support of the Health and Safety Team.

2.4 Health and Safety Audit Tool

The Risk Management Framework is the basis of the Health and Safety Management System for the Trust. This provides a structure for managers to follow to ensure compliance with legislation in their areas of work.

The tool is the process by which, the Trust can provide assurance that there is an effective system of internal control to monitor Health and Safety risk and continually improve to provide a safe and healthy environment.

The Risk Management Framework consists of a number of standards each supported by a set of performance criteria, policies and guidance. The standards and criteria have been taken from key legal requirements relating to Health and Safety.

Risk Assessments	Night Work
Workplace Transport	Home Working
Control of Substances Hazardous to Health	Fire Safety
New and Expectant Mothers	Display Screen Equipment
First Aid	Incident Reporting
Work at Height	Legionella
Work Equipment	Radiation
Welfare Provisions	Stress at Work
Health and Safety Local Induction	Young Persons
Management of Sharps	Slips, Trips and Falls
Personal Protective Equipment	Management of Ligatures
Risk Assessment Tool	Manual Handling

2.4.1 Assurance:

There are policies and guidance documents in place to assist managers in following processes and procedures which will enable them to reach full compliance.

Due to the Covid-19 pandemic, audits towards the year end were suspended. However the Health and Safety team have ensured that all wards have been supported to optimise compliance with statutory risk assessments by providing these in a pack for clarity. These risk assessments are kept within each individual Department.

The Trust remains compliant with all statutory risk assessments with continual audits of compliance scheduled to take place throughout 2021/22. This will be supported by investment in an additional senior Health and Safety manager.

2.5 Control of Substances Hazardous to Health (COSHH)

To ensure compliance with the Control of Substances Hazardous to Health Regulations, the Trust records the following information on a system called "SYPOL":

- COSHH Risk Assessments
- COSH Control Sheets
- COSHH Safety Data Sheets

To-date, there are 1,192 completed COSHH assessments available with new assessments being added on a regular basis and there are 1,060 different materials used across the Trust.

2.5.1 Assurance

- The majority of products and their activities fall within the category of low risk.
- During May to July 2020 there was an increase of activity with new COSHH risk assessments being completed within Pathology relating to COVID. This shows a proactive and positive health and safety culture with the management of COSHH.
- All new COSHH risk assessments are created, approved and returned to the appropriate Departments to be shared with staff. Compliance will continue to be audited via the Health and Safety team throughout 2021/22. This will be reported and monitored via the Health and Safety Sub Committee.
- Bi-monthly reports are produced and circulated throughout the Trust to ensure Wards and Departments are notified of any updated risk assessments.
- Any substance rated as high is managed with a robust Standard Operating Procedure (SOP), following advice from the safety data sheet and/or manufacturer.

2.6 Inspections

The Health and Safety team have a formal inspection programme in place each year. Observations include:

- The Building and Estate
- The Environment
- Procedures and Assurance Checks

These inspections are unannounced to provide a true reflection of the working environment. If any issues/concerns are highlighted an action plan is provided to the relevant manager. The action plan will be reviewed on the next inspection date to ensure actions are complete or in progress to be complete.

During the pandemic inspections have remained with environmental plans being put into place. This has included an Environmental Action Plan monitored via the Quality Assurance Committee. This successfully led to further strengthen systems of work relating to social distancing, hygiene, cleaning and waste management.

2.6.1 Inspections of Internal Corridors

Corridor inspections for both Warrington and Halton hospitals are carried out by the Health and Safety Team. Findings are recorded and significant issues e.g. damage or waste, are raised immediately to the relevant departments. Reports are generated from the inspections and also any concerns or good practice is highlighted via Communications, Health and Safety Newsletter or safety alerts.

2.6.2 Assurance

The management of Covid-19 has brought many challenges in order to ensure that staff and patients have been protected throughout. This includes:

- All wards and clinical areas have clear curtains to manage the risk of Covid19 transmission whilst ensuring patient safety. These are either attached to the same privacy curtain rail or some areas have had additional tracks mounted. Privacy curtains are pulled across when required for clinical needs to maintain patient dignity.

- All clinical areas have individual environmental risk assessments in place which details controls in place for social distancing including social distancing between bed spaces as per national guidance. Where this has not been achievable due to the layout of the estate, robust risk assessments are in place.

- An inspection programme is in place which is undertaken by the Health and Safety team and a Clinical Lead. The inspections review the controls on all risk assessments ensuring that they have been implemented and are being adhered to. These inspection findings are reviewed at the weekly Silver Command meetings and a formal report will be presented at the Health and Safety Sub Committee from January 2021.

- Weekly observations takes place across all areas within the Trust intermittently to gain continual assurance of Health, Safety and compliance. These are unannounced 20 minute

observations to ensure work activities are being carried out in a safe manner following Trust Infection Control and Health and Safety measures.

- Main entrances have mask dispensers for staff and patients. These have been and continue to be checked on inspections to ensure that there is an adequate supply.

- Weekly corridor inspections take place including stair wells, lifts and waiting areas.

- Chairs have been removed from waiting areas to ensure patients can socially distance by 2 meters. There are stickers within the waiting rooms to ensure that chairs are positioned properly.

- There is a one way system to be followed on the corridors whereby staff and patients must keep to the left to ensure that they can adhere to social distancing rules.

- There is a tight restriction on visiting within the Trust and the limited visits that are permitted to take place have risk assessments in place.

- Estates and Facilities have restricted access to the Hospital by identifying all access points with a number of them being closed.

- In March 2020 the Digital Services Department implemented Microsoft Teams to enable remote meetings to take place and avoid the use of meeting rooms. This further supported the agile working policy.

- An increased cleaning regime was implemented across the Trust for high touch areas such as toilets, door handles, lift button etc. Cleaning is monitored daily by the Task Team.

- Waste Management included additional portering provision put in place by Domestic Services. Additional arrangements were put in place with the external clinical waste contractor for a separate collection of COVID 19 waste. There is a Standard Operating Procedure in place for this.

- The Trust has a traffic light system for contaminated zones throughout the hospital. Red zone is a contaminated zone and green is a clean area. Donning of PPE happens in clean areas outside of the red zone and doffing takes place within the red zones before staff enter a green zone.

- There is a Trust requirement is to have the donning poster outside of a bay or cubicle area and the doffing poster on the inside of the door to remind staff to remove PPE.

- All reception desks have been fitted with plastic screens. The majority of screens are fixed to the reception counters and cover the whole area. There are a number that are

standalone screens but provide the same protection. Applicable reception desks also have taped areas on the floor to maintain appropriate distancing.

- Within a number of areas, offices have been supplied with screens to separate office staff, examples being Postgraduate Centre and Surgical Consultants Seminar Room. The screens are placed in between staff to ensure that distancing and protection is maintained at all times.

- There are over 50 designated PPE Champions throughout the Trust. Posters are displayed identifying information relating to this. The PPE Champions have offered information and advice on PPE and have provide support needed by staff 7 days a week. They have visible across the organisation throughout the pandemic.

- The Trust has in place a Freedom to Speak Up Guardian supported by Freedom to Speak Champions, thus enhancing patient safety and supporting staff to raise any concerns with timely responses provided.

- A paper based COVID19 Workforce Risk Assessment Tool was introduced in March 2020. This was launched electronically in July 2020 alongside the Accountable Manager's Tool which has reduced the risk of staff not completing self-assessments. Human Resources utilise ESR data relating to age, gender and ethnicity to identify high risk groups of staff. The electronic system automatically populates the Accountable Managers tool, indicating that a full risk assessment is required. The tool consists of:
  - An initial self-assessment to be completed by all staff.
  - If any question is answered with a yes than this could potentially identify a vulnerable member of staff.
  - A risk assessment must then be completed by the line manager and member of staff to identify appropriate controls and actions to ensure the safety of the member of staff.

2.7 Display Screen Equipment (DSE) Assessments

The Health and Safety team provide formal individual DSE workstation assessments for members of staff following a referral process undertaken by their Manager or recommendation from Workplace Health and Wellbeing. The assessments generally take place when a member of staff is suffering pain and discomfort at their workstation or they have a pre-existing medical condition.

During the period April 2020 to March 2021, the department carried out 31 workstation assessments for referred staff. 7 referrals were due to previous accidents such as car incidents, falls, heavy gardening, resulting in pain and discomfort. The majority recorded related to health issues such as:

- Disc degeneration.
- Facet joint arthritis.
- Coccyx damage.
- Osteoarthritis
- Osteoporosis.

Reasonable adjustments were made to the workstations and additional equipment purchased such as coccyx cushions, full adjustable DSE chairs with pump action back rests and footrests.

2.7.1 Assurance

The assessments undertaken are to support staff within the workplace to prevent harm or any exacerbation of existing conditions. This is carried out by making reasonable adjustments to workstations.

Additional support and advice is also offered in relation to the setting up of workstations, the use of 2 screens, positioning of the mouse and keyboard with regular breaks from a static position.

During the Covi-19 pandemic the Trust has adopted an agile working policy with staff working from home. The Trust has provided appropriate equipment and advice for these staff where necessary.

2.8 Management of Sharps

The Trust has in place a clear process for the prevention of exposure to blood borne viruses. Safer sharps have been implemented throughout the Trust and areas that could not find a suitable alternative sharp, are required to have an equipment specific risk assessment in place.

The Health and Safety team carried out a sharps audit across the Trust in November 2020.

This included:

- Check areas of compliance, identifying the type of sharps device used in each area.
- To identify any non-safe devices and ascertain why they are still in use.
- To calculate the amount of non-safety devices (old stock) still in circulation.
- To ensure all sharps training is up to date.

The table below shows compliance ratings:
(Due to COVID not all Wards could be accessed at the time of the audit)

	Total
Areas achieving 100% compliance	12
Areas achieving above 90% compliance	8
Areas achieving above 80% compliance	9
Areas not reaching below 80% compliance	7

The audit found no bins overflowing and no items protruding out of the bin.

2.8.1 Assurance:

The Trust has in place arrangements to provide a safe working environment in relation to sharps management, which includes the provision of safe equipment, training and guidance on safe systems of work.

All relevant areas have sharps management packs in place which include information and instruction on the management of sharps. Each area has been provided with an action plan following audits to highlight areas of poor compliance (under 95%) with clear recommendations to ensure full compliance with sharps management. The action plans will continue to be monitored by the Health and Safety team throughout 2021/22 with regular audits undertaken. This will continue to be reported via the Health and Safety Sub-Committee.

2.9 Incidents Reportable to the Health and Safety Executive under the RIDDOR Regulations

2.9.1 RIDDOR Reporting for COVID19

During the pandemic, the Health and Safety Executive (HSE) altered the guidance for RIDDOR in relation to COVID19.

The Trust must now report:

- When an accident or incident at work has, or could have, led to the release or escape of coronavirus.
- A member of staff has been diagnosed as having COVID attributed to an occupational exposure.
- A member of staff dies as a result of occupational exposure to coronavirus.

Member of the public and non- work-related cases are not required to be reported.

To date the Trust has reported one incident on the sad death of an employee. A comprehensive investigation was undertaken as requested by the HSE. This included documentation and assurance of processes and systems the Trust had implemented. The HSE were satisfied that the Trust did not exposed the employee to COVID 19 and have consequently closed the investigation.

2.9.2 Assurance

- It is recognised by the HSE that it will be challenging for any organisation to establish whether or not a member of staff has contracted the virus as a result of their work. The Trust has not made any reports of this nature to date but has actively sought HSE advice as necessary throughout the pandemic.
- All non-clinical incidents are reviewed each morning by the Head of Health, Safety and Risk. Each incident is allocated to the relevant manager for action.
- There is a tracking spread sheet in place to ensure that all information is monitored and relevant actions are in place before the incident is closed.
- The Health and Safety Team investigate any incident that has resulted in loss or harm.
- Data is collected in relation to any lost time incidents due to injury or ill-health.
- A report of incident data is produced bi-monthly and reviewed by the Health and Safety Sub Committee. Throughout COVID the incidents were monitored closely by Health and Safety. For any incidents relating to COVID, a separate spreadsheet was established to record all

relevant information and ensure any reportable incidents were addressed. For assurance: there were no reportable incidents.

- A lessons learnt section is provided in the Health and Safety bi-monthly newsletter.
- There is an additional spread sheet in place to record COVID-19 related incidents. The incidents are reviewed and the Health and Safety Team ensure that a risk assessment is in place. There is then an inspection within the relevant area to ensure controls within the risk assessment have been implemented and embedded.

All non-clinical incidents are reviewed daily by the Health and Safety Team and allocated to the appropriate manager for action.

All incidents reportable under RIDDOR are graded moderate and are fully investigated.

The Table below shows an overview of all RIDDOR Incidents reported within the period April 20 to March 2021. This also includes days lost due to sickness absence relating to the incident.

ID	Month	Department	Work Status	Injuries	Days Lost
141428	April	Grounds	Temp Staff	Bone Fracture	0
142049	May	Theatres	Staff Member	Dislocation without fracture	49
141828	May	A&E Majors	Staff Member	Concussion	11
142688	June	Radiology	Member of Public	Contusions and Bruising	0
142696	June	Ward C20	Staff Member	Burn	27
143265	July	Theatres	Staff Member	Hepatitis C	0
143619	July	Supplies	Staff Member	Sprain and Strain	73
144141	July	Ward A9	Staff Member	Sprain and Strain	9
143679	July	Ward A5	Staff Member	Contusions and Bruising	158
144057	August	Catering	Staff Member	Sprain and Strain	13
144130	August	A&E Majors	Staff Member	Sprain and Strain	20
144320	August	ITU	Staff Member	Contusions and Bruising	43
145306	September	Warrington CT	Staff Member	Sprain and Strain	14
148112	November	Ward B14	Staff Member	Sprain and Strain	14
148244	December	Theatres	Staff Member	Sprain and Strain	24
148652	January	Physiotherapy	Staff Member	Sprain and Strain	7
149093	January	Ward A4	Staff Member	Hepatitis C	0

149422	February	CSTM Theatres	Staff Member	Strain and Sprains	14
150022	February	Ward A6	Staff Member	Strain and Sprains	0
150727	March	CSTM building	Staff Member	Bone Fracture	15
150854	March	Ward B3	Staff Member	Burn	8
151126	March	Corridor	Staff Member	Bone Fracture	0
Total					**499**

2.10 Management of Personal Protective Equipment (PPE)

PPE has been an essential mitigation in controlling the risk of transmission to staff caring for COVID19 patients. There were initial concerns regarding a national shortage of PPE; however the Trust has always maintained a supply of appropriate PPE as advised by the Health and Safety Executive and Public Health England.

2.10.1 Assurance

The management of PPE stock has been monitored daily via the Tactical Group and reported via the Procurement Department.
As the UK moved into the Recovery Stage, usage estimates were increased to ensure sufficient quantities of PPE were available recognising the impact of usage as part of covid19 recovery. The Trust has continually held sufficient stock of PPE and there has been a clear process in place to ensure access to equipment at short notice if required. This involved the Procurement Department extending daily working hours and providing a 7 day service. Internal distribution schedules were set up and a process was put in place to ensure staff could access PPE out of hours.

During the Covid19 pandemic a PPE control room was implemented whereby all PPE was monitored daily and recorded. There has been strict control regarding the use and provision of PPE throughout the pandemic with IPC and Health and Safety risk assessments as appropriate. Practices have been altered in accordance with PHE guidance efficiently. PPE champions also supported troubleshooting in realtime to support individual staff and departments.

All organisations' Procurement Departments were provided with information on PPE stock deliveries across the local Health Economy. This was supported by the mutual aid agreement, which was in place to share the stock of PPE as required.

Further Assurance for Fit Testing

All Fit Testers were trained by an accredited Fit2Fit company. (Fit Testing is only conducted by staff who have received this training). All managers were asked to identify staff who perform/or work in areas where aerosol generating procedures were being undertaken with appropriate staff referred for fit testing. Social distancing is adhered to when staff attend for fit testing. It is important to note that a Pre Fit Test Assessment is carried out and passed before Fit Testing proceeds. A suitable disposable respirator is identified using the Fit Check method.

Fit Testing equipment (collar/hood and nebuliser chambers) are assessed to ensure that they are in good condition and there is a SOP for qualitative fit testing for FFP3 and FFP2.

2.11 Staff Support throughout the Pandemic

Staff engagement has been of huge importance throughout the pandemic ensuring that any worries and concerns have been heard throughout. Staff have been provided with daily communications to ensure that appropriate information, guidance and advice has been shared timely with a range of additional staff welfare support including:

- Childcare – a facility was set up at the Peace centre.
- Accommodation
- Staff spaces
- Welfare support
- Free car parking for all staff across both hospital sites. Transport
- Staff Welfare Champions were developed (42 active across 157 areas in the Trust), focusing on offering advice, support, information and guidance on the following:

2.11.1 Assurance

The Trust introduced PPE Safety Champions across the organisation to provide on-going support, advice and guidance to staff about the correct wearing of PPE and to allay any anxieties in realtime.

The Occupational Health Service was extended to provide a 7 day service and a Mental Health Hub was developed where staff could attend without an appointment. This was offered on both the Halton and Warrington site. All staff working at home were provided with a 'working from home pack', including access to mental health support.

Facilitated conversation guidance was provided to provide staff with the opportunity to have a conversation to reflect on their day, enabling them to go home healthy, to rest, recuperate and get ready for their next shift. This was further supported by additional welfare measures including the launch of Project Wingman, a first class lounge experience for all staff facilitated by furloughed cabin crew. Restrooms were improved and additional staff provision including picnic tables and access to additional refreshments supplied by WHH charitable donations were put in place. The local Seikh community also provided hot meals for staff.

All staff were made to feel valued in their contribution with a redeployment hub established for staff who could no longer work in areas for which they were normally employed.

Keeping in Touch guidance and postcards were developed for line managers to send to members of staff redeployed or working from home.

Enhanced on-site counselling developed with recruitment of two new counsellors to complement existing Employee Assistance Programme in place.

Accommodation was put in place for staff on a medium or long term basis at the Peace Centre and Gullivers World. This was advertised through daily Coronavirus updates to staff and signposted by the Staff Welfare Champions.

2.12 Identifying and Protecting Vulnerable Workers during the Pandemic

The Trust must ensure all appropriate controls are put in place to protect those who are particularly vulnerable to COVID19.

2.12.1 Assurance

A paper based COVID19 Workforce Risk Assessment Tool was introduced in March 2020. The tool consists of:

- An initial self-assessment to be completed by all staff.
- If any question is answered with a yes than this could potentially identify a vulnerable member of staff.
- A risk assessment is then required to be completed by the line manager and member of staff to identify appropriate controls and actions to ensure the safety of the member of staff.

As more knowledge and information became evident nationally around vulnerable groups, the Trust wrote to all BAME staff in May 2020 to address concerns and outline the support available including the COVID19 Workforce Risk Assessment.

- In July 2020 the COVID19 Workforce Risk Assessment online tool was launched. This captured the same information but electronically making it easier for staff to complete. The launch included:
    - A letter to all staff.
    - Staff flyer.
    - Staff guidance.
    - Management guidance.
    - Manager training.

The Accountable Managers Tool was made available to all managers identified as accountable for ensuring COVID Workforce Risk Assessments were completed. This tool contained information of everyone who required a full manager individual risk assessment and action plan.

To mitigate the risk of staff not completing self-assessments, Human Resources utilised ESR data on age, gender and ethnicity. This system automatically populates the Accountable Managers tool, as all staff identified required a full individual risk assessment.

The Workforce Risk Assessment was amended so that it could be used for volunteers and a bespoke report was designed for them.

2.13 Safe Systems of Work (COVID Secure Workplace) during the Pandemic

The Health and Safety Executive give a definition of COVID secure as:

"putting in place workplace adjustments to manage risk and protect workers and others from coronavirus".

The Trust has put safe systems of work in place to ensure compliance with social distancing rules and to enable working environments to be COVID secure as well as corridors, stair wells and rest rooms.

2.13.1 Assurance

All offices have a risk assessment with suitable and sufficient controls in place for social distancing. This includes, changing the layout so that staff are not facing each other, use of screens, ensuring that there is appropriate ventilation and hand hygiene procedures in place. All offices have been formally risk assessed to ensure that staff are provided with appropriate advice as to how many people should be in the office at any one time. This is clearly documented on a poster on the each entrance door.

Rest rooms on Wards have limited space so each room was measured to provide accurate information on the maximum number of chairs, tables and people that can be in the room at any one time. This is documented on a poster which is visible on the door and monitored by the Ward Manger continually throughout the day, via Health and Safety inspections and Senior walkrounds.

All other rest rooms have been assessed and tables and chairs removed to ensure only the maximum number of staff can use each area and are appropriately social distanced.

Corridors and stair wells have been risk assessed with weekly inspections carried out.

All clinical areas have risk assessments in place with suitable and sufficient controls to mitigate the risk of transmission and provide assurance of social distancing.

2.14 Risk Management

The Trust has a planned and systematic approach to the identification, evaluation and control of risks.

Assurance

- This process has remained the same during throughout the pandemic. Risk assessments and risk registers continue to be developed accordingly to optimise both staff and patient safety. The Risk review Group has been held intermittently during the pandemic but at the time of writing this report has been held as routine for the last few months. Risk registers have been maintained throughout the pandemic across all departments with routine escalation to the Corporate Risk Register or Strategic Risk Register as per normal process.

- has been stood down due to operational pressures work undertaken by the Clinical Business Units has continued with the support of the Head of Health and Safety.

- The Covid-19 risk register, Corporate risk register and Board Assurance Framework have been continually updated and reported via the Quality Assurance Committee which has continued to function throughout the pandemic. This meeting was initially bi-monthly but for increased oversight has taken place monthly during the pandemic. This information is also presented at the Patient Safety and Clinical Effectiveness Sub-Committee which has run intermittently during the pandemic. Risk is also discussed as required during the tactical and recovery meetings with escalation to the Strategic Executive Oversight Group in accordance with the Trust Decision Making Framework.
- During the pandemic a log of service change and recovery proformas was initiated. This was to ensure clear oversight of the decisions made by all necessary parties, avoiding decisions being made in isolation, thus reducing risk. This log is held by the Clinical Governance team. A standard Operating Procedure is in place.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

3.1 Future Development

The priorities over the next 12 months are to: -

- Review the Health and Safety Strategy.
- Provide quarterly inspection reports to include compliance ratings with COVID controls.
- Provide bi-monthly claim reports to triangulate with incidents and complaints.
- Implement a programme of risk assessment training from June 2021.
- Raise awareness and develop a campaign to be disseminated across the Trust to promote safer user of sharps and correct disposal.
- Sharing feedback and learning on non-clinical incidents.
- Provide good practice links in Communications to highlight areas of excellent housekeeping or other areas of outstanding performance in Health and Safety.
- Continue to analyse lost time incidents identifying trends and themes.
- Ensure investigations have appropriate detail and are completed within required timescales.
- Ensure all RIDDOR incidents are effectively tracked and reduce the incidence of claims due to ensuring robust risk assessment and training is available.
- Review of incident reports.
- Review statutory risk assessments to ensure that they are appropriate to the needs of the organisation and effectively implemented.
- Review all COVID related risk assessments.
- Review policies and guidance documents in accordance with current legislation.
- Produce comprehensive DSE reports for staff and managers to minimise the risk of work-related upper limb disorders.
- Audits of specific Health and Safety legislation.
- Form part of and advice upon the national Covid-19 look back at local level with Health and Safety Assurance.
- Appoint a second Senior Health and Safety Advisor.

4. MEASUREMENTS/EVALUATIONS

There is an established pro-active safety management system across the Trust in particular with audits and inspections. Documentation is standardised and Departments are meeting compliance with Health and Safety legislation.

The Trust has maintained a positive Health and Safety culture throughout the pandemic ensuring staff have had the relevant instruction, advice, equipment and training to continue in their work safely throughout.

A number of processes, risk assessments, policies and standard operating procedures have been put in place to ensure that there is compliance with new legislation and guidance in an agile and flexible manner with robust governance mechanisms in place. Risks have been appropriately cited and have moved flexible as necessary across risk registers ensuring clear oversight from Ward to Board. This was further supported by a specific Covid Risk Register and Service Change proformas.

There are clear lines of communication for staff via the Trust daily briefing and COVID19 update.
All new processes will be embedded within the Health and Safety Management system and audited on an annual basis as required.

5. MONITORING/REPORTING ROUTES

All Health and Safety matters are reported and monitored via the Health and Safety Sub Committee. The terms of reference are updated annually. During the pandemic where the Health and Safety Sub-Committee was paused relevant discussion and ratification occurred at the Tactical Group meeting.

6. RECOMMENDATIONS

The Board of Directors is requested to note the Annual Report as a means of assurance that Health and Safety risks across Warrington and Halton Hospitals NHS Foundation Trust have been managed and controlled accordingly. This has been approved via Quality Assurance Committee.