TRUST BOARD - 30 September 2020

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/09/101**			
SUBJECT:	**Council of Governors – Terms of Reference 2020-21**			
DATE OF MEETING:	30 September 2020			
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 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)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust Board is asked to review to and approve the Council Terms of Reference. There is one proposed amendment to the Terms of reference previously approved by the Council of Governors in 2019. The proposed amendment in section 10 relates to the change in title from the Head of Corporate Affairs to Trust Secretary.			
PURPOSE: *(please select as appropriate)*	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Council of Governors approved the Terms of Reference.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors		
	Agenda Ref.	COB/20/08/41		
	Date of meeting	15.08.2020		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

TERMS OF REFERENCE OF THE COUNCIL OF GOVERNORS

COUNCIL OF GOVERNORS (COG)

Approved by the Council of Governors on 15.08.2020

Council of Governors - Terms of Reference

1. PURPOSE

The role of the Council of Governors is derived from Schedule 7 and other sections of the National Health Service Act 2006 as amended by the Health & Social Care Act 2012. This document should be read in conjunction with the act.

2. GENERAL DUTIES

The general duties of the Council of Governors are:

- To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the members of the Trust as a whole and the interests of the public

3. STANDING

The full meeting of the Council of Governors and its Nomination & Remuneration Committee are the bodies in which Governors have official standing. All other forums are advisory.

4. MEMBERSHIP

The composition of the membership of the Council of Governors is set out in the Constitution. The Chair of the Board of Directors is the Chair of the Council of Governors and presides over meetings of the Council of Governors. In the absence of the Chair, the Senior Independent Director will take the Chair.

5. **QUORUM**

The quorum for the Council of Governors is set out in the Constitution and states that 'No business shall be transacted at a meeting of the Council of Governors unless at least one third of all the members are present, at least five of which are elected Governors, are present.

If a Governor has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of a declaration of a conflict of interest she/he will no longer count towards quorum.

6. COUNCIL OF GOVERNORS COMMITTEES

The Council of Governors will establish the following committees:

- Nomination & Remuneration Committee
- Quality in Care and Governors' Engagement Group
- Such other committees as may be required from time to time
- Task & Finish Working Groups as necessary

7. THE ROLE OF THE COUNCIL OF GOVERNORS

Non-Executive Directors; Chief Executive and the Auditors

- Approve the policies and procedures for the appointment and where necessary for the removal of the Chair of the Board of Directors and Non-Executive Directors of the Trust Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee.
- Approve the appointment or removal of a Chair of the Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee.
- Approve the appointment or removal of a Non-Executive Director on the recommendation of the Council of Governor's Nomination & Remuneration Committee.
- Approve the policies and procedures for the annual appraisal of the Chair of the Board of Directors and Non-Executive Directors of the Trust Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee.
- Approve changes to the remuneration, allowances and other terms of office for the Chair of the Board and other Non-Executive Directors on the recommendation of the Council of Governor's Nomination & Remuneration Committee.
- Approve or where appropriate, decline to approve the appointment of a proposed candidate as Chief Executive recommended by the Non-Executive Directors.
- Approve the criteria for appointing, re-appointing or removing the Auditor.
- Approve the appointment or re-appointment and the terms of engagement of the Auditor on the recommendation of the Audit Committee

Constitution and Compliance

- Jointly approve with the Board of Directors amendments to the Constitution, subject to any changes in respect of the powers, duties or role of the Council of Governors being ratified at the next general meeting of members (at which a member of the Council of Governors needs to present the change.)
- Notify Monitor, via the Lead Governor, if the Council of Governors is concerned that the Trust is breaching its Licence if these concerns cannot be resolved at the local level.

Governors

- Approve the allocation of Governors to sub-groups of the Council of Governors, working groups and any joint working groups set up by the Board of Directors.
- Approve the appointment and the role of the Lead Governor.
- Receive quarterly reports from the Chairs of the Council of Governors sub-groups in the discharge of the sub-groups' duties
- Approve the removal from office of a Governor in accordance with procedure set out in the Constitution.
- Approve jointly with the Board of Directors the procedure for the resolution of disputes and concerns between the Board of Directors and the Council of Governors.

Strategy, Planning, Reorganisations

- Provide feedback on the development of the strategic direction of the Trust to the Board of Directors as appropriate.
- Contribute to the development of stakeholder strategies, including member engagement strategies.
- Act as a critical partner to the Board of Directors in the development of the forward plan.
- Where the forward plan contains a proposal that the Trust will carry on an activity other than the provision of goods and services for the purposes of the NHS in England, determine whether the proposal will interfere or not in the fulfilment by the Trust of its principal purpose (the provision of goods and services for the purposes of the health service in England). Notify the Board of its determination.

  Approve or not approve increases to the proposed amount of income derived from the provision of goods and services other than for the purpose of the NHS in England where such an increase is greater than 5% of the total income of the Trust.
- Approve or not approve proposals from the Board of Directors for mergers, acquisitions, separations and dissolutions. More than half of the total number of Governors needs to approve such a proposal.
- Approve or not approve proposals for significant transactions where defined in the Constitution or such other transactions as the Board may submit for the approval of Governors from time to time. Such transactions require the approval of more than half of Governors voting at a quorate meeting of the Council of Governors.

Representing Members and the Public

- Approve the Membership Engagement Strategy.
- Contribute to Members' and other stakeholders' understanding of the work of the Trust in line with engagement and communication strategies.
- Seek the views of stakeholders, including members and the public and feedback relevant information to the Board of Directors or to individual managers within the Trust as appropriate.
- Act as ambassadors in order to raise the profile of the Trust's work with the public and other stakeholders.
- Promote membership of the Trust and contribute to opportunities to recruit members in accordance with the membership strategy.
- Attend events during the year that facilitate contact between members, the public and Governors to promote Governor accountability
- Report to members each year on the performance of the Council of Governors.

Holding the Non-Executive Directors to Account

- The Council of Governors must hold the Non-Executive Directors individually and collectively to account for the performance of the Board. It must agree a process and dialogue with the Board that will enable them to fulfil this duty.
- As part of this a good working relationship between the Board of Directors and Council of Governors is critical; it can be fostered by meeting regularly and with sufficient frequency to establish appropriate channels of communication and constructive challenge.

Some of the following may support this process and dialogue:

- Receive the agenda of the meetings of the Board of Directors before the meeting takes place.
- Be equipped by the Trust with the skills and knowledge they require in their capacity as governors.
- Receive the Annual Report of the Audit Committee on the work, fees and performance of the auditor.
- Receive the Annual Report and Accounts (including quality accounts).
- Receive the quarterly report of the Board of Directors on the performance of the Foundation Trust against agreed key financial, operational, quality and regulatory compliance indicators and stated objectives.
- Participate in opportunities to review services and environments such as PLACE inspections/quality reviews/ local activities and evaluation of user/carer experience.
- Receive and review quarterly assurance reports.
- Receive reports from the Board on important sectoral or strategic issues.
- Use information obtained through the above sources to monitor performance and progress against the key milestones in the strategic and annual plans and to hold the Non-Executive Directors to account for the performance of the Board of Directors.
- If considered necessary (as a last resort), in the fulfilment of this duty, obtain information about the Trust's performance or the Directors' performance by requiring one or more Directors to attend a Council of Governor meeting

8. COLLECTIVE EVALUATION OF PERFORMANCE

The Council of Governors will carry out an annual review of its effectiveness and efficiency in the discharge of its responsibilities and achievement of its objectives.

9. FREQUENCY OF MEETINGS

The Council of Governors will meet 4 times per year. Members are expected to attend all meetings of the Council and of Committees of which they are a member, or give timely apologies if absence is unavoidable.

10. MINUTES

The Council of Governors will be supported by the Trust Secretary ~~Head of Corporate Affairs~~ and the Secretary to the Trust Board who will agree the agenda with the Chair and produce all necessary papers. Minutes will be circulated promptly to all members as soon as reasonably practical.

11. REVIEW

The Council of Governors will review these Terms of Reference annually.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee	Council of Governors
Version	V4 ~~V3~~
Implementation Date	August 2020
Review Date	August 2021 ~~2020~~
Approved By	Council Of Governors xx.xx.2020 ~~13 August 2019~~

REVISION			
Date	**Section**	**Reason for Change**	**Approved By**
V3 19.01.2017	5	Changes to section 5 for clarity on quorum – item as described in the Trust's Constitution	CoG 19.01.2017
V3 19.01.2017	6	To include the named Committees established as Quality in Care and Governors Engagement Group	CoG 19.01.2017
V3 19.01.2017	10	The Council of Governors will be supported by the Secretary to the Trust Board.	CoG 19.01.2017
V3 17.05.2018	9	Changes to section 9 to provide clarity on the expectations relating to attendance.	CoG 17.05.2018
V3 17.05.2018	10	The Council of Governors will also be supported by the Head of Corporate Affairs.	CoG 17.05.2018
V3 13.08.2019		No changes to the ToR approved on 17 May 2019	CoG 13.08.2019
V4 13.08.2020	10	Change in title from Head of Corporate Affairs to Trust Secretary	CoG 13.08.2020

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved By**
13.08.2020	V3 replaced by V4	13.08.2020

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/09/102**			
SUBJECT:	**Audit Committee Chairs Annual Report 2019-20**			
DATE OF MEETING:	30 September 2020			
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 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)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report seeks to deliver assurance to the Board and Council of Governors that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the efficacy of the Trust's internal system of controls.			
PURPOSE: *(please select as appropriate)*	Information	**Approval √**	To note	Decision
RECOMMENDATION:	**The Board reviews the document, ensure it meets its purpose and ratifies the Committee Chair's Annual Report.**			
PREVIOUSLY CONSIDERED BY:	Audit Committee Date: 6.08.2020 Agenda Ref: AC/20/08/70 Outcome: Approved		Council of Governors Date: 13 August 2020 Agenda Ref: COG/20/08/42 Outcome: Approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

AUDIT COMMITTEE

AGENDA REFERENCE:	**AC/20/08/70**			
SUBJECT:	**Audit Committee Chairs Annual Report 2019-20**			
DATE OF MEETING:	6 August 2020			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive Officer			
EXECUTIVE SUMMARY:	This report seeks to deliver assurance to the Board and Council of Governors that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the efficacy of the Trust's internal system of controls. The overall Head of Internal Audit opinion for the period 1st April 2019 to 31st March 2020 provides Substantial Assurance. This provides assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently			
PURPOSE: (please select as appropriate)	Information	**Approval** ✓	To note	**Decision** ✓
RECOMMENDATION:	**The Committee reviews 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			

AUDIT COMMITTEE REPORT 2019-20

The Committee

The Audit Committee is required to report annually to the Board and to the Council of Governors outlining the work it has undertaken during the year and, where necessary, highlighting any areas of concern. I am pleased to present my Audit Committee Annual Report which covers the reporting period 1 April 2019-31 March 2020.

The Audit Committee is responsible on behalf of the Board for independently reviewing the systems of integrated governance, risk management, assurance and internal control. The Committee's activities cover the whole of the Trust's governance agenda, and are in support of the achievement of the Trust's objectives.

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 been composed of at least three Non-Executive Directors with a quorum of two. I have been the Chair of the Committee since 1st December 2014.

The required relevant and recent financial experience and background necessary for the membership of the Audit Committee is met by myself, the Chair of the Committee and the details of my biography can be found on page 22 (*of the Annual Report and Accounts*).

Member	**Attendance (Actual v Max)**
Ian Jones, Non-Executive Director & Chair	5/5
Margaret Bamforth, Non-Executive Director	5/5
Terry Atherton, Non-Executive Director	4/5
Anita Wainwright, Non-Executive Director	5/5
Cliff Richards, Non-Executive Director (wef 10.06.2019)	3/3
Jean-Noel Ezingeard, Non-Executive Director (to 30.04.2019)	1/1

Regular attendees at the Committee Meetings were Grant Thornton (External Auditors), Mersey Internal Audit Agency ("MIAA") (Internal Audit & Anti-Fraud Services), the Chief Finance Officer and Deputy Chief Executive and the Trust Secretary

Terms of Reference

The Committee's Terms of Reference were reviewed and agreed in March 2020 to ensure they continue to remain fit-for-purpose.

Frequency of Meetings & Summary of Activity

The Committee met five times during the year. A summary of the activity covered at these meetings follows:

Governance & Risk Management

During the Year the Trust continued to develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and the Quality Assurance Committee on a bi-monthly basis. In year, there was further alignment of the relevant elements of the Board Assurance Framework to the Committees of the Board.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a **Substantial Assurance** rating from the Head of Internal Audit (HOIA).

Internal Audit Activities

MIAA acted as Internal Auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is agreed with the Committee and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the Committee uses a three cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency.

Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting. The assurance level for each audit completed during the year are listed below:

High Assurance	Substantial Assurance	Moderate Assurance	Limited Assurance
• Combined Financial System Review	• Freedom to Speak Up Review • ESR Payroll Review • Data Security and Protection Review	• Diagnostic Policy Review • Data Quality Review • Physician Associate Review	• Quality Spot Check Review • Discharge planning review • Business Continuity Review

An efficient and effective Assurance Framework is a fundamental component of good governance, providing a tool for Boards to identify and ensure that there is sufficient, continuous and reliable assurance, organisational stewardship and the management of the major risks to organisational success.

The Assurance Framework Review concluded that the organisation's Assurance Framework is structured to meet the NHS requirements, all elements rated Green.

Opinion	
Structure	The organisation's AF is structured to meet the NHS requirements.
Engagement	The AF is visibly used by the organisation.
Quality & Alignment	The AF clearly reflects the risks discussed by the Board.
Deep Dive ***'Controls & Assurances'***	The identified controls and assurances are relevant.

It was also confirmed that the Trust's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.

The Internal Audit reports include detailed recommendations to improve systems and address weaknesses identified. Based on these recommendations, actions are agreed with Line Management and the Audit Committee tracks the implementation of the agreed actions to ensure implementation within an appropriate timeframe.

An Assurance Framework opinion test against NHS best practice was undertaken and the standards were met.

External Audit

Grant Thornton commenced its 3-year term as Auditors to the Trust in October 2016 following a competitive procurement exercise and review and recommendation by the Council of Governors.

In July 2019 the Trust published an invitation to tender (ITT) for the provision of statutory audit services to commence 1st October 2019. The Trust did not receive any proposals for the above service. The Trust had the option to extend the existing contract with Grant Thornton LLP for the provision of statutory audit services for a further 12 month period commencing 1st October 2019.

During the year the Auditors reported on the 2019-20 Financial Statements and Quality Accounts. No material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Committee and the Trust and representatives of Grant Thornton attended each Audit Committee.

Anti-Fraud Activity

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Anti-Fraud Service (AFS) working to a programme agreed with the Audit Committee. The role of AFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.

During the financial year 2019/20 the AFS has completed a wide range of work across the main key areas of activity.

In the area of Strategic Governance, the AFS has undertaken a fraud risk assessment which requires fraud risks to be added to the organisation's risk registers. 7 risks were identified in line with the Trust's risk management procedures and were added to the appropriate departmental risk registers.

The Trust's Communications Department has supported the dissemination of various fraud awareness raising materials and updated the intranet and website fraud pages. Awareness raising materials include use of the NHSCFA Awareness Toolkit, NHSCFA Fraud awareness video's and reporting channels, recent NHS fraud prosecutions and promotion of the recent BBC 'Fraud Squad' series 'The Hunt'.

The AFS reviewed a number of Trust policies including the Nursing and Midwifery Rostering, Freedom to Speak up, Residential Accommodation and Special Leave.

NHSCFA introduced the role of a fraud champion, the fraud champion will complement the AFS role. The role includes promoting awareness of fraud, bribery and corruption within the trust, understanding the threat posed by fraud, bribery and corruption and understanding best practice to counter fraud. Layla Alani has been nominated as the Fraud Champion for the Trust.

The AFS has ensured prompt distribution of multiple NHS CFA and MIAA fraud alerts, as well as NHS CFA intelligence bulletins, Fraud Prevention Notices, Newsletter, Fraud Spotlight (working whilst off sick) local warnings and professional guidance to the Trust (i.e. Procurement fraud, Mandate fraud, fraud against suppliers and ESR phishing), follow-up was undertaken in relation to confirming actions taken locally.

The AFS has also supported the Trust by providing advice, guidance and consideration for two enquiries that did not meet the threshold for criminal investigation, both allegations were relating to working whilst off sick. No evidence of fraud was found and the enquiries were not pursued.

Issues Carried Forward

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

In the reporting period there were no significant and material issues raised by the Committee to the Board of Directors or the Council of Governors.

Whilst the outcomes of the Clinical Audit programme falls under the remit of the Quality Committee and are reported and challenged in that forum, this Committee will review its approach purely from an audit perspective and to obtain assurance of methodology and approach as well as its contribution to improving quality.

With respect to the Internal Audit plan for 2019-20, a certain number of risk areas will be kept under review to see if they should be made a priority above those proposed in the 2020-21 Internal Audit Plan which has already been approved. This will be based on alignment with the strategic risk assessment for the Trust.

During 2019-20, alongside the Audit Committee, three main Board assurance committees were in place: (1) Quality Assurance, (2) Finance & Sustainability and (3) Strategic People. All of these Committees were Chaired by Non-Executive Directors and each Committee included at least two

Non-Executive Directors. This structure gave strong visibility and focus at Non-Executive level on the key issues facing the Trust. The NEDs meet several times a year to assess a wide range of Trust issues including the appropriateness and effectiveness across the Committees and to address any potential gaps in assurance.

Summary

In year, the Committee has considered a wide range of issues in relation to financial statements, operations and compliance and has sought to gain assurance on each element by working closely with Internal Audit, the other Board Committees and key individuals across the Trust.

Throughout the reporting period, the Chair of the Committee reported in writing on the nature and outcomes of its work to the Board of Directors highlighting any area that should be brought to its attention through a Chair's Key Issues Report.

The Chair of the Committee will provide an overview of the work of the Committee to the Council of Governors in August 2020

The Committee has also assessed its own performance during the year and will report to the Board of Directors in September 2020.

The Audit Committee acknowledges the significant amount of work carried out by the Quality Assurance Committee in continuing to refresh and embed the Trust's governance and risk management systems.

I would also 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.

Ian Jones
Chair of Audit Committee
August 2020

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/09/103**	
SUBJECT:	**Workforce Flu Vaccination Programme**	
DATE OF MEETING:	30 September 2020	
AUTHOR(S):	Deborah Smith, Deputy Director of HR and OD	
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People 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.	X 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.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper details the plan for vaccinating frontline staff as identified by Public Health England (PHE) with the season's flu vaccination. This paper also includes the Trust's self-assessment against the Department of Health & Social Care and PHE besgt practice checklist. The Communications Team and Occupational Health Department have developed a comprehensive and pro-active campaign to support uptake. An increase procurement of flu vaccinations has occurred to meet the anticipated demand for flu vaccination in light of the COVID -19. Peer vaccinators volunteers have increased to over 50; this is an encouraging result to achieve herd immunity.	

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

RECOMMENDATION:	Trust Board members are asked to: • Note the Workforce Flu Vaccination Programme 2020 • Approve the self-assessments against the best practice checklist.	
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	Workforce Flu Vaccination Programme	AGENDA REF:	BM/20/09/103

1. BACKGROUND/CONTEXT

This paper details the plan for vaccinating frontline staff as identified by Public Health England (PHE) with the season's flu vaccination. In light of COVID-19 the vaccine delivery will differ from previous years but remains essential to protect vulnerable people and support the operational resilience of the organisation.

In their letter dated 5th August 2020, The Department of Health & Social Care (DHSC) andPHE have advised providers that they should focus on achieving maximum uptake of the flu vaccine in existing eligible groups. They have stipulated that the self-assessment checklist should be published in public board papers at the start of the flu season to ensure public assurance (Appendix 1).

Evidence has shown COVID 19 is having a disproportionate impact on our BAME (Black, Asian and Minority Ethnic) colleagues. This year's campaign will require an increased uptake of flu vaccination for the BAME workforce in order to help protect those who are most at risk if they are to get COVID-19 and flu.

In order to deliver this campaign we will need the organisation to have a positive and encouraging approach. Communications Team and Occupational Health Department have developed a comprehensive and pro-active campaign this year. An increase procurement of flu vaccinations has occurred to meet the anticipated demand for flu vaccination in light of the COVID -19. Peer vaccinators volunteers have increased to over 50; this is an encouraging result to achieve herd immunity.

2. KEY ELEMENTS

This year the campaign is planned to commence September 28th for a 3 month period. This can be extended until Feb 28th if required. This year order of Quadrivalent (QIVe) has increased to 2800 individual vaccines and the over 65+ Trivalent (TIV) remains the same at 200 vaccines. This is to reflect the expected demand for flu vaccine, as a result of the COVID-19 pandemic.

As requested in the DHSC and PHE national Flu Immunisation Programme 2020 to 2021, the organisation must ensure the delivery of maximum coverage of the flu immunisation programme to our workforce, by building on good practice from previous flu seasons. Due to the risk of flu and COVID-19 co-circulating this winter it is essential that we protect vulnerable people and support the operational resilience of our Organisation.

Our workforce with pre-existing health conditions and/or from the BAME community are at increased risk of severe illness from COVID-19 and they should be targeted for flu

vaccination in view of this bilateral increased susceptibility. We need to ensure equitable access to help protect those who are more at risk and we require a robust plan to enable our ability to offer vaccinations over 7 days and across all shift configurations. In addition, decisions on the prioritisation of areas / specialties will be made dependent upon the emerging situation in relation to COVID-19.

A Trust-wide campaign has been designed supported by the Communications Team and weekly uptake reporting to the Exectutive Team will take place.

3. RECOMMENDATIONS

Trust Board members are asked to:

- Note the Workforce Flu Vaccination Programme 2020
- Approve the self-assessments against the best practice checklist

A	Committed leadership	Evidence	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Board support the flu campaign at the commencement. Staff members declining the offer of a flu vaccine will be captured by their manager and the quantity and reason should be provided to Occupational Health throughout the campaign.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	Quadrivalent influenza vaccines for adults up to the age of 64 (amount 2800) Trivalent influenza vaccines for adults over 65 (amount 60)	
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	**Data:** • Achieved 87% vaccination for front line healthcare workers across both sites. **Successes** • Achieved 'herd immunity' (at least 70%) which provides the best protection for our staff and patients (and wider community). • Front line healthcare professionals fully engaged in programme. **Challenges** • Previous campaigns have been successful, NHS Employers/PHE and DHSC target/aspiration to offer vaccine to 100% of healthcare workers. Challenging in that not all staff will accept the vaccine. • Taking the campaign to staff, gives us the best uptake but requires additional resource in order to comply with social distancing (PHE guidance) • Peer to peer vaccinations to be supported in all clinical areas. The training is lengthy but meets the guidance from the NMC. • Drop in clinics will have to be managed and monitored closely to ensure compliance with social distancing	

		Lessons learnt from previous campaigns: • Executive team and senior managers to support 'peer to peer vaccinations' • Peer to peer vaccination in all clinical areas to ensure the vaccine in given to as many staff as possible in the shortest possible timeframe. • Peer to peer vaccinators to ensure staff on all shift patterns can access the vaccine • Accessible clinics for non-clinical staff, ensuring social distancing • Weekly reporting to key stake holders • Communicate regularly to staff on progress • Celebrate success	
A4	Agree on a board champion for flu campaign	Michelle Cloney Director of Human Resources & Organisational Development identified as board champion	
A5	All board members receive flu vaccination and publicise this	Due to the delay in receipt of all the vaccines the board including NED's will be offered the vaccine within October. With consent this will be publicised to promote within the organisation.	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	The occupational health team will lead on the vaccination programme and this year be supported with 50 peer vaccinators, trained to the National Minimum Standards and vaccinating within a Patient Group Direction. Weekly reports will be sent to the board champion to cascade	
A7	Flu team to meet regularly from September 2020	Monthly review on MS teams	
B	**Communications plan**		
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trade unions	Delivered under the supervision of the Head of Communications.	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Drop in clinics for non-clinical staff ensuring compliance with social distancing. Peer to peer vaccinators to support mobile vaccination schedule.	

		All opportunities for vaccination to be published, electronically, on social media and on paper.	
B3	Board and senior managers having their vaccinations to be publicised	Photographs captured and promotion through Trust media	
B4	Flu vaccination programme and access to vaccination on induction programmes	Access to clinical induction incorporated into flu programme (following national guidance with regards to safety and social distancing).	
B5	Programme to be publicised on screensavers, posters and social media	Support provided from communication team and a clear plan detailing delivery of messages across all available means. The theme this year is 'super heroes'	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Weekly figures will be submitted to the key stakeholders and headline figures promoted widely	
C	**Flexible accessibility**		
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Support required from senior leadership for identified peer vaccinators. Support required from Chief Nurse in relation to peer vaccinators from various work areas. Support required to support the training and release of peer vaccinators	
C2	Schedule for easy access drop in clinics agreed	Easy access to drop in clinics for non-clinical staff included in flu vaccination programme schedule. (following national guidance with regards to safety and social distancing).	
C3	Schedule for 24 hour mobile vaccinations to be agreed	Effective utilisation of peer vaccinators to support coverage 24 hour 7 day operation, including early mornings, nights and weekends	
D	**Incentives**		
D1	Board to agree on incentives and how to publicise this	Stickers showing visible support and fruit vouchers for all vaccinated staff	
D2	Success to be celebrated weekly	Feature in Trust publication and key messages on social media weekly	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/09/104**	
SUBJECT:	Charitable Fund Annual Report and Accounts for year ending 31st March 2020	
DATE OF MEETING:	30th September 2020	
AUTHOR(S):	Pat McLaren, Director of Community Engagement + Fundraising	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance + Commercial Development	
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.	x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus. #145 (a) Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In accordance with the Charities Commission in England and Wales the Corporate Trustee is required to produce an annual report and accounts for the charity on a yearly basis and file with the Charities Commission within ten months of the financial year end. Therefore the 2019-20 Annual Report and Accounts will be submitted to the Charities Commission following approval of the enclosed annual report. The 2019-20 Annual Report and Accounts have been reviewed by Voisey & Co, Independent Examiners. All findings have been addressed and the review has now concluded. The Annual Report and Accounts have been prepared in accordance with Part 8 of the Charities Act 2011, the Statement of Recommended Practice for charities and Financial Reporting Standard 102. For the year ending 31st March 2020 the Charity generated income of £177K and disbursed £356K on furtherance of charitable objectives leaving a fund balance of £316K carried forward to 2020-21.	

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

RECOMMENDATION:	The Board of Directors is requested to approve the Charitable Funds Annual Report and Accounts for year ending 31st March 2020.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee
	Agenda Ref.	**CFC20/09/035**
	Date of meeting	10th September 2020
	Summary	Present to the Corporate Trustee
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	

Warrington and Halton Teaching Hospitals NHS Foundation Trust Charitable Fund

Trustee's Annual Report & Independently Examined Financial Statements

For the Year to 31 March 2020

Registered Charity No 1051858

Contents

Reference and administrative details

Address of Charity:	Lovely Lane Warrington Cheshire WA5 1QG Tel: 01925 662835
Registered Charity no:	1051858
Bankers:	Government Banking Service 7th Floor, Southern House Wellesley Grove Croydon CR9 1TR
Independent examiners:	Voisey & Co 8 Winmarleigh Street Warrington Cheshire WA1 1JW

Report of the Trustee for the year ended 31 March 2020

Foreword

Warrington and Halton Teaching Hospitals NHS Foundation Trust (the "Corporate Trustee") presents the Charitable Funds Annual Report together with the independently examined financial statements for the year ended 31 March 2020 of Warrington and Halton Teaching Hospitals NHS Foundation Trust Charitable Fund ("the Charity"). Under Part 8 section 145 of the Charities Act 2011, the Corporate Trustee has exercised the Charity's exemption from audit. External scrutiny through *independent examination* is permitted and deemed appropriate for the Charity as its gross income is below a statutory threshold.

The Charity's Annual Report and Accounts for the year ended 31 March 2020 have been prepared by the Corporate Trustee in accordance with Part 8 of the Charities Act 2011 and the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014. The Charity's report and accounts include all of the separately established funds for which the Warrington and Halton Teaching Hospitals NHS Foundation Trust is sole beneficiary.

Structure, governance and management

Corporate Trustee

The sole corporate trustee of the Charity is the Warrington and Halton Teaching Hospitals NHS Foundation Trust. The Charity was established in accordance with paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990.

The Corporate Trustee is managed by its Board of Directors which consists of executive and non-executive directors. It has responsibility for planning, directing and controlling the activities of the entity, ensuring that the NHS body fulfils its duties in managing the charitable funds.

The members of the Board of Directors of the Corporate Trustee who served during the financial year and up to the date of compilation of this report were as follows.

Name	Title	Notes
Steve McGuirk	Chairman	
Jean-Noel Ezingeard	Non-Executive Director	Left 30 April 2019
Ian Jones	Non-Executive Director	
Cliff Richards	Non-Executive Director	Commenced 10 June 2019
Terry Atherton	Non-Executive Director	
Anita Wainwright	Non-Executive Director	
Margaret Bamforth	Non-Executive Director	
Mel Pickup	Chief Executive	Left 31 October 2019
Simon Constable	Chief Executive /Deputy Chief Executive & Executive Medical Director	Chief Executive from 14 November 2019 (2)
Alex Crowe	Medical Director	
Andrea McGee	Chief Finance Officer and Deputy Chief Executive	
Chris Evans	Chief Operating Officer	
Kimberley Salmon-Jamieson	Chief Nurse	
Pat McLaren	Director of Community Engagement and Fundraising (1)	
Phillip James	Chief Information Officer(1)	
Michelle Cloney	Chief People Officer(1)	
Lucy Gardner	Director of Strategy(1)	

(1) Non-voting Executive Directors.
(2) Acting Chief Executive from 1 to 13 November 2019.

The Charity is established as an umbrella charity, registered with the Charity Commission (no. 1051858). The umbrella charity covers the existence of a single unrestricted general fund containing 8 (2018/19 7) designated funds as at 31 March 2020, and, currently, 10 restricted funds (2018/19 10). The Charity was first registered as both Halton General Hospital NHS Trust Charity and Warrington Hospital NHS Trust Charity in April 1996 under the Charities Act 1993, which is now been incorporated into the Charities Act 2011.

In April 2001, supplemental deeds were executed to amalgamate the administration, trustees, objects and powers of the two charities following merger of the two organisations, creating the single body known as North Cheshire Hospitals NHS Trust Charitable Fund. On 1 December 2008, the Trust changed its name to Warrington and Halton Hospitals NHS Foundation Trust, following its transition to Foundation Trust status. The name of the Charity was changed accordingly by way of a supplemental deed and registered with the Charity Commission on 16 March 2010.

Supplemental deeds were further submitted in January 2020 to formally amend the Charity's name to Warrington and Halton Teaching Hospitals NHS Foundation Trust Charitable Fund following the Trust's formal name change in November 2019 to Warrington and Halton Teaching Hospitals NHS Foundation Trust.

Charitable Funds Committee

The Board of Directors (the Board) established a committee on 5 April 2001, known as the Charitable Funds Committee, (the Committee) reporting to the Board, in accordance with standing order 6 for the practice and procedure of the Board of Directors (annex 7 of the Trust's Constitution). The role of the Committee is to oversee the management of the affairs of the Charitable Fund. This is a delegated duty carried out on behalf of the Corporate Trustee. The role is to ensure that the Charity acts within the terms of its declaration of trust and appropriate legislation, and to provide information to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across its full range of activities.

Aside from any restricted funds held, the Charity holds a single general fund, within which designated funds have been created to acknowledge expressions of wish from donors about the particular department or ward which should ideally benefit from their generosity. The Trustee has an intention to use the income of designated funds in the areas indicated by donors. However the Committee may choose to apply the funds to general purpose in any area of the Trust's hospitals in accordance with the Health Service Act 1977.

Membership of the Committee

The Committee shall be composed of all independent Non-Executive Directors (excluding the Chairman), one of whom will be appointed as Chair of the Committee.

Attendance

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

- Chief Finance Officer/Deputy Chief Executive or nominated deputy
- Chief Nurse or nominated deputy
- Director of Community Engagement and Fundraising
- Fundraising Manager
- Head of Financial Services
- Publicly Elected Governor

During the year under review, and up to the date of compilation of this Report, the members of the Charitable Funds Committee were as follows.

Name	Position held	Notes
Jean-Noel Ezingeard	Non-Executive Director (Chair of Charitable Funds Committee)	Left 30 April 2019
Cliff Richards	Non-Executive Director (Chair of Charitable Funds Committee)	Commenced 10 June 2019
Ian Jones	Non-Executive Director (Interim Chair of Charitable Funds Committee)	From 1 May to 9 June 2019 (1)
Terry Atherton	Non-Executive Director	
Anita Wainwright	Non-Executive Director	
Margaret Bamforth	Non-Executive Director	
Andrea McGee	Chief Finance Officer and Deputy Chief Executive	From 19 May 2020
Kimberley Salmon-Jamieson	Chief Nurse	From 19 May 2020

(1) Relates to time as Interim Chair, permanent member of Charitable Funds Committee.

All expenditure is referred for approval to the Charitable Funds Committee on a quarterly basis.

Members of the Trust Board and the Charitable Funds Committee are not individual Trustees under Charity Law, but act as agents on behalf of the Corporate Trustee.

Corporate Trustee's appointments

The methods of appointment to the key governance roles within the Board of Directors and Council of Governors of the Corporate Trustee are reported in the Corporate Trustee's Annual Report and Accounts 2019/20 and contained within the Corporate Trustee's Constitution. Copies of these documents can be obtained from the Corporate Trustee's website or from its Communications office, located at Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG.

All appointments to the Charitable Funds Committee are made in accordance with the Charitable Funds Committee's approved Terms of Reference.

Trust staff including executive and non-executive directors, are required to complete the Trust's corporate induction programme, and are encouraged towards continuous professional development through the Trust's on-going performance management arrangements. Directors are able to seek individual professional advice or training at the Trust's expense in the furtherance of their duties.

Governors' knowledge is refreshed through a range of briefing sessions and workshops. The Board of Directors, Charitable Funds Committee and governors all have direct access to advice

from the Board Secretary who is responsible for ensuring that the Corporate Trustee's procedures are followed and that applicable regulations are complied with.

Administration

The accounting records and day to day financial administration of the funds are dealt with by the Trust's Finance Department. Fund raising and promotion of the charity is administered by the Trust's Fundraising team located at the Main Entrance, Warrington Hospital, both are located at Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG.

Risk management

The major risks to which the Charity is exposed have been identified and considered. A risk register has been compiled which is reviewed by the Charitable Funds Committee on a twice-yearly basis. Income and expenditure is monitored as part of the risk management process, to avoid unforeseen calls on reserves.

The Charities Commission Checklist for Trustees is reviewed twice yearly by the Committee and submitted by the Chair to the Trust Board thereafter.

Objectives and strategy

The objective of the Charity is to provide for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by Warrington and Halton Teaching Hospitals NHS Foundation Trust.

To support Warrington and Halton Teaching Hospitals to be OUTSTANDING for our patients, our staff and our communities by fundraising to provide:

- State-of-the-art equipment, technology or training
- Funding for WHH-related research
- Improving the hospital environment
- Enhancements to support the care and comfort of our patients, carers and visitors while on our premises
- Support to enable the health and wellbeing of our patients and staff

The Corporate Trustee attempts to balance the purchasing of essential equipment for essential services against expenditure which improves the general environment and facilities of the hospitals for its patients beyond that which the NHS is obliged to provide as part of patient care. In achieving this balance, the Corporate Trustee always has in mind the wishes of the donors to the Charity.

Public interest benefit

The Corporate Trustee ensures that the *public interest benefit* criteria, as detailed in the Charities Act 2011, are met by critically assessing each funding application from sub-fund holders. Applications for funding can be made by any department within the hospitals, and applications are only restricted by the availability of funds and the quality of the application.

Where possible, funds are used to provide benefit to a wide range of patients, and funds used for staff enablement are allocated to projects that will directly benefit patients. A summary of major purchases made by the Charity during the year under review is contained in the Annual Review of Income and Expenditure Activities (page 8).

Reserve policy

Requirement

In accordance with Charity Commission guidance, the Corporate Trustee acknowledges that there is a requirement to hold reserves. The reserves policy should take into account future commitments from the general unrestricted funds held by the Charity. Assuming that funds have been designated appropriately and will be spent within a reasonable timescale the charity should not rely on the unrestricted designated funds for the absorption of overheads on a continuing basis. Therefore the level of reserves held in the general unrestricted funds of the charity should be sufficient to cover the annual support costs and overheads of the charity.

The Charity approves expenditure on a case by case basis taking into account the level of funds available and the Corporate Trustee reserves the right to cancel any past delegation and transfer monies to the general unrestricted funds of the Charity. This may be considered where designated funds have not been spent within a reasonable timescale or where the original purpose of the designation no longer exists. Likewise the Corporate Trustee may choose to designate funds for a particular purpose.

Level of reserves

As at 31 March 2020 the Corporate Trustee considers that a minimum reserve of £70,000 (£90,000 as at 31 March 2019) in the unrestricted general purpose fund should be permanently maintained.

Monitoring

The Chief Finance Officer and Deputy Chief Executive will report on the progress of the reserves and make recommendations to the Charitable Funds Committee in order to comply with the policy. The Charitable Funds Committee has authority to vary the minimum level of reserves.

At 31 March 2020 the unrestricted general purpose fund held reserves of £88,842 (£92,375 as at 31 March 2019).

Investment policy

Introduction

Where NHS charitable funds have surplus monies in excess of the minimum reserves plus those required to fund commitments that have not yet been realised, Trustees may elect to

invest some or this entire surplus in order to generate additional income to fund future charitable activities.

Investment criteria

The investment policy of the Corporate Trustee is to deposit the entire value of the fund with the Government Banking Service in an interest-bearing account. This decision is based upon the intention in the short term to spend the funds, such that long-term investment would not be appropriate.

Interest receivable, interest payable and bank charges

It is the policy of the Corporate Trustee to apportion interest payable and bank charges across all funds, and to credit all funds with the proceeds of the Charity's investments based on the average balance of the funds held.

Annual review of income and expenditure

Income

During 2019/20, the Charity continued to support a wide range of charitable and health-related activities, by purchasing supplementary and complementary equipment or services which may not ordinarily have been provided from NHS sources.

Total income in 2019/20 was £177,229 (£193,364 in 2018/19) per the table below:

	2019/20	2018/19
Legacies	£1,068	£28,966
Donations and fundraising activities	£173,602	£161,667
Income from investments	£2,559	£2,731
Total Income	**£177,229**	**£193,364**

Analysis of income from donations and fundraising activities in 2019/20

• Corporate donations	£82,620
• Donations In Memory	£23,289
• Community donations	£21,999
• Donations, unsolicited	£34,781
• WHH Events	£9,491
• Grant makers	£1,000
• Gaming and trading	£422
Total income from fundraising activities	**£173,602**

Expenditure

The Charity's unrestricted general fund contains a number of designated funds in order to assist the donors in matching their donation with a particular department. All donations are accepted taking into account the donors' intentions and are held in the general fund unless a restriction has been applied; in this case, a separate restricted fund may be created. Legacy income where subject to a legal trust is held as restricted funds.

The Corporate Trustee is committed to ensuring that all funds are directed to the purposes identified in the Terms of Reference as soon as possible. Total expenditure in 2019/20 was £356,351 (£305,977 in 2018/19) per the table below:

	2019/20	**2018/19**
Expenditure on the furtherance of the Charity Objects (see following table)	£187,774	£181,809
Support costs and overheads	£58,790	£30,202
Staff costs	£68,007	£60,125
Governance costs	£20,675	£18,998
Expenditure on charitable activities	**£335,246**	**£291,134**
Costs incurred in fundraising	£21,105	£14,843
Total expenditure	**£356,351**	**£305,977**

Expenditure in 2019/20 (items costing more than £1,000) *

• Contribution to CT Scanner	£53,000
• Children's Outdoor Play Area	£37,461
• Patient Centred Clinical Courses	£18,187
• Intensive Care Motomed Device	£9,685
• B11 Shower Enhancements	£6,537
• Equipment for Neonatal Unit	£6,197
• Equipment for Intensive Care	£5,785
• Enhancements to Diabetic Clinic environment	£3,852
• Diabetic Clinic furniture	£3,505
• Intensive Care Patient Transfer Scale	£1,970
• Equipment for Breast Screening	£1,490
Total expenditure on individual items greater than £1,000	**£147,669**
Other Charitable purchases (under £1,000 per item)	£40,105
Total Charitable expenditure	**£187,774**

*Items listed relate to expenditure on the furtherance of the Charity Objects contained within note 6 on page 18.

Future plans

The Corporate Trustee does not expect significant changes in the objectives of the Charity in the forthcoming year and is committed to utilising funds to ensure that funds expended are directed to patient benefit and volunteer and staff health and wellbeing as soon as is practicable. The Charitable Funds Committee will continue to seek spending plans from holders of both restricted and designated income funds with the intention of disbursing donated funds in a timely and appropriate manner.

Two sizeable projects have been identified by fund-holders within the Trust and these will be supported by individual capital campaigns: The new Birth Centre at Croft Wing and an outdoor garden space adjacent to the Intensive Care Unit Burtonwood Wing, Warrington Hospital.

At the time of producing this report, the Covid-19 (coronavirus) pandemic has affected people, communities, businesses and economies across the globe. The impact of the pandemic is likely to be felt for many years and it is difficult at this time to predict how this will affect the charitable giving sector.

In the first weeks of the pandemic we, like other NHS Charities in England, we are extremely fortunate to be the recipient of a fraction of the financial support raised up and down the country, among these the unprecedented fundraising success of the Hon Col Tom Moore. These funds were channelled through our membership charity 'NHS Charities Together' and days into the new financial year WHH Charity received donations to support patient and staff health and wellbeing. We will continue to support our patients and their families, our staff and volunteers within the limits of our charitable objects as long as we are able.

Funds committed but not deployed as at 31 March 2020 are summarised below:

- Funding to support the care and environment of children and young people and their parents/guardians £17,530
- Funding for equipment and patient facilities £22,530

Acknowledgement

The Corporate Trustee would like to extend its sincere thanks on behalf of the patients and staff who have felt the impact of this year's donations and legacies.

The Corporate Trustee would also like to acknowledge the fundraising activities of our donors and our staff, who have been holding events and undertaking a variety of sponsored events to generate awareness and funds for the Charity. Their contributions, imagination and enthusiasm are greatly appreciated.

Information regarding the independently examined accounts can be obtained from the Trust's Finance Department on 01925 662835.

Approved on behalf of the Corporate Trustee.

PAT MCLAREN

Date: 4th June 2020
Director of Community Engagement and Fundraising

Statement of Trustee's responsibilities

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year, and of its financial position at the end of the year. In preparing financial statements that give a true and fair view, the Trustee should follow best practice and:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in operation;
- keep proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Charity, and which enables the Trustee to ensure that the financial statements comply with the requirements in the Charities Act 2011, the Charity (Accounts and Reports) Regulations and the provisions of the trust deed; and
- Safeguard the assets of the Charity, therefore taking reasonable steps in the prevention and detection of fraud and other irregularities.

The Corporate Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 13 to 23 attached have been compiled from, and are in accordance with, the financial records maintained by the Corporate Trustee.

Approved by the Corporate Trustee on dd Month 2020 and signed on its behalf by:

STEVE MCGUIRK ……Chairman

ANDREA MCGEE……Chief Finance Officer and Deputy Chief Executive

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEES OF WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CHARITABLE FUND

I report on the accounts for the year ended 31st March 2020 set out on pages 13 to 23

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year under section 144 of the Charities Act 2011 ("the Charities Act") and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act,
- to follow the procedures laid down in the general Directions given by the Charity Commission (under section 145(5)(b) of the Charities Act, and
- to state whether particular matters have come to my attention.

Basis of independent examiner's statement

My examination was carried out in accordance with general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from the trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

1. which gives me reasonable cause to believe that in, any material respect, the requirements:

- to keep accounting records in accordance with section 130 of the Charities Act; and
- to prepare accounts which accord with the accounting records and comply with the accounting requirements of the Charities Act have not been met; or

2. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Philip Urmston BSc FCA
Voisey & Co, Chartered Accountants
8 Winmarleigh Street
Warrington, Cheshire WA1 1JW ……2020

Statement of Financial Activities

	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Prior Year Total Funds
		2019/20	2019/20	2019/20	**2019/20**	2018/19
		£000	£000	£000	**£000**	£000
Incoming and endowments from:						
Incoming resources from generated funds	2	107	8	-	**115**	103
Donations and legacies	3	42	17	-	**59**	87
Other trading activities		-	-	-	**-**	-
Income from Investments	4	3	-	-	**3**	3
Total income and endowments		152	25	-	**177**	193
Expenditure on:						
Raising funds	5	(21)	-	-	**(21)**	(14)
Charitable activities	6	(172)	(163)	-	**(335)**	(292)
Total expenditure		(193)	(163)	-	**(356)**	(306)
Net income/(expenditure)		(41)	(138)	-	**(179)**	(113)
Transfers between funds	16	-	-	-	**-**	-
Net movement in funds		(41)	(138)	-	**(179)**	(113)
Reconciliation of funds						
Total funds brought forward		150	345	-	**495**	608
Total funds carried forward		**109**	**207**	**-**	**316**	**495**

Balance Sheet as at 31 March 2020

	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Prior Year Total Funds
		2019/20	2019/20	2019/20	**2019/20**	2018/19
		£000	£000	£000	**£000**	£000
Fixed Assets						
Intangible assets	9	3	-	-	**3**	7
Total fixed assets		3	-	-	**3**	7
Current assets						
Cash at Bank and in hand	10	137	218	-	**355**	507
Debtors	11	5	-	-	**5**	37
Total current assets		142	218	-	**360**	544
Current liabilities						
Creditors: amounts falling due within one year	12	(36)	(11)	-	**(47)**	(56)
Net current assets		106	207	-	**313**	488
Total assets less current liabilities		109	207	-	**316**	495
Non current liabilities		-	-	-	**-**	-
Net assets		109	207	-	**316**	495
The funds of the Charity						
Total Charity funds	16	109	207	-	316	495
Total funds carried forward		**109**	**207**	**-**	**316**	**495**

The notes on pages 15 to 23 form part of these accounts.

Signed:

Chairman……Date dd Month 2020

Chief Finance Officer and Deputy Chief Executive……Date dd Month 2020

Notes to the accounts

Note 1 Accounting policies

The financial statements have been prepared under the historical cost convention and in accordance with Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Charities Act 2011.

The financial statements are presented in Pounds Sterling, rounded to the nearest thousand.

There is no requirement for the Charity to prepare a cash flow statement since it is exempt due to being a 'smaller' charity (i.e. income less than £500,000).

1.1 Accounting judgements and key sources of estimation uncertainty

In the application of the Charity's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates, and underlying assumptions are continually reviewed. Revisions to estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of revision and future periods if the revision affects both current and future periods.

The following are the areas of critical judgements that management have made in the process of applying the entity's accounting policies.

Going concern

After making enquiries, the Corporate Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, it continues to adopt the going concern basis in preparing these financial statements.

There are currently no sources of estimation or uncertainty that are judged to cause a significant risk of material adjustment to the financial statements.

1.2 Funds structure

Restricted funds are to be used in accordance with the specific restrictions imposed by the donor. The Charity held 10 restricted funds at the end of the year under review.

The Charity did not hold any endowments, expendable or otherwise, during the year under review.

Unrestricted funds comprise those funds which the Corporate Trustee is free to use for any purpose in furtherance of the Charity's charitable objects. The Charity has a single unrestricted general fund containing 8 designated funds. These unrestricted designated funds are created to honour donors' expressions, or are created by the Trustee, at its discretion, to designate monies for specific future purposes. Any funds held within a designated fund can be merged or transferred within the general fund at any time, at the discretion of the Trustee, in accordance with the Health Service Act 1977.

1.3 Incoming resources

All incoming resources are recognised once the Charity has entitlement to the resources, it is probable that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

The cost of donations in kind (Gifts in Kind) for charitable activities is deemed to be the fair value of those gifts at the time of their receipt. They are recognised on receipt as income from fundraising activities in the reporting period in which the goods are received.

Donations in kind are recognised as an expense at the carrying amount of the goods upon application to charitable activities.

1.4 Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt, or where the receipt of the legacy is probable and the ability to estimate with sufficient accuracy the amount receivable. This would require that confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred, and that all of the conditions attached to the legacy have been fulfilled.

1.5 Resources expended

All expenditure is accounted for on an accruals basis, and has been classified under the headings that aggregate all costs related to that category. All expenditure is recognised once there is a legal or constructive obligation committing the Charity to the expenditure.

The Charity does not make grants to third parties.

Contractual arrangements are recognised as goods or services are supplied.

1.6 Costs of raising funds

These are costs associated with generating incoming resources, and are recognised as per the Charity's other expenditure.

1.7 Charitable activities

The costs of charitable activities include all costs incurred in the pursuit of the charitable objects of the Charity. These costs comprise the direct costs of charitable purchases, support costs, overheads and governance costs as shown in Note 6.

Governance costs comprise all costs incurred in the governance of the Charity. These costs include fees pertaining to the provision of governance and financial reports to the Charitable Funds Committee, the creation of this Annual Report and Accounts, the audit or independent examination of the accounts, and any associated support costs.

1.8 Intangible fixed asset investments

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Charity's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to or service potential be provided to, the Charity and where the cost of the asset can be measured reliably.

Intangible assets are initially recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating.

Intangible assets are amortised over a useful economic life of 5 years using a straight line on cost method.

1.9 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise.

2. Analysis of income from generated funds (Fundraising activities)

	Unrestricted Funds 2019/20 £000	Restricted Funds 2019/20 £000	**Total Funds 2019/20 £000**	Total Funds 2018/19 £000
Corporate donations	82	1	**83**	52
Community donations	16	6	**22**	36
WHH Events	8	1	**9**	10
Grant makers	1	0	**1**	4
Gaming and trading	0	0	**0**	1
Total	107	8	**115**	103

3. Analysis of voluntary income

	Unrestricted Funds 2019/20 £000	Restricted Funds 2019/20 £000	**Total Funds 2019/20 £000**	Total Funds 2018/19 £000
Donations	41	17	**58**	58
Legacies	1	-	**1**	29
Total	42	17	**59**	87

4. Analysis of investment income

	Unrestricted Funds 2019/20 £000	Restricted Funds 2019/20 £000	**Total Funds 2019/20 £000**	Total Funds 2018/19 £000
Bank interest	3	-	**3**	3
Total	3	-	**3**	3

5. Analysis of expenditure on raising funds (Fundraising activities)

	Unrestricted Funds 2019/20 £000	Restricted Funds 2019/20 £000	**Total Funds 2019/20 £000**	Total Funds 2018/19 £000
Expenditure on fundraising events	3	-	**3**	7
Promotional items and branding	18	-	**18**	7
Consultancy fees	-	-	**-**	-
Total	21	-	**21**	14

6. Analysis of charitable activities

	Unrestricted Funds 2019/20 £000	Restricted Funds 2019/20 £000	**Total Funds 2019/20 £000**	Total Funds 2018/19 £000
Patient welfare	94	29	**123**	138
Staff enablement	-	-	**-**	-
Medical equipment	53	12	**65**	44
Sub Total	**147**	**41**	**188**	**182**
Support costs and overheads*	4	54	**58**	31
Staff costs	19	49	**68**	60
Governance costs	2	19	**21**	19
Total	172	163	**335**	**292**

*Support costs and overheads comprise of an apportionment from the Trust's administration charge (Note 6) of £17,198 (£16,000 in 2018/19) plus other sundry items not categorised elsewhere.

6.1 Governance costs

	Unrestricted Funds 2019/20 £000	Restricted Funds 2019/20 £000	**Total Funds 2019/20 £000**	Total Funds 2018/19 £000
Independent examination	0.1	1.4	**1.5**	1.5
Administration Charge	1.3	15.9	**17.2**	16.0
Fees and subscriptions	0.1	1.8	**1.9**	1.5
Total	1.5	19.2	**20.7**	19.0

Independent examination consists of an accrual for the independent examination fee of £1,560 (£1,560 in 2018/19) for the period of this review.

7. Staff Costs

	2019/20 £000	2018/19 £000
Salaries and wages	**54**	49
Social Security costs	**5**	4
Pension Costs	**9**	7
Total	**68**	60

During the period under review no employees received employee benefits (excluding employee pension costs) of more than £60,000.

The Trustee is defined as the Corporate Trustee that does not constitute employment with the charity. Accordingly no Trustees are paid any remuneration nor receive any other benefits and expenses from employment with the charity.

7.1. Average number of employees in the year (Whole time equivalent)

	2019/20	2018/19
Fundraising	**1.0**	1.0
Administration	**0.5**	0.5
Total	**1.5**	1.5

7.2. Pension Costs

Employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded defined benefit scheme that covers NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. It is not possible for the Corporate Trustee

to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to the Statement of Financial Activities as and when they become due.

8. Allocation of administration charge

The costs of administering the Charity have been split between support costs and overheads (Note 6) governance costs (Note 6.1) and staff costs (Note 7).

During the year under review an administration charge was raised to cover the governance, financial and procurement resources of Warrington and Halton Hospitals NHS Foundation Trust. The charge for 2019/20 was £34,396 (£32,000 in 2018/19) the charge is apportioned equally between support costs and overheads and governance costs. The element of the administration charge that is attributed to governance costs pertains to the costs associated with the preparation of Committee papers and the Annual Report and Accounts.

During the year under review the Corporate Trustee considered the charity's policy on the allocation of overheads in conjunction with guidance as issued by the Charities Commission.

As at 31 March 2020 all shared costs for administration and governance costs have been apportioned across all funds using a combination of transactional and average balance techniques.

Overheads will continue to be apportioned on an annual basis. In the event that a restriction does not permit the allocation of overheads the costs will be met by way of a transfer from the unrestricted funds held by the charity.

9. Analysis of Intangible Fixed Assets

	2019/20 £000 Software
Cost	
Balance brought forward at 1 April 2019	**17.0**
Additions in year	**0**
Disposals in year	**0**
Balance carried forward at 31 March 2020	**17.0**
Amortisation*	
Balance brought forward at 1 April 2019	**10.0**
Charge in year	**3.4**
Balance carried forward at 31 March 2020	**13.4**
Net Book Value at 31 March 2020	**3.6**
Net Book Value at 31 March 2019	**7.0**

*The cost of intangible fixed assets relates to the purchase of the Harlequin fund raising database and associated finance package. The asset was purchased in 2015/16 and came into use from 1 April 2016.

10. Analysis of cash at bank and in hand

	2019/20 £000	2018/19 £000
Bank current account	**355**	507
Total	**355**	507

11. Analysis of debtors

	2019/20 £000	2018/19 £000
Prepayments and accrued income	**3**	35
Other debtors	**2**	2
Total	**5**	37

During the year under review, and the prior year, other debtors represent amounts to be reclaimed by the Charity in respect of Gift Aid.

12. Analysis of current liabilities and long term creditors

	2019/20 £000	2018/19 £000
Accruals and purchases made on behalf of the Charity	**47**	56
Total	**47**	56

13. Related party transactions

The Charity is a subsidiary of the Trust and is therefore a related party. Warrington and Halton Teaching Hospitals NHS Foundation Trust is the sole beneficiary of the Charity. The Charity provides funding to the Trust for approved expenditure made on behalf of the Charity. During 2019/20 the Charity made payments to Warrington and Halton Teaching Hospitals NHS Foundation Trust totalling £256,846 (£234,643 in 2018/19).

At 31 March 2020 the Charity owed Warrington and Halton Teaching Hospitals NHS Foundation Trust £44,283 for purchases made by the Trust on behalf of the Charity (£52,982 at 31 March 2019).

All transactions entered into during the year were conducted on an arm's length basis.

During the year, none of the members of the Trust Board or senior Trust staff, or parties related to them, were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the

Trust Board has received honoraria, emoluments or expenses in the year. The Corporate Trustee has not used the funds of the Charity to purchase trustee indemnity insurance.

Board members, and other senior staff, take decisions on both Charity and exchequer matters, but endeavour to keep the interests of each discrete, and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public in the Corporate Information section of the Trust's website.

From 1 April 2013 NHS charitable funds considered to be subsidiaries are to be consolidated within the Trust accounts in accordance with an accounting direction issued by NHS England and NHS Improvement. For 2019/20 the Trust has opted not to consolidate charitable funds with the main Trust Accounts on the basis that they are immaterial. This will continue to be reviewed each year for appropriateness.

14. Events after the reporting period

There have been no events since the Balance Sheet date that would indicate that any revision to the financial statements is necessary.

15. Legacies

Legacy income is recognised in line with the Charities Statement of Recommended Practice (SORP) in accordance with the Financial Reporting Standard applicable FRS 102) whereby in addition to establishing entitlement, a legacy is only recognised in the accounting period where:-

- There is sufficient evidence that receipt is probable; and
- It is possible to estimate with sufficient accuracy the amount receivable.

16. Fund structure and summary of movements

Charitable funds

The Charity has 11 funds. These are the (unrestricted) General Fund, and 10 Restricted Funds. The restriction has arisen due to the legacy donor's stipulation that the monies be spent within a particular department.

A summary of fund movements is given in the following table:

Fund	Balance as at 1 April 2019	Incoming resources	Outgoing resources	Transfers	Balance as at 31 March 2020
	£	£	£	£	£
Unrestricted Funds	150,379	134408	(175,685)	-	109,102
Breast Screening	29,003	922	(11,974)	-	17,951
Cancer Patient Support	17,881	1,803	(6,464)	-	13,220
Diabetes	37,797	1,050	(22,523)	-	16,324
COVID 19 Gifts In Kind	-	17,944	(17,944)	-	-
Heart Unit	16,862	1,493	(6,103)	-	12,252
Intensive Care	157,048	10,806	(74,213)	-	93,641
Neonatal	43,151	7,406	(21,796)	-	28,761
Ophthalmology	2,057	58	(743)	-	1,372
Radiology	31,698	690	(15,539)	-	16,849
Stroke Unit	9,307	649	(3,364)	-	6,592
Total Funds	**495,183**	**177,229**	**(356,351)**	**-**	**316,060**

Unrestricted general fund: sub-fund balances

Fund	Balance as at 1 April 2019	Incoming resources	Outgoing resources	Transfers	Balance as at 31 March 2020
	£	£	£	£	£
General Unrestricted	92,375	110,250	(110,345)	(3,436)	88,844
Children's Unit Appeal	28,644	12,105	(44,185)	3,436	-
Maternity	15,483	2,279	(8,611)	-	9,152
Children's Respiratory Fund	1,935	-	(1,935)	-	-
Forget Me Not Appeal	-	3,388	(2,793)	-	595
Heartbeat Halton Appeal	2,920	343	(1,055)	-	2,207
Halton Hospital Outdoor Spaces	-	3,726	(3,500)	-	226
Ophthalmology Appeal	6,080	42	(2,198)	-	3,925
SIC Programme	2,942	2,275	(1,063)	-	4,153
Unrestricted Fund Total	**150,379**	**134,408**	**(175,685)**	**-**	**109,102**

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PRIVATE & CONFIDENTIAL

The Board of Trustees
Warrington & Halton Hospitals
NHS Foundation Trust
Charitable Fund
Warrington Hospital
Lovely Lane
WARRINGTON
WA5 1QG

24th August 2020

Dear Sirs

WARRINGTON & HALTON HOSPITALS NHS FOUNDATION TRUST CHARITABLE FUND

In accordance with our normal practice we are writing to draw your attention to various matters, which arose during the course of our independent examination of the Charity's accounts for the year ended 31st March 2020.

Qualitative aspects of the entity's accounting practices and financial reporting
We have no comments to make concerning the qualitative aspects of the entity's accounting practices and financial reporting.

Letter of Representation
A letter of representation is attached for approval and signature.

Unadjusted misstatements
There are no unadjusted misstatements which have arisen during the course of our independent examination, other than those considered to be clearly trivial.

Expected modifications to the independent examiner's report
There are no expected modifications to the independent examiner's report.

We would like to take this opportunity of expressing our thanks to your staff for their assistance during the course of our independent examination.

Please note that this report has been prepared for the sole use of Warrington & Halton Hospitals NHS Foundation Trust Charitable Fund. It must not be disclosed to third parties, quoted or referred to, without prior written consent. No responsibility is assumed by us to any other person.

If we can be of further assistance, please contact Philip Urmston.

Yours faithfully

C.J. Thomson P. Urmston L.M. Warburton J.E. Boyo

Voisey & Co
Chartered Accountants
8 Winmarleigh Street
Warrington
Cheshire
WA1 1JW

24th August 2020

Dear Sirs

WARRINGTON & HALTON HOSPITALS
NHS FOUNDATION TRUST CHARITABLE FUND

During the course of your independent examination of the financial statements of the charity for the year ended 31st March 2020, the following representations were made to you by management and trustees.

1. We have fulfilled our responsibilities as trustees under the Charities Act 2011 for preparing financial statements, in accordance with the applicable financial reporting framework, that give a true and fair view and for making accurate representations to you as our independent examiner.

2. We confirm that all accounting records have been made available to you for the purpose of your independent examination, in accordance with your terms of engagement, and that all the transactions undertaken by the charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management, trustees' and members' meetings, have been made available to you. We have given you unrestricted access to persons within the charity in order to obtain appropriate evidence and have provided any additional information that you have requested for the purposes of your independent examination.

3. We confirm that significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

4. We confirm that all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the independent examiner and accounted for and disclosed in accordance with the applicable financial reporting framework.

5. We confirm that there had been no events since the balance sheet date which require disclosure or which would materially affect the amounts in the financial statements, other than those already disclosed or included in the financial statements.

6. We confirm that we are aware that a related party of the charity is a person or organisation which either (directly or indirectly) controls, has joint control of, or significantly influences the charity or vice versa and as a result will include: trustees/directors, other key management, close family and other business interests of the previous. We confirm that the related party relationships and transactions set out below are a complete list of such relationships and transactions and that we are not aware of any further related parties or transactions.

Party	*Relationship*	*Nature of transaction*
Warrington & Halton Hospitals NHS Foundation Trust	Parent	Funding is provided to the Trust for approved expenditure

7. We confirm that all related party relationships and transactions have been accounted for and disclosed in accordance with the applicable financial reporting framework.

8 We confirm that the charity has had, at no time during the year, any arrangement, transaction or agreement to provide credit facilities (including advances and credits granted by the charity) for trustees, nor to provide guarantees of any kind on behalf of the trustees.

9. We confirm that the charity has not contracted for any capital expenditure other than as disclosed in the financial statements.

10. We confirm that we are not aware of any possible or actual instance of non-compliance with those laws and regulations which provide a legal framework within which the charity conducts its activities and which are central to the charity's ability to conduct its activities.

11. We acknowledge our responsibility for the design and implementation of internal controls to prevent and detect fraud. We confirm that we have disclosed to you the results of our own risk assessment that the financial statements may be misstated as a result of fraud.

12. We confirm that there have been no actual or suspected instances of fraud involving trustees, management or employees who have a significant role in internal control or that could have a material effect on the financial statements. We also confirm that we are not aware of any allegations of fraud by former trustees, employees, regulators or others.

13. We confirm that, having considered our expectations and intentions for the next 12 months and the availability of unrestricted reserves, the charity is a going concern.

14. We confirm that all grants, donations and other income, including those subject to special terms or conditions or received for restricted purposes, have been notified to you. There have been no breaches of terms or conditions during the period regarding the application of such income.

15. We confirm that we are not aware of any matters of material significance that should be reported to the Charity Commission.

16. We acknowledge our legal responsibilities regarding disclosure of information to you as independent examiners and confirm that:

- so far as each trustee is aware, there is no relevant information of which you as independent examiners are unaware; and
- each trustee has taken all the steps that they ought to have taken as a trustee to make themselves aware of any relevant information and to establish that you are aware of that information.

We confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate of supporting documentation) sufficient to satisfy us that we can properly make each of the above representations to you and that to the best of our knowledge and belief they accurately reflect the representations made to you by the trustees during the course of your independent examination.

Yours faithfully

.....
Signed on behalf of the board of trustees Trustee .....

Date.....

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/09/105**	
SUBJECT:	**Learning from Deaths Q1 - 2020-21**	
DATE OF MEETING:	30 September 2020	
AUTHOR(S):	Dr P. Cantrell, Lead Clinician for Mortality Layla Alani, Deputy Director of Governance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
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.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***		
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides an overview of the Trust mortality data, including; • total number of deaths of patients; • number of reviews of deaths; • number of investigations of deaths; • lessons learned, actions taken, improvements made During Quarter 1, 2020/21; • 319 deaths occurred within the Trust • 58 Structured Judgement Reviews (SJRs) were completed • 12 of the 58 SJRs were presented to the Mortality Review Group (MRG) that quarter A Focused Review into deaths on Ward C21 was completed in the quarter, the findings of which can be seen in section 3.5 and Appendix 2 of this report. An update on the Medical Examiner and Medical Examiner Officer roles can be seen in section 3.6 of this report. Details relating to the investigation of the deaths of healthcare and social care workers who contracted the coronavirus can be seen in section 3.7 of this report.	

PURPOSE: *(please select as appropriate)*	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to note the contents of the briefing paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.			

	Date of meeting	
	Summary of Outcome	The reported was noted by Quality Assurance Committee
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning From Deaths Report Quarter 1, 2020-21	AGENDA REF:	BM/20/09/105

1. BACKGROUND/CONTEXT

The National Quality Board report published in March 2017 - National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care stated that;

"Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This report followed the findings of the CQC report published in December 2016 - Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. The report found that none of the Trusts contacted by the CQC were able to demonstrate best practice in identifying, reviewing and investigating deaths or in ensuring that learning was implemented. The purpose of the publication was *'to help to initiate a standardised approach, which will evolve as we learn'*.

All Trusts were tasked with reviewing their processes and to implement systems to review, understand and learn from deaths that occurred. National Guidance set the requirements of this:

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

The content of this report provides an overview of the process and systems that are in place to ensure that deaths are reviewed appropriately.

2. KEY ELEMENTS

The Trust use the HED (Healthcare Evaluation Data) system to asses overall mortality data, highlighting any themes or trends that support the requirement for focused reviews. This also enables benchmarking against other Trusts.

Using both the HED and the Datix Risk Management system to obtain data, this report will include;

- The total number of deaths of patients.
- The number of reviews of deaths.
- The number of investigations of deaths.
- The themes identified from reviews and investigations.

- The lessons learned, actions taken and improvements made.

3. MEASUREMENTS/EVALUATIONS

Total number of deaths and investigation levels

During 1st April 2020 to 30th June 2020, 319 of WHH patients died.

By 30th June 2020, 58 SJRs had been completed.

40 cases had been allocated to a reviewer in relation to the 319 deaths from quarter 1.

There were no Serious Incidents relating to deaths during quarter 1 (Details of the SJRs and RCAs can be seen later within this report).

a. Investigations of deaths

Structured Judgement Reviews of deaths - Structured Judgement Reviews are presented to the Mortality Review Group (MRG), to present an assessment of problems in care. Any actions or lessons to be learned are sent to the appropriate forum. Particular groups of patients are reviewed at the MRG:

- All deaths of patients subject to care interventions with elective procedures. These are identified using the electronic patient record which provides a daily update as to patients that have died.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust.
- Death of a patient with mental health needs (this covers Inpatients who are detained under the Mental Health Act) identified via the Trust Patient Safety Manager. If the death may have been due to, or partly due, to problems in care including suspected self-inflicted death it will be investigated as a serious incident.
- Death of a patient who had a DoLs in place during their admission.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality process.
- At the request of the Medical Director or Chief Nurse.

During Quarter 1, 58 Structured Judgement Reviews were completed by members of the MRG.

Table 1 below details their overall care rating:

Apr / May / Jun 20	Overall Assessment Care Rating Following SJR					Total
	1: Very Poor	2: Poor	3: Adequate	4: Good	5:Excellent	
	0	**1**	**19**	**35**	**3**	**58**

Cases rated as *1:* ***Very Poor*** or *2:* ***Poor*** are reviewed by MRG and then referred to the Governance Department for further discussion and possible further investigation. Consideration is also given to external reporting via StEIS where appropriate.

Cases rated as *3:* ***Adequate*** are referred to MRG for further discussion and cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Mortality & Morbidity Meetings.

3.3 Focused Reviews

The MRG analyses data in relation to Mortality and where is it indicated that there is a high SHMI/HSMR (i.e. greater than expected number of deaths) in a diagnosis group or further review is required into a specific topic then a request is made for a Focused Review to be undertaken.

- **Ward C21 Focused Review**

During Quarter 1 the MRG were asked to review 8 deaths from Ward C21 that occurred during 25th March to 31st May 2020. Three reviewers from the MRG were asked to review the deaths using the Royal College of Physicians Structured Judgement Review tool (SJR). The learning from this review can be seen in Appendix 2.

- **COVID Deaths Focused Review**

The MRG have also prepared a term of reference for a Focused Review into COVID deaths. This review will commence in quarter 2 with the aim to complete the review by October and present to this committee in November.

3.4 Cases subject to Root Cause Analysis investigation –

Where MRG have concerns that problems in care may have attributed to a persons' death, discussion is held with the Governance Department and where appropriate a Root Cause Analysis (RCA) investigation is undertaken. Some cases may be referred from Mortality Review Group to ensure a Root Cause Analysis investigation is undertaken. RCAs are also shared with patients/families, commissioners and where applicable HM Coroners and regulators/external agencies such as NHS Resolutions.

Appendix 1 provides an update on cases from Q1 2020/21 that were deemed to have identified problems in care which may have contributed to death or are still outstanding.

3.5 Learning from Deaths

A summary of learning from deaths for Quarter 1 can be seen in **Appendix 2.**

3.6 Medical Examiner

At the time of writing this report the roles for the Medical Examiner (ME) and Medical Examiner Officer (MEO) are currently being advertised and the interviews are set for the 23rd and 24th July.

The ME and MEO will offer a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one.

Acute trusts in England and local health boards in Wales have been asked to begin setting up medical examiner offices to initially focus on the certification of all deaths that occur in their own organisation.

The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

Medical examiners are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

Medical examiner offices will be staffed by a team of medical examiners, supported by medical examiner officers (and in our case the Bereavement Team).

The role of these offices is to examine deaths to:

- agree the proposed cause of death and the overall accuracy of the medical certificate cause of death
- discuss the cause of death with the next of kin/informant and establishing if they have any concerns with care that could have impacted/led to death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contributing to other clinical governance procedures.

Initially medical examiner offices are being asked to focus on the certification of deaths that occur within the acute trust where they are based. In time, they will be encouraged to work with local NHS partners and other stakeholders to plan how they can increase the service to cover the certification of all deaths within a specified geographical area. This will expand the service to cover deaths in other NHS and independent settings, as well as deaths in the community.

3.7 Investigation of the deaths of healthcare and social care workers who contracted the coronavirus

On 29 May 2020, the Secretary of State wrote to the Chair of the Health and Social Care Committee describing a process for investigating the deaths of healthcare and social care workers who died after contracting the coronavirus.

As part of their independent scrutiny, medical examiners will be asked to consider whether the death may have been caused by disease acquired in employment. When they suspect a health service or social care worker acquired coronavirus infection in the course of employment, NHS England and NHS Improvement will ensure the Trust is aware of the staff fatality. This will enable the Trust to consider if it has an obligation to notify the death to the Health and Safety Executive, in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

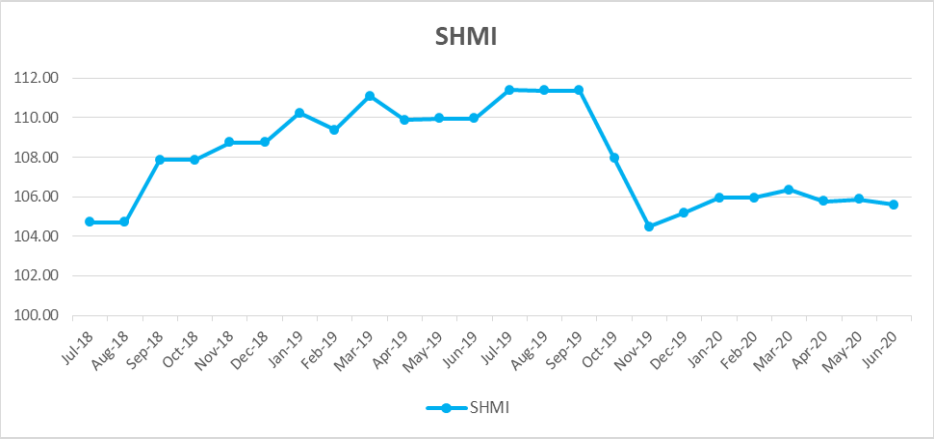
In cases where medical examiners find coroners have opened investigations the medical examiner scrutiny will end. As we currently do not have an experienced Medical Examiner in post the Regional Medical Examiner will assign any applicable cases to a Medical Examiner from another Trust.

4. TRAJECTORIES

SHMI / HSMR Summary
In 2010 the Department of Health endorsed the national review of HSMR commissioned by the NHS Medical Director who committed to implementing SHMI as the single hospital level of mortality indicator to be used across the NHS. Therefore, although we continue to consider HSMR, it is the SHMI which is being used and evaluated nationally as the mortality indicator.

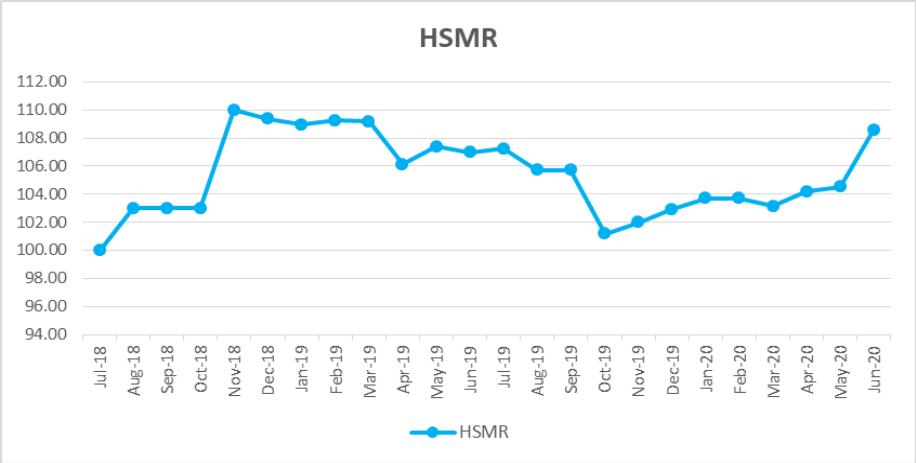
SHMI (Summary Hospital Mortality Indicator)
All observed deaths in hospital and within 30 days of discharge. Adjustments are made only for age, admission method, comorbidities. Still births, specialist community, mental health and independent sector hospitals, day cases, regular day and night attenders are excluded.

Table 2 below shows the Trust position since July 2018 and demonstrates the current position as 105.59 compared to our peer group at 105.44; we are not an outlier for SHMI.



HSMR (Hospital Standardised Mortality Ratio)
All patient stays culminating in death at the end of a patient pathway defined by the primary diagnosis for the stay. It uses 56 diagnosis groups which account for about 80% of in-hospital deaths; therefore it does not included 'all' deaths.

Table 3 shows the Trust position since July 2018 and demonstrates our current position at 108.56. Our peers' average is 98.87. The Trust is not showing as an outlier in any of the diagnosis groups that are monitored by HSMR.



The committee are asked to note that the above results are based on data up to March 2020.

5. MONITORING/REPORTING ROUTES

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

6. IMPACT ON QPS?

The learning from deaths helps us to make changes that will ensure high quality, safe care and an excellent patient experience.

7. TIMELINES

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

8. ASSURANCE COMMITTEE

Reports to both the Patient Safety and Clinical Effectiveness Sub-Committee and the Quality Assurance Committee.

9. RECOMMENDATIONS

The Board of Directors are asked to note this report

Appendix 1

STEIS Reference	INC Description	Deemed as having problems in care
2019/20 – Q1 – Of the 3 cases in Q1, 2 are awaiting Inquest and the remaining case was found to have no problems in the care provided to the patient.		
2019/8122	The patient was admitted to Warrington Hospital on 31/03/2019 after a fall at home, shortness of breath and increased confusion. The patient was admitted to AMU. On 02/04/2019 the patient had an unwitnessed fall and was found on the floor at the end of the bed. Following a brief loss of consciousness the patient displayed acute confusion, pain to right shoulder, laceration to right arm and hematoma to right temporal region. The x-ray confirmed the patient also sustained a fractured clavicle. The CT scan showed a large right hemispheral, falcine and left tentorial subdural haematoma which had progressed since the previous imaging. In the right front parietal region there was an impression of extension of haemorrhage. The CT results however were not documented in the patient's records until 04/04/2019. The patient's condition deteriorated and the patient sadly passed away on 08/04/2019. *This case was not subject to an SJR as a 72 hour review was already underway.	Subject to inquest – no date set as yet.
2019/11932	Patient care reviewed in MRG. A brief summary of the issues found; The patient died of Sepsis and Pneumonia following a fall Relatively little medical input for 3 days Went for 3 days without repeated bloods Problems with pain management Considered for discharge but she had an overwhelming infection No IV access for 3-4 days *This case was subject to an SJR and MRG requested that this be reviewed by Governance. This was subsequently deemed to be a Serious Incident.	Subject to inquest – no date set as yet
2019/20 – Q2 - Of the 3 cases in Q2 2 investigations are complete and deemed to have no problems in care and 1 is awaiting Inquest.		
2019/16094	Patient was sat at the side of the bed with the Occupational Therapist. Patient went to reach down to put slippers on, lost her balance and started to fall forward. Occupational Therapist attempted to facilitate balance, but the patient continued to fall forward. Patient assisted to the floor. *This case was not subject to an SJR as a 72 hour review was already underway.	Subject to inquest – no date set as yet.
2019/20 – Q3; 4 cases. All investigations are complete and it was deemed there were problems in care with two of the cases but no problems in care for the remaining two.		
2019/20 – Q4 - Of the 3 cases in Q4 an investigation is complete for 1 case and was deemed there were no problems in care and 2 cases are subject to Inquest.		
2020/700	On 24/09/19, the patient was admitted for elective open sub-total colectomy and a plan for post-operative management in HDU. The operation took place as planned. There were no documented intraoperative issues and the patient was transferred to HDU/ITU for post-operative management as planned. The patient remained on ITU until 30/09/19 with observations stable and occasional episodes of an elevated temperature, with one complaint of increasing abdominal distension and constipation. 6 days following surgery, the patient became unstable and rapidly deteriorated. The patient was reviewed and an urgent CT scan was booked. It was identified that the patient	Subject to inquest – no date set as yet

STEIS Reference	INC Description	Deemed as having problems in care
	had suffered abdomen perforation and an anastomotic leak. The patient suffered a cardio-respiratory arrest and sadly passed away on 30/09/19 at 17:55.	
2020/5852	The patient was admitted through ED on to AMU with confusion and weakness. He had a witnessed seizure in ED and was treated initially for hyponatraemia and hyperkalaemia. As part of a retrospective MRG review of the patient's care leading up to his death the MRG raised concerns regarding the post take ward round not giving a definitive plan regarding the patient's hyperkalaemia and hyponatraemia. A review was completed considering the MRG concerns and it was felt that this needed further investigation and escalation.	No problems in care.
2020/4597	Called to AED for adult trauma call at approx. 00:30 hrs. with 2nd on call anaesthetist. Patient arrived and transferred over onto trolley and vac-mat. Assisted the anaesthetist with IV cannulation and was dismissed from the call by the AED trauma team leader DR. Received further call from 2nd on call anaesthetist at 02:00 stating patient had deteriorated and was for trauma transfer to Aintree. Attended AED, patient peri-arrest required intubation. Anaesthetist wanted central line before proceeding. Attempt failed, so preceded with intubation. After insertion of cvp and arterial line, patient arrested. ROSC after 6 minutes. Pelvic Binder was applied by ODP and 1st on call anaesthetist post arrest approx. 03:50. Surgeon, anaesthetist and AED doctor decided patient was for resuscitative laparotomy at 03:55. Patient arrested on operating table further 2 times and ROSC was achieved. Decision made by cons surgeon and cons anaesthetist to not resuscitate if patient was to arrest again.	Subject to inquest – no date set as yet
2020/21 – Q1 – There were 0 cases during quarter 1 that required a serious incident review.		

Appendix 2 – Learning from Deaths

Ward C21 Focused Review

Clinical Summary

1. All extremely frail with multiple co-morbidities
2. All over 70; average age 83; range 73-98
3. 5 male; 3 female
4. 3/8 dementia
5. 4/8 hypertensive
6. 3/8 type 2 diabetes
7. One patient had advanced metastatic neuroendocrine tumour (managed at RLUH)
8. 7/8 admitted with #NOF
9. 1/8 transfer from hospital in Spain with # L1 vertebra and ribs
10. There were no problems with surgery and good documentation re appropriateness of procedure

Learning and recommendations

1. Fractured Neck of Femur should have been listed in Part 2 of the Death Certificate.
2. Medical Care input needed in these frail orthopaedic patients at all times.
3. Swabs for COVID on admission.
4. Immediate isolation of suspected COVID patients.
5. Good PPE should be practiced in all areas at all times.
6. There should be excellent environmental cleanliness at all times.
7. Review Estate to consider barriers between beds in bays.
8. The rigorous practice of screening and monitoring patients and staff entering clinical areas such as has been introduced in the elective surgical areas and now on C21 following the Nosocomial Infection Review should be standard practice Trust wide.
9. Actions from this review have been submitted to the Medical Director, Chief Nurse and Associate Chief Nurse for IPC to be included in the overarching Nosocomial Infection Review Action Plan.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/09/106**			
SUBJECT:	**Learning from Experience Report - Q1 2020/21**			
DATE OF MEETING:	30 September 2020			
AUTHOR(S):	Layla Alani, Deputy Director Governance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
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.			X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	None			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The following report provides an overview of the Learning from Experience Report. The information within the Learning from Experience report is extracted from the Datix system and other Clinical Governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 1, 2020/21.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Board of Directors are asked to: • Discuss and note the contents of the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.			
	Date of meeting	01 September 2020		
	Summary of Outcome	Report noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Experience Report 2020/21 Q1	AGENDA REF:	BM/20/09/106

1. BACKGROUND/CONTEXT

This report relates to the period 1st April – 30th June 2020 (2020/21 Q1). It contains a quantitative and qualitative analysis (using information obtained from the Datix risk system) including incidents, complaints, claims and inquests. The report includes a summary of the key findings identified in Quarter 1 with specific recommendations.

The purpose of the report is to:

- Identify themes arising from; Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit data that have been reported during Quarter 1.
- Make recommendations to the Clinical Business Units/ Care Groups highlighting areas for improvement.
- Provide a summary of Incidents, Complaints and Claims reported during the review period, highlighting any trends apparent from the review of the data.

2. KEY ELEMENTS

2.1 Items for Assurance from 2020/21 Q1

2.1.1. Incident Reporting There was a decrease in incident reporting in Q1 (2310 in Q4 vs 1891 in Q1), with notable reductions in reporting between April and May 2020 – likely to have been affected by the Covid-19 pandemic. As a result, the 'Report to Improve' campaign is being re-launched across the Trust and will continue for the remainder of the year to ensure that incident reporting increases back to levels previously reported. June 2020 data indicates that incident reporting has started to increase.

2.1.2. Learning and Actions from Incidents

- Medication - 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, Medical Handover and sent across the Trust.

- Medication - 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 (known side effects of olanzapine) before the incident was identified. A Rapid Incident Review took place and identified the following learning actions:

    - 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:
        - To ensure all medicines in the POD locker belong to the current patient.
        - 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.

- Pressure Ulcer incidents, actions from learning:
    - Repose proning kit has been purchased for use in the Intensive Care Unit to reduce the risk of pressure ulcer development.
    - Trial of Parafricta underwear on Ward B12 (FMN Unit) to reduce the risk of friction damage.

- Information Governance - A letter intended for a patient was typed with a partially incorrect address and sent via mail. This resulted in a suspected data loss incident which was externally reported to NHS Digital and the ICO. The following actions were taken:

    - The staff member that sent the letter has been made aware that automatic processes are available to populate the address fields as opposed to manually adding the address. This will prevent reoccurrence.
    - It subsequently transpired that the letter had reached its intended destination despite the partially incorrect address. The ICO were informed of this and the incident was closed.

- Filming incident on the Intensive Care Unit - A Covid-19 positive patient was receiving ventilator support in the prone position during a time that Sky News was filming the care being provided by Warrington Hospital in the fight against Covid-19. Prior to entering the department, the Sky Team were advised that patients in the unit did not have

capacity to give consent to be filmed. Whilst filming the Lead Consultant, the Sky cameraman transferred filming from the Consultant to treatment being performed by the physiotherapists. The final footage aired showed a short focus on the patient receiving treatment from the physiotherapists. This is currently being responded to as a complaint. Learning points:

- Clinical teams must ensure that curtains are drawn around a patient's bed for privacy and dignity prior to commencement of treatment.
- Planned filming could have been discussed with families prior to the Sky News attending the Intensive Care Unit.
- Families should have been informed prior to filming and consent gained to film unidentifiable footage.

NG Tube incident - Nasogastric tube was checked and found at 24cm (previously documented at 59cm), feed had been running through, but was stopped during handover as the bottle was empty and needed changing. Actions following the no harm incident:

- Safety Brief to be circulated on ITU to share the lessons learned at the review (to be circulated for 2 weeks).
- Ensure that the NG tube length is monitored and documented on the observation chart and nursing care plan: minimum 4 hourly.
- Ensure that any NG fixings / fastenings are secure (e.g. increased temperatures may make adhesive fastenings become lose).
- Ensure that all safety checks are completed during handover and involve both the nurse handing over and the nurse receiving the patient.

Women's Health incident trend in 2020/21 Q1 - There was a small trend in incidents related to delay in treatment / screening / observations. The root cause is that ICE had not been checked for mother's test results following admission. Actions taken:

- Midwives reminded to check ICE following admission to birth suite or induction of labour bay for results.
- Standard Operating Procedure in progress to embed process for checking results.

2.1.3. Complaints and PALS

- Over the 2019/20 financial year, all Clinical Business Units made significant improvement in responding to complaints on time. There were no breached complaints throughout 2019/20 Quarter 4 and throughout 2020/21 Quarter 1.

- There was a 48% decrease in complaints opened Trustwide in Q1 (54 in Q1 versus 104 in Q4). The Trust currently has 5 complaints over 6 months old due to the period of Covid-19.
- Themes identified in complaints mirror those found across PALS and incident reporting; delays in treatment, appointments issues and communication issues.
- Actions from complaints are monitored via the speciality governance dashboards and the Clinical Governance Department, reporting to the Complaints Quality Assurance Group. Complaints action reports are also made available Trustwide on a weekly basis.
- The Trust currently has 5 open PHSO cases. The PHSO closed no investigations in Q1 as the PHSO paused their investigation process on 22nd March 2020 due to the Covid-19 pandemic.

2.1.4. Mortality

- As part of the mortality review process, 58 SJRs were conducted during Quarter 1. Most of these cases were rated 'Good' with some 'Adequate' also being discussed. 3 SJRs reported the overall care grading as Excellent'.
- Comparing to Quarter 4, patients Under 55 has become the highest trigger for an SJR.
- The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR) are within expected range.
- The Mortality Review Group has become a virtual meeting due to the period of Covid-19. Deaths are being reviewed and discussed at the group which continues to have external representation from our Commissioning bodies.
- The Clinical Business Unit with the highest number of mortalities in Q1 was Digestive Diseases, this was due to the cohorting of COVID patients as wards A4 and A5 were wards for patients requiring supportive management and enhanced palliative care.
- The Medical Director requested a focused review to be conducted following a Covid-19 outbreak into 8 patient deaths that occurred between 25th March to 31st May 2020, on the Trauma & Orthopaedic Ward, C21. This focused review has been completed and actions from this review are to be included in the overarching Nosocomial Infection Review Action Plan. The Clinical Commissioning Group, Care Quality Commission and NHSE/I were informed.

2.1.5. Clinical Audit

- There are a number of audits ongoing across the Trust. For Q1 this briefing makes reference to the National Ophthalmology Database Audit. The audit findings are favourable indicating high quality surgery is being delivered to NHS patients.
- A Bone health assessment for all Rheumatoid arthritis (RA) patients audit was completed in Quarter 1 to assess how often we evaluate our RA patient's bone health at their annual review appointments. NICE guidance (NG100) states it should be done every year. The result of this audit provided the Trust with "Significant" assurance.

2.2 Key Learning from SI Investigations concluded in 2020/21 Q1

- **Patient death following anastomotic leak post-surgery - Lessons Learned**
  - Patients post anastomosis have a leak until clinically proven otherwise. The particularly high risk period is between days 5-7 post surgery. Staff should have a lower threshold for considering any temperature spike a possible indication of an anastomosis leak.
  - Similarly, there should be a low threshold for asking for a senior surgical review and a Computed Tomography (CT) abdomen. Regular senior surgical review is likely to be better at considering an anastomotic failure - even if the patient is being regularly reviewed by the Intensive Care team and there are no concerns. In level one (ward fit) patients remaining on Intensive Care use NEWS2 charts and escalate to the Intensive Care medical team rather than MET.

- **Non-accidental injury to baby not suspected in ED - Lessons Learned**
  - Safeguarding is everyone's concern and any member of the team can escalate safeguarding concerns.

- **Delayed Cancer Diagnosis - Lessons Learned**
  - It is important to ensure that each clinical speciality has a process for ensuring that any follow up imaging or other recommendations made on Radiology reports (e.g. referral to a different speciality) are reviewed and acted upon.
  - It is important that the minutes of Multi-Disciplinary Team meetings accurately reflect the care plan discussed and include any necessary actions.

- **Trauma patient passed away following arrival to ED – Lessons Learned**
  - The Trauma Team Leader should maintain oversight and co-ordinate all activities of the trauma team. In the event that there is a clinical deterioration or following intervention, it is the responsibility of the Trauma Team leader to lead a re-assessment of the patient, which may involve a re-grouping of the Trauma Team if the team has already been dismissed.
  - In the event that one Trauma Team Leader hands over to another Team Leader, the information and plan handed over should be clearly documented.
  - Trauma Team documentation should be completed for all team members and specialties involved. It is good practice for a scribe to be present at trauma calls. It is the responsibility of the Trauma Team leader to ensure that all trauma call documentation is complete.
  - Pelvic binders should be applied early in anticipation of potential pelvic injuries for haemorrhage control. Consideration should be given to preparing the pelvic binder for use based on the pre-hospital mechanism of injury prior to patient

arrival. The ability to mobilise from an ambulance to an ED trolley does not preclude the potential for pelvic injury.

- In accordance with NICE guidelines, Tranexamic acid should be administered early when haemorrhage is suspected and must be given within 3 hours of injury.
- On recognition of the presence of haemorrhagic shock, the MHP should be immediately activated and an assigned member of the Trauma Team should be allocated the task of communication with transfusion and ensuring that the required blood samples are sent. The Trauma Team leader has overarching responsibility for ensuring closed-loop communication with team members to check that tasks are completed, such as sending blood group and save samples to transfusion and blood products are made available for administration.
- Blood products should be used as the primary resuscitation fluid of choice in the presence of haemorrhage. IV crystalloid and colloid should not be used in the treatment of haemorrhage in trauma because it is associated with harm, including causing the dislodging of small clots and causing dilution coagulopathy thereby propagating haemorrhage and mortality and should only be used as a resuscitation measure in the absence of the availability of blood products and in the absence of a radial pulse.
- Traumatic cardiac arrest should be managed in accordance with Resus (UK) guidelines. Adrenaline should not be used in the management of traumatic cardiac arrest.

2.3 Items for Escalation from 2020/21 Q1

2.3.1. Clinical Incidents

- There was a decrease of 20 incidents causing Moderate to Catastrophic harm in Q1 (37 in Q4 vs 17 in Q1).
- The Trust reported 224 incidents open in CBUs in Q4. To date this has increased to 281.
- The number of no harm incidents reported fell by 18.1% in Q1, with notable reductions in reporting in April and May 2020 – partly attributed to the Covid-19 pandemic. In response to this, the 'Report to Improve campaign' is being re-launched and led by the Patient Safety Manager and Senior Governance Manager. Reporting of no harm incidents is essential for learning and analysis of clinical and non-clinical issues across the organisation.

2.3.2. Non-Clinical Incidents

- From 1st April 2020 to 30th June 2020, there were 280 non-clinical incidents reported. The top 2 categories were Security Incidents and Health & Safety Incidents. There were inaccuracies in security incident reporting and work has been undertaken with the team to understand the criteria for incident reporting.

- Injury to staff was the top reported sub-category for Health & Safety Incidents – this is being monitored by the Health & Safety team for themes and trends.

2.3.3. Complaints

- Staff attitude and behaviour complaints decreased significantly in Q1 following the overall decrease in complaints received by the Trust.
- Complaints around clinical treatment have reduced in Q4 - mirroring Q4 incident reporting which saw clinical care issues reduce.

2.3.4. Claims

- Payments for clinical claims settled with damages totalled: £2,234,966 excluding costs; and
- Payments for non-clinical claims settled with damages totalled £28,750. Learning from individual claims continues to be disseminated.

2.3.5. Mortality

- The Clinical Business Unit with the highest number of mortalities in Q1 was Digestive Diseases, this was due to the cohorting of COVID patients; Wards A4 and A5 were for patients requiring supportive management and enhanced palliative care.

3. IMPACT ON QPS?

In relation to quality we aim to provide high quality, safe care and an excellent patient experience. By providing a Learning from Experience report, we are ensuring quarterly key Trustwide learning from incidents, complaints, claims, mortality and clinical audits. Through this reflective analysis from the previous quarter, we are able to capture learning and generate improvements which will support the aims concerning quality.

4. MONITORING/REPORTING ROUTES

The information within this Learning from Experience report is provided and overseen by the Clinical Governance Team and Clinical Audit Department.
Learning from investigations is provided monthly at each Specialty and CBU governance meeting through monthly learning newsletters. Learning from SI investigations is also reported to the Patient Safety and Clinical Effectiveness Sub-Committee on a monthly basis.

Key learning from governance information at a Trustwide level is captured and analysed on a quarterly basis, and is submitted to the Quality Assurance Committee – contained within this report and the accompanying slides.

5. TIMELINES

Trustwide learning was captured and analysed from the period April 2020 to June 2020 (2020/21 Q1).

6. ASSURANCE COMMITTEE

A quarterly report will be submitted to the Quality Assurance Committee, then to the Board of Directors.

7. RECOMMENDATIONS

The Board of Directors are asked to discuss and note this highlight report and accompanying slides.

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Learning From Experience Q1 Report

Layla Alani

Deputy Director of Governance

August 2020

Overview

The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 1, 2020/21. They should be viewed in conjunction with the High Level Briefing Report.

Incident Headlines Q4 vs Q1

How many staff are raising incidents Q4 vs Q1?

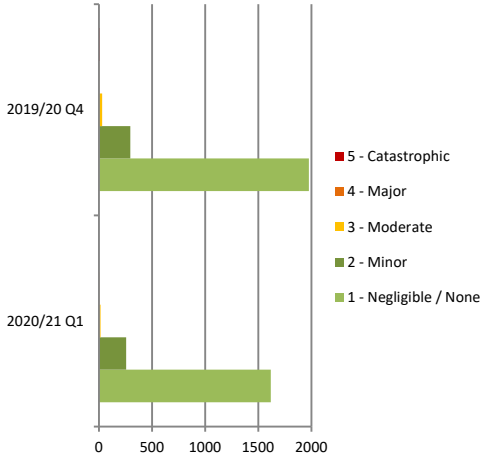
- There was a 18.1% reduction in incident reporting within the Trust in 2020/21 Q1 (2310 in 2019/20 Q4 vs 1891 in Q1).
- There was a **decrease** in incidents causing Moderate to Catastrophic harm in Q1 (37 in Q4 vs 17 in Q1)
- The number of no harm incidents reported fell by 18.1% in Q1, with notable reductions in reporting in April and May 2020 – partly attributed to the Covid-19 pandemic. In response to this, the 'Report to Improve' campaign has been relaunched.

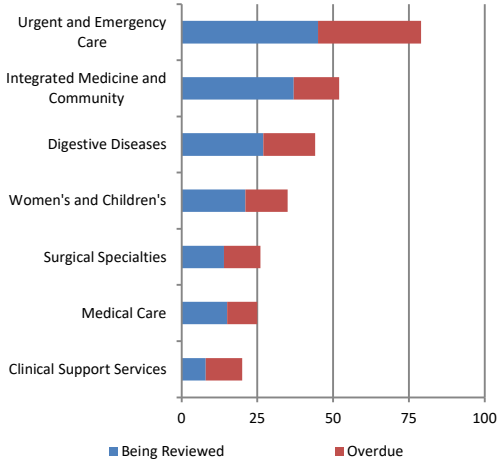
How many incidents are open Q4 vs Q1?

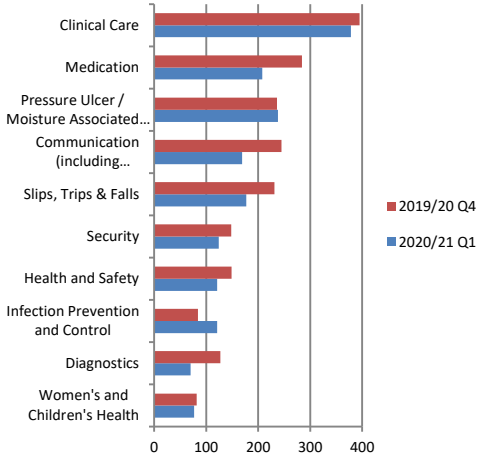
- The Trust reported 224 incidents open in CBUs in the 2019/20 Q4 LFE. To date that has increased to 281. The graph below shows the 7 CBUs with open incidents and the number of which are overdue.
- Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that performance continues to improve.

What type of incidents are we reporting Q4 vs Q1?

- As stated, there was a decrease in the amount of incidents reported. Incidents relating to infection control increased in Q1.
- Incidents relating to clinical care, medication, communication and security all decreased in Q1 following the overall reduction in incident reporting.

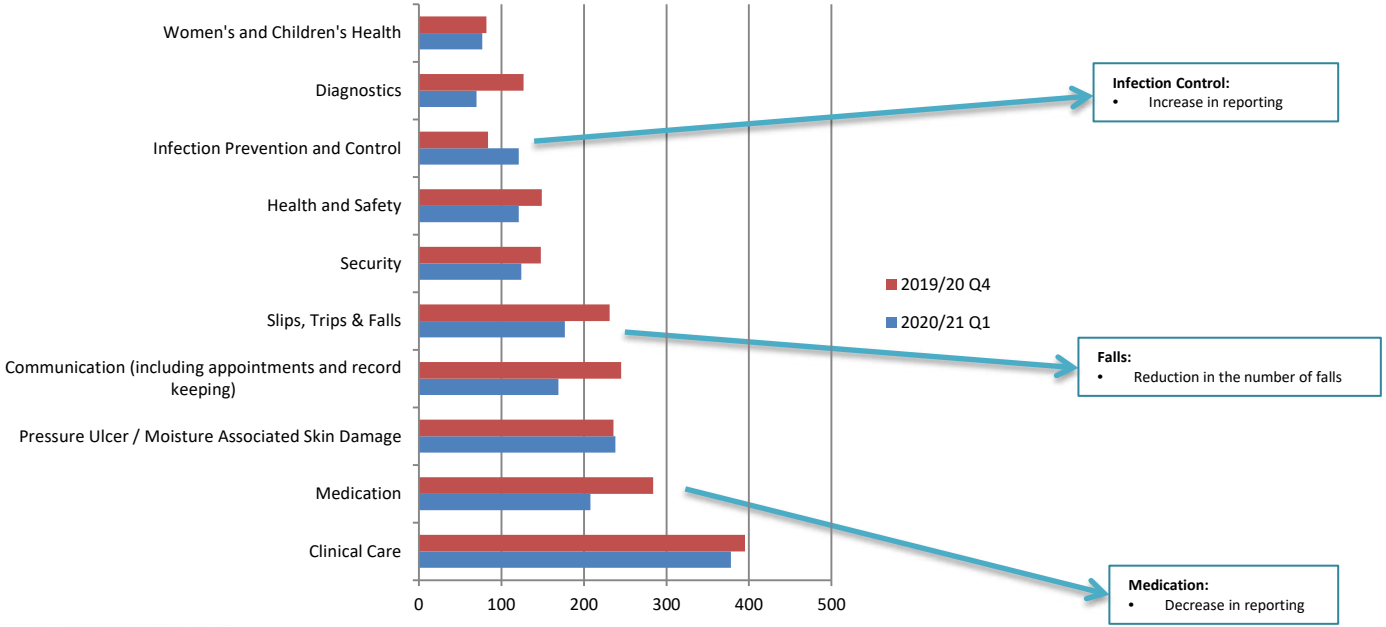






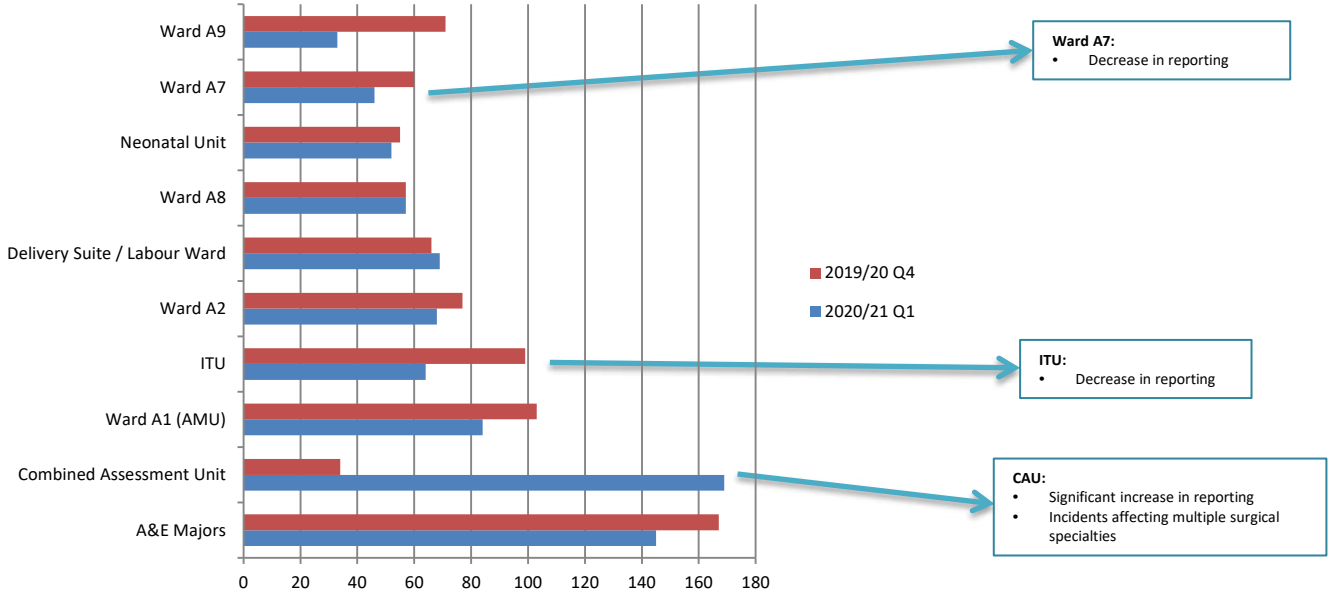
Incident Category Analysis Q4 vs Q1

The information shows the top categories reported incidents how they differ between the 2 quarters.



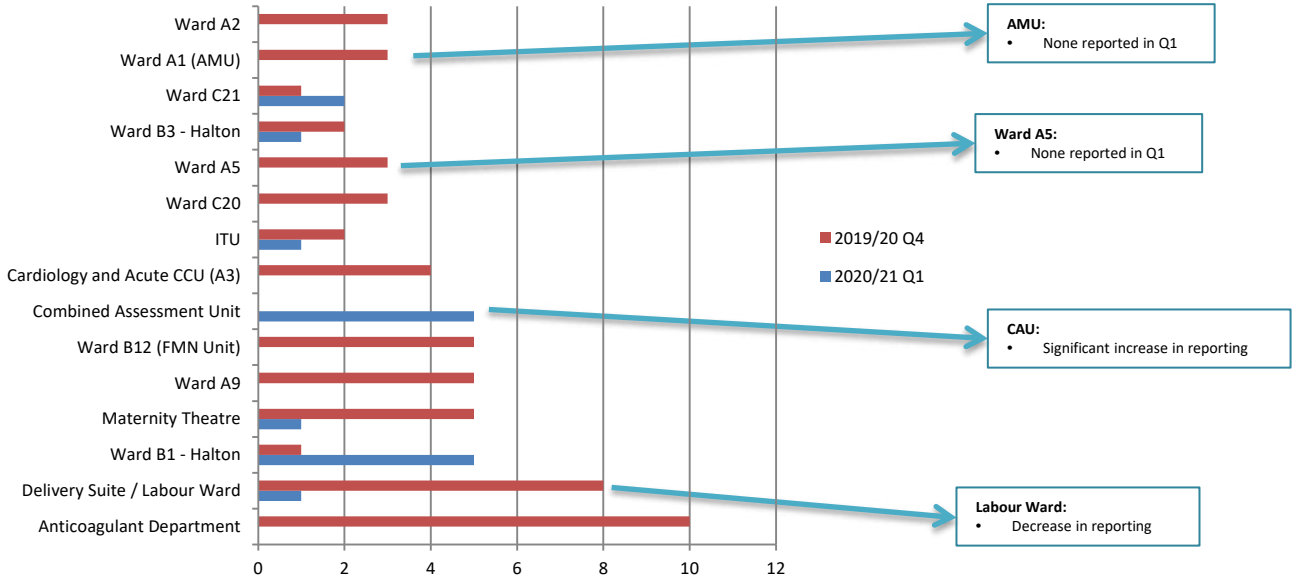
Incident Location Analysis Q4 vs Q1

The information shows the top reporting locations and how they differ between the 2 quarters.



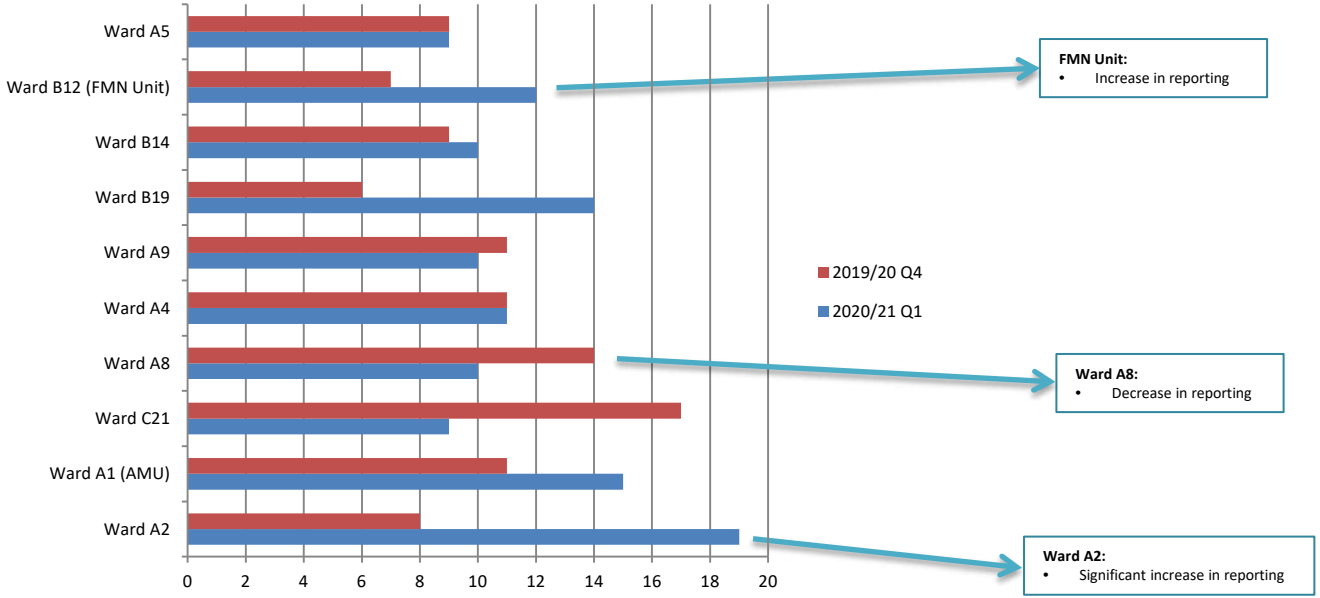
Staffing Incidents Location Analysis Q4 vs Q1

The information shows the top reporting locations in relation to staffing incidents and how they differ between the 2 quarters.



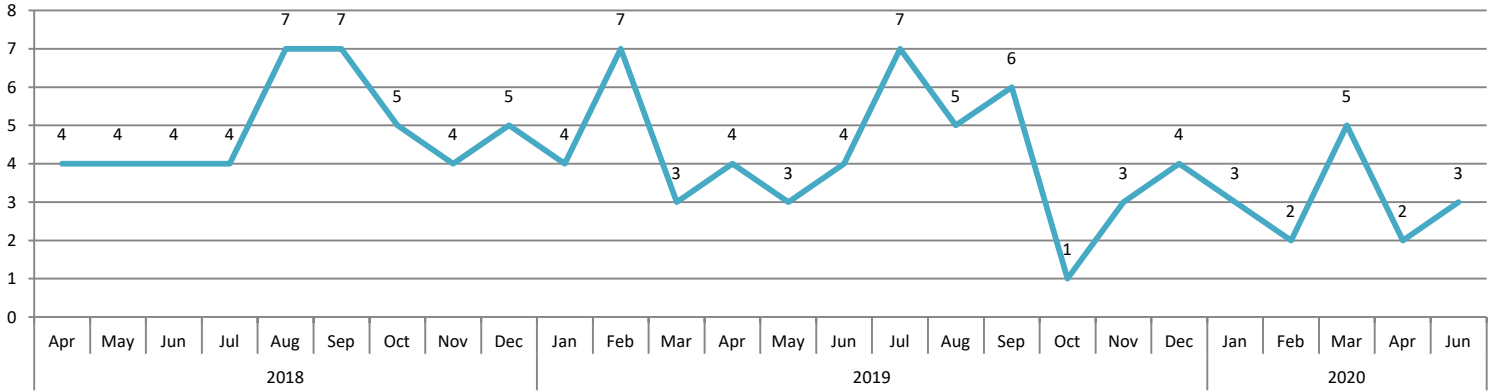
Patient Falls Location Analysis Q4 vs Q1

The information shows the top reporting locations in relation to patient falls and how they differ between the 2 quarters.

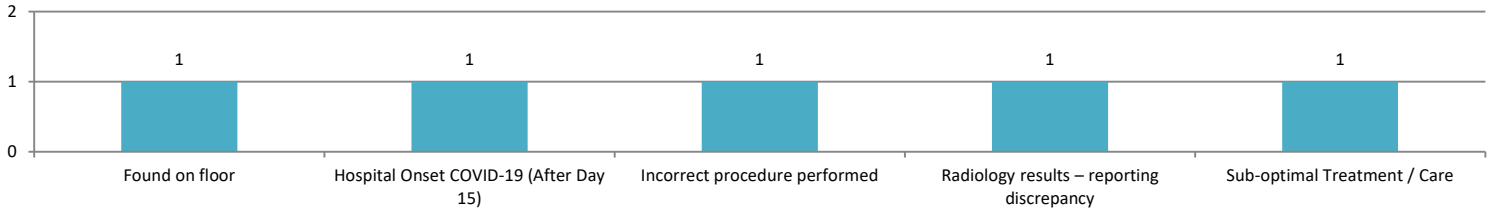


Serious Incident (SI) Reporting

SIs reported by Month



SI Cause Groups Q1



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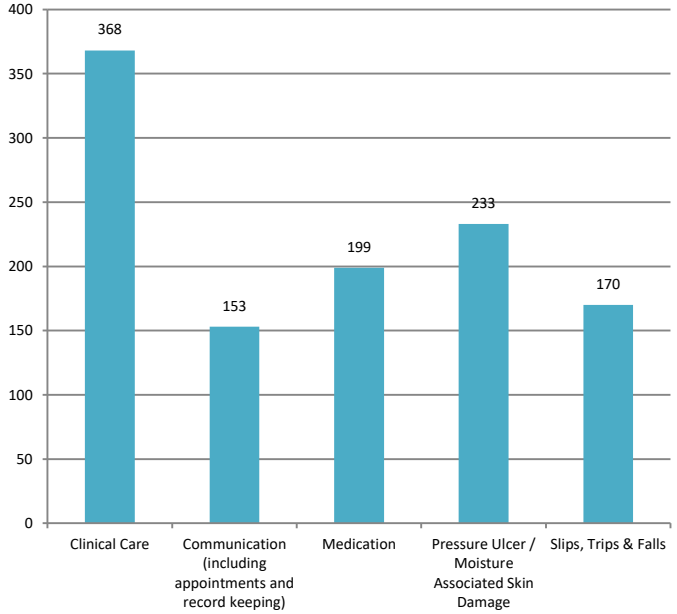
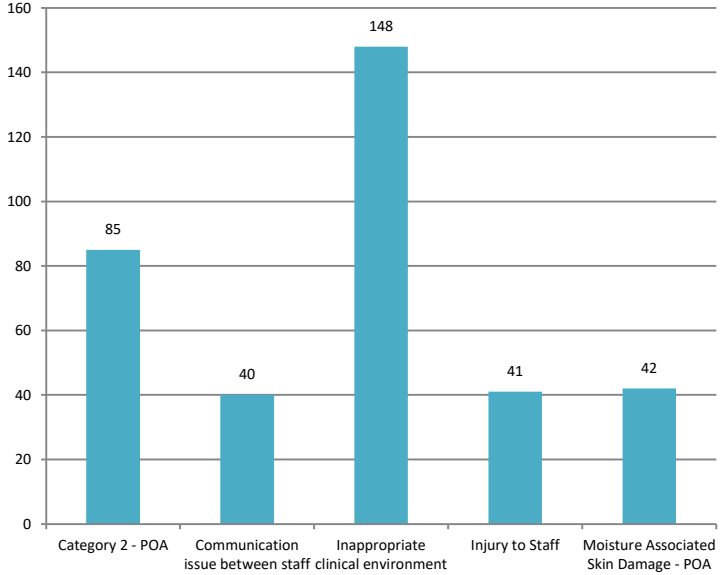
Across the 7 CBUs in Q1

A total of 1759 incidents were reported across the 7 CBUs in Q1, this has decreased from 2108 from Q4.

The top 5 categories and subcategories in Q4 were reported as follows:





Learning from Incidents – Medical Care

We found….	We Acted….
A Covid-19 positive patient was receiving ventilator support in the prone position on the ICU department during a time that Sky News was filming the care being provided by Warrington Hospital in the fight against Covid-19. Prior to entering ICU the Sky Team were advised that patients in the unit did not have capacity to give consent to be filmed therefore all images of patients must be pixelated to obscure identity. The film crew entered the unit before families had not been made aware of their presence. Whilst filming the Lead Consultant the Sky cameraman transferred filming from the ICU Consultant to treatment being performed by the physiotherapists. The Communications Specialist reminded the Sky News team that consent to be filmed had not been provided and specifically requested filming not focus on the patient but on the Therapists performing the treatment. The final footage aired showed a short focus on the patient receiving treatment from the physiotherapists	
• Clinical teams must ensure that curtains are drawn around a patient's bed for privacy and dignity prior to commencement of treatment. • Planned filming could have been discussed with families prior to the Sky News attending ICU. • Families should have been informed prior to filming and consent gained to film unidentifiable footage.	➢ A verbal apology was given to the patient ➢ The rapid incident review report was shared with the patient with a written apology ➢ The Communications Director contacted Sky to ensure the footage was not to be included in the final documentary
Immediately after morning handover a nasogastric tube was checked and found at 24cm (previously documented at 59cm), feed had been running through, but was stopped during handover as the bottle was empty and needed changing. The patient not moving to pull at the lines, the tape was in place, but had become very loose around the NG tube. Respiratory observations were stable, FiO2 and respiration rate were unchanged. The NG tube was aspirated - nil. Cuff pressure on ETT checked noted to be low so inflated. Oral and in-line suction had copious, purulent/creamy secretions, loose and easily suctioned. A new NGT was sited and a chest x-ray confirmed the tube was safe to use and report of no significant changes in lung field	
There is a significant migration from 59 to 24 cm but this does happen and the possible reasons are: • Patient agitated / coughed /moved • The weather (it was a significantly hot day) • Medical input requiring drapes to be placed over the face. The panel felt that all actions had been appropriate and no harm was caused but there were some lessons to be shared with the ITU staff and this will be achieved through the safety brief.	➢ Safety Brief to be circulated on ITU to share the lessons learned at the review (to be circulated for 2 weeks) ➢ Ensure that the NG tube length is monitored and documented on the observation chart and nursing care plan: minimum 4 hourly ➢ Ensure that any NG fixings / fastenings are secure (e.g. increased temperatures may make adhesive fastenings become lose). ➢ Ensure that all safety checks are completed during handover and involve both the nurse handing over and the nurse receiving the patient.

Learning from Incidents – Clinical Support Services

We Found….	We Acted….
A 24 year old female, BMI 38, second pregnancy previous pregnancy induced hypertension and an emergency caesarean. Seen in maternity triage at 31+ week's gestation - second incidence of reduced fetal movements, no fetal heart was detected - IUD confirmed by ultrasound. Following induction two days later a male infant was born showing no signs of life RIP. Discharged home with anticoagulation treatment. 17 days later the lady contacted the bereavement midwife with a constant left sided headache for four days. Following discussion with the shift leader was advised to attend A&E for medical review. A CT venogram was performed and showed an acute Dural Venous Thrombosis discussed with neurosurgery and The Walton Centre, admitted and following neurology review was prescribed three months of warfarin. Follow up was a further neurology review in 4 months and a daily review by the anticoagulation team.	
▪ Postnatally the correct dose and regime of LMWH was prescribed for the appropriate length of time as per the policy by the maternity department. ▪ The CT Venogram was initially telephone requested by the FY1 and not on the ICE system but was performed and reported on in just over 1 hour = no delay ▪ All staff to be reminded that the policy for requesting radiology scans from the hub should be made by the designation of registrar and above.	➢ The bereavement midwife and shift coordinator to be congratulated for an early referral to the emergency department - fed back ➢ ED and radiology staff congratulated by the consultant obstetrician for a speedy discovery of what is usually a late diagnosis of this condition – fed back to both teams ➢ All staff were advised that the request for scans from the hub should be submitted on the ICE system prior to telephoning and requesting the scan. ➢ All staff were reminded that the policy for requesting radiology scans from the hub should be made by the designation of registrar and above.
A 40 year old, right hand dominant gentleman who works in a physical job and competes in body building competitions attended the Trauma & Orthopaedic (T&O) clinic in February 2016 with a history of having 14 months previously suffered a hyperextension type injury of the right elbow causing significant swelling playing rugby : reviewed at Arrowe Park Hospital. Further injury occurred 2 months later and the patient attended Warrington ED was reviewed and offered an exploration of the elbow for assessment – declined. The Biceps looked clinically intact with no neurological deficit n the hand. Referrals for physiotherapy and an MRI scan were completed in March 2016 and reported as: Normal appearances of the distal biceps and triceps tendon attachments, normal appearances of the elbow joint, no evidence of partial or full thickness tear. The patient was reviewed in May 2016 and referred to Wrightington Hospital . The images were reviewed following a clinical Claim in May 2020 and the original report was found to be incorrect.	
• On review the findings have been misreported as the biceps tendon was not normal. • No harm was caused as the action taken for this kind of injury, would have been that which was taken: to refer to Wrightington Hospital.	➢ This case to be shared with the other 4 Radiologists who specialise in this field ➢ The Radiologist involved in this case to complete a reflective practice to be discussed at their annual appraisal

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Learning from Incidents – Urgent & Emergency Care

What happened…	Learning action points
MH Triage process – During a patient attendance to ED there was a noted decline in mental health (MH). A MH triage tool was completed and noted the patient at high risk requiring 1:1 observations as they had described on-going suicidal ideation. The patient was transferred to A1 where a MH review was conducted. Whilst discussing the patient on-going plan with external liaison service the patient absconded from the ward. 90 minutes later the patient was returned to the hospital by ambulance after being found on the floor by a member of the public. The patient was triaged via ED and a MH triage tool graded the patient as moderate risk. This did not appreciate the collateral history of hearing voice to self-harm. Intermittent observations were performed and in-between observations the patient implemented a ligature using a sock. The patient was found and the emergency buzzer pulled, ligature cut away and moved to Resus were she was reviewed and noted to be medical stable.	It was detected that handover of observation requirements are not documented. Mental health observation requirements were not formally reassessed if it was deemed that patient did not require 1:1 observations When patient absconded from A1 security should have been called to help bring her back to the ward and /or inform the ward where the patient was last seen. When the patient absconded from A1 the police should have been informed as she had verbally informed staff of attempts at causing herself harm.
Use of medical equipment in simulation – Major Trauma Simulation was underway, TRAUMA call made in simulation. Switchboard put MET call through and "none" briefed doctor turned up to simulation. As the Surgical SHO arrived later than rest of team, they were not aware it was a simulation. Trauma lead asked Surgical SHO to cannulate patient who actually cannulated member of staff who was acting as patient. Simulation stopped at that point, participants reminded not to actually cannulate in Simulation. Simulation patient debriefed	A review of the incident found that a risk assessment not completed. The current SOP does not include requirement of risk assessment, gatekeeper and advocate The SOP should include requirement that no Sharps (or medication) should be in the simulation environment and that simulation equipment should be distinctive.

Learning from Incidents – Integrated Medicine & Community

What happened…	Learning action points
Fall resulting in fractured NOF: Patient fell and suffered fractured neck of femur whilst awaiting plan of care for discharge. A review of their care found the lessons learnt and choice of equipment could have provided an alternative outcome; this could have included a fall sensor pad. This would have given additional time to respond to patient mobilising and could not be deactivated like a falls tab.	During the review the patient was noted to be hard of hearing; after the fall whilst being cared for on A6 a battery change is documented to improve communication. This could have been considered earlier. Although a call bell was provided it is not documented that the patient knew how to use the bell. This incident is being investigated further

Learning from Incidents- Surgical Specialities

What Happened?	Learning action points
A patient was asked to stop dual antiplatelet therapy by the Waiting list staff on the advice of Consultant Urologist. The patient had a CABPG 11 months ago and needed to be on the medication for at least 12 months according to the advice of the Cardiologist. When the patient came for his pre-operative assessment the patient was discussed with the Cardiologist and restarted one of his antiplatelet therapy as it is not advisable to leave the patient without it.	• When a patient awaiting a surgical procedure is on anticoagulants the Surgeon must liaise with The Cardiology Team before omitting medication.
A patient with ischaemic bowel had flexible sigmoidoscopy and later went on to develop bowel perforation. Although investigation found that all care and management was correct and the bowel perforation could not have been avoided, there was no knowledge of the adverse event linked to a procedure. All significant recognised complications of surgery are reviewed in the Endoscopy Users group to discuss any further learning.	• When any recognised complication of an Endoscopic procedure is identified the team responsible for the patient should inform the Endoscopy Unit in charge of the event.

Learning from Incidents - Digestive Diseases

What happened…	Learning action points
A patient was seen by the Surgical team for hip pain. A CT scan was booked and report suggested bone metastases. The GP delivered the news to the patient of potential bone metastases but after discussion in Colorectal MDT this was found to be more likely a pathological fracture related to past radiotherapy. This information was delivered to the patient but not the GP.	➢ Once a treatment plan is made through Colorectal MDT this discussion must be communicated to the patient and their GP.
A patient with haemetemesis was referred from ED to surgical team as he had PR bleeding. The Surgical SpR was in emergency theatre and there were no surgical SHOs on duty that evening. Advice was given to refer the patient to the medical team due to Upper GI bleed whilst he was in emergency theatre. The ED team left a message with the surgical SHO for them to complete a medical referral. The patient showed signs of cirrhosis, portal hypertension and varices when reviewed and sadly died from his worsening condition.	• If the patient is showing signs of deterioration within the ED department and the surgical team are not available or in Theatre there should be escalation within the ED team to complete further plans and interventions.

Learning from Incidents – Children's Health

What happened…	Learning action points
An incident occurred when flushing long line when administering IV antibiotics and the cannula filter made a pop noise and on observation the filter had split and began to leak. This was a no harm incident.	This was a one off and has not happened before. If the incident occurs again then the manufacturer will be contacted along with defective part to investigate.
Feeds not increased for neonate on B11 as required over 3 days patient was in hospital. Feeds were then increased.	Learning from the incident has been shared with all staff and discussed on the safety brief. Feeding regime printed out and posters presented around ward for staff to use to review and as prompt.
60hr old baby (born at 37+2 week gestation) referred by midwife as transcutaneous bilirubin (TcB) level was 258. The Serum Bilirubin (SBR) was 250 but was wrongly plotted on 38 week SBR graph. This resulted in sending the baby home in error. Baby was safety netted as the SBR was repeated by the PART team the next day. Baby was admitted and received phototherapy for 22 hrs and discharged home. No harm done to the patient.	Email sent out to medical staff to remind the importance of plotting SBRs on correct graphs. Graphs being monitored and staff supported to ensure the correct charts are used.

Learning from Incidents – Women's Health

What happened…	Learning action points
Learning from Gynaecology complaint:	• Senior colleagues asked to address pain management in the earlier consultations and advise patients to seek GP help sooner or consider in-patient assessment for pain management. • Medical staff asked to consider what they can do to support patients with pain who have a cancer diagnosis. • Senior clinicians to advise patients of the Somerset Cancer Register framework and this way, the patient does not feel pressured to call to check or chase progress.
There had been a small trend in incidents related to delay in treatment / screening / observations. The root cause is that ICE had not been checked for mother's test results following admission.	• Midwives reminded to check ICE following admission to birth suite or induction of labour bay for results. • SOP in progress to embed process for checking results.
15 year old primigravida Preterm labour at 34+5 weeks gestation Prolonged labour – delay in the first stage Emergency caesarean section at 9cms. Epidural topped up for emergency caesarean section Deeply impacted head resulted in difficult delivery	• Excellent care was delivered to the patient in theatre by the surgical team when the head of the baby could not be delivered easily. • Patient was started on a partogram when not in established labour, and was then stopped. If the partogram is stopped, ensure the indication is clearly documented. • Of the 7 Fresh Eyes CTG reviews in the notes, only 2 were countersigned – New fetal-monitoring lead in post to complete audit and targeted support. • Consider whether epidural top ups for caesarean section are appropriate during the COVID pandemic as they increase the likelihood of requiring a general anaesthetic

Learning from Incidents - Radiology

We found….	We are doing….
• A patient on critical care required a cardiac CT scan as per LHCH. Metoprolol was given to slow the heart rate as required for the scan. • Heart rate and BP fell too far and a call was made to the cardiac arrest team. After the second cycle of CPR there was a return to spontaneous circulation. • Observations were not recorded immediately prior to the incident although continuous haemodynamic monitoring was in place. • Medications given during the procedure were recorded on CRIS but not on Lorenzo. • There was no SOP or consent form for the procedure.	• Producing an SOP for the procedure to cover both inpatients and outpatients. • To include a consent form for the procedure. • Radiologists to receive further training in the use of the electronic prescribing system. • To discuss the use of metoprolol with Radiology departments across the region to gain a consensus opinion.

Learning from Medication Incidents

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, 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.

Learning from Incidents – Pressure Ulcers

- The Pressure Ulcer Collaborative programme is recommencing in September.
- New Cheshire and Merseyside pressure ulcer patient information leaflet finalised and will be available to order in the near future.
- Accurate documentation on care and comfort charts to be reinforced including prescribed care.
- Repose proning kit has been purchased for use in ITU to reduce the risk of pressure ulcer development.
- Trial of Parafricta underwear on Ward B12 (FMN Unit) to reduce the risk of friction damage.
- Band 6 TVN appointed and has now commenced. This will increase the teams capacity to provide training and support in pressure ulcer prevention.

Learning from Incidents – Information Governance

We Found	We Acted….
A letter intended for a patient was typed with a partially incorrect address and sent via mail. This resulted in a suspected data loss incident which was externally reported to NHS Digital and the ICO.	• The staff member that sent the letter has been made aware that automatic processes are available to populate the address fields as opposed to manually adding the address. This will prevent reoccurrence. • It subsequently transpired that the letter had reached its intended destination despite the partially incorrect address. The ICO were informed of this and the incident was closed.
IG Manager became aware that a member of staff was using unencrypted email to send emailing containing sensitive information.	• Staff member was referred to their line manager and reminded of Trust, and NHS policy, in this regard. • New staff awareness materials have been developed in Digital Services to clarify which applications are regarded as secure communications methods such as NHS mail and Pando instant messaging.

Complaints Headlines Q4 vs Q1

How many people are raising complaints Q4 vs Q1?

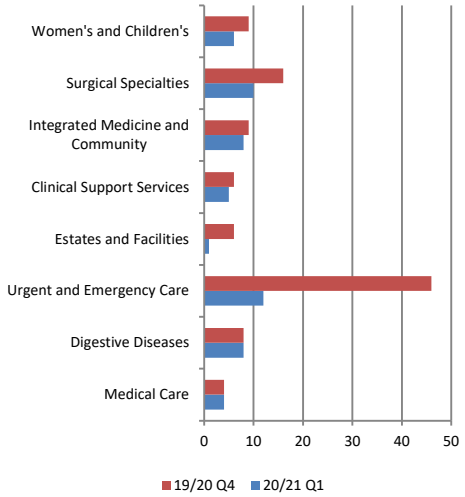
- There was an 48% decrease in complaints opened Trustwide in Q1 (54 in Q1 versus 104 in Q4). The decrease is as a result of the Covid-19 pandemic and the national pause that was placed on the complaints process.
- Urgent and Emergency Care , Surgical Specialities, Women's and Children's, Estates and Facilities and Clinical Support Services saw a decrease in the number of complaints received in Q1.
- Digestive Diseases and Medical Care remained consistent in Q1 to Q4.

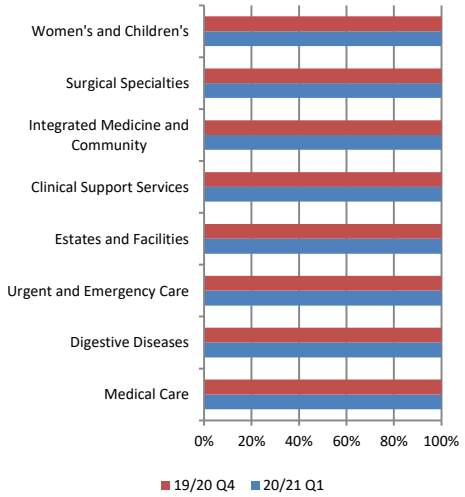
Are we Responsive Q4 vs Q1?

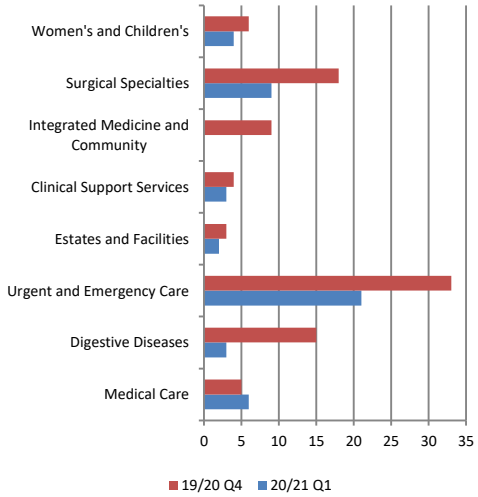
- All CBU maintained performance for responding to complaints on time.
- The Trust had a target to respond to 90% of complaint on time and in Q1 the Trust achieved 100%.
- The Trust currently has 0 breached complaints
- There are 5 complaints over 6 months old

How many complaints has the Trust closed Q4 vs Q1?

- There was a decrease in the number of complaints closed in the Trust in Q1 (48 in Q1 versus 93 in Q4).
- Urgent and Emergency Care, Surgical Specialties, Women's and Children's , Integrated Medicine and Community, Digestive Diseases, have decreased in the number of complaints closed in Q1. Digestive Diseases have seen the highest decrease.
- Medical Care have increased the amount of complaints they have closed.

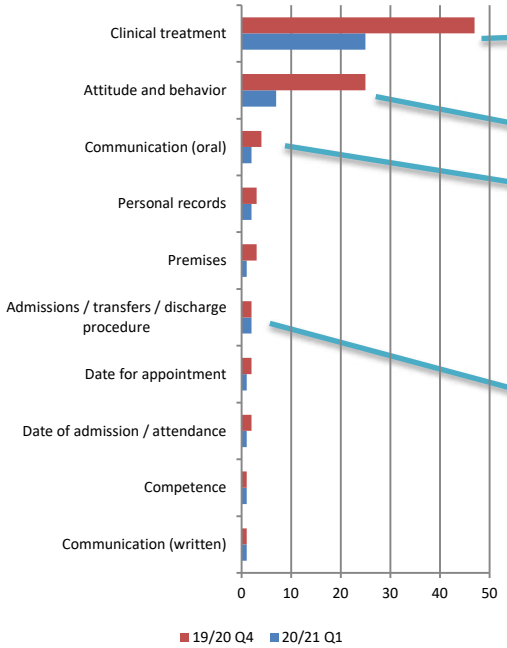






Complaints Analysis Q4 vs Q1

The information shows the top subjects in complaints in Q4 vs Q1.
Note: Complaints can have more than one subject.



Clinical treatment:
- There was a decrease in the number of complaints received in Q1 compared to Q4 regarding clinical treatment (25 in Q1 verses 47 in Q4). Concerns include wrong diagnosis, delay in treatment, coordination of medical treatment and poor nursing care.
- Insensitive to patients needs and communication issues can also be linked to when the Trust is on full capacity.

Communication and Attitude and Behaviour:
- Staff attitude and behaviour has decreased by 18 in Q1 compared to Q4.

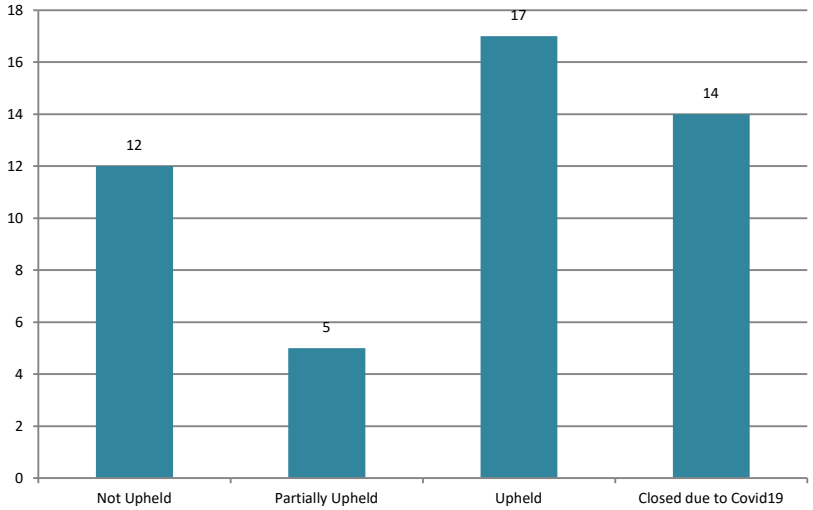
Admissions, transfers or discharge procedures:
- In Q1 there has been a similar theme for complaints relating to inappropriate discharges.

Complaints Outcomes Q1

Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome will be recorded in line with the findings of the investigation.

A complaint will be “upheld”, “upheld in part” or “not upheld”.

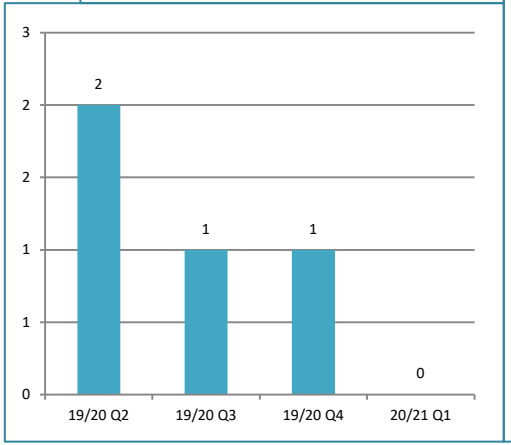
During the Covid-19 pandemic the Executive Team made the decision to close complaints that were considered low to moderate risk and invited the complainants to contact the Trust if they still required a written response. These complaints are recorded as “closed due to Covid-19”.



PHSO Q1

So how many complaints do they investigate?

From 22 March 2020 the PHSO placed a pause on their investigation process due to the Covid-19 pandemic and therefore there were no new investigations into the Trust in Q1.

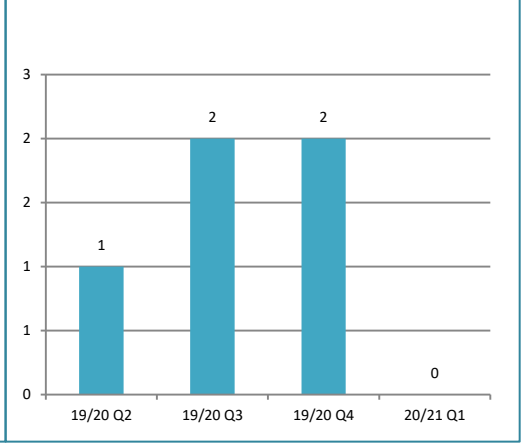


Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and / or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

NOTE: The PHSO have changed how they investigate complaints and when investigations start; therefore previous graphical data may have changed in this report.

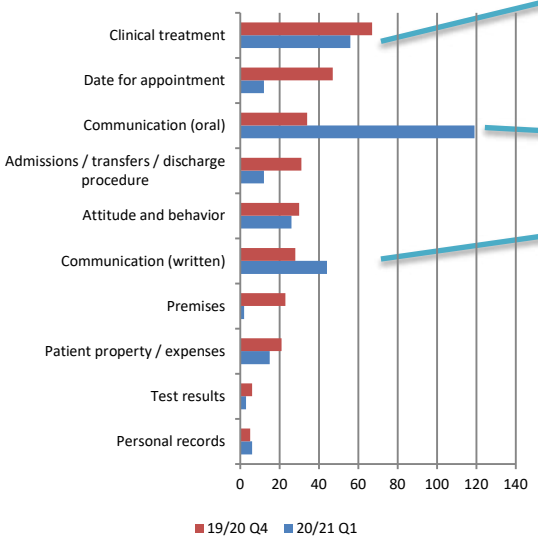
And what are the outcomes?

The Trust currently has 5 open PHSO cases.
The PHSO closed no investigations in Q1.



PALS Analysis Q1

The information shows the top subjects in PALS.
Note: PALS can have more than one subject.



Clinical Treatment:
- Co-ordination of medical treatment
- Delay in treatment
- Poor aftercare
- This is also mirrored in the complaints analysis.

Communication:
During the Covid-19 pandemic there has been an increase in the number of PALS concerns relating to Communication including : -
- Difficulties with telephone communication
- Lack of clear explanation
- Misunderstandings
- Wording in letters
- Test results not communicated to patient

The average response time for a PALS concern of those closed:

Q4	Q1
5 days	7 days

PALS to Complaints:

Q4	Q1
2	0

Learning from Complaints

You Said….	We Did….
A patient raised a concern that they had to wait 2 hours for their son to be triaged in the Emergency Department.	The Paediatric team in the Emergency Department have developed and introduced a new flowchart to guide staff through the 15 minute triage process. This includes an escalation process when there is an increase in the volume of patients attending the department.
A relative raised concerns that pain management was not being addressed during the period where investigations were ongoing to establish a diagnosis.	The Women's and Children's CBU have produced guidance for providing effective advice for patients experiencing pain in a non-inpatient setting. The guidance includes providing advice to patients to seek advice from their GP as soon as possible for pain management.
A patient raised concerns about the lack of parking facilities at Warrington Hospital.	We have introduced a Car Park Improvement Group to review the car park facilities. Through our procurement process, the group has secured off site car parking facilities for staff members to use. This will enable patients and visitors to park more easily.

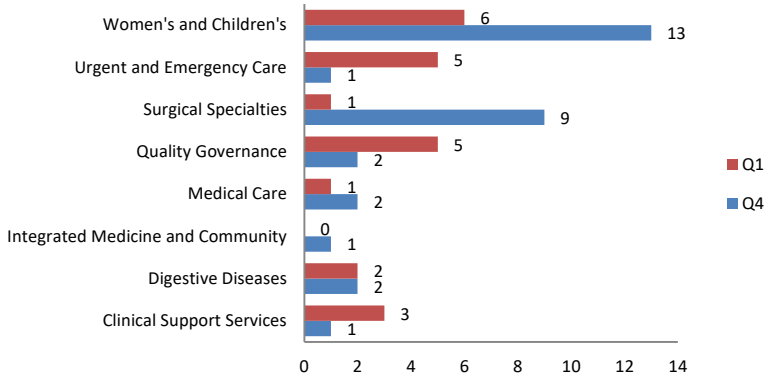
Complaints Headlines

- 54 complaints were opened during Q1 2020/21, which is a decrease of 48% compared to Q4. The decrease is a result of the Covid19 pandemic and the national pause placed on the complaints process.
- In Q1, the number of complaints relating to wrong diagnosis have decreased compared to Q4.
- There has also been a decrease in the number of delay in treatment and poor nursing care complaints in Q1 compared to Q4.
- In Q1 there has been a similar number of concerns regarding co-ordination of medical treatment and staff being insensitive to patient needs.
- 308 PALS concerns were received during Q1 2020/21, which is a 5% decrease compared to Q4
- There has been an increase in the number of PALS concerns received regarding communication where difficulties with telephone calls and lack of clear explanations has been raised.
- The Trust received 8 dissatisfied complaints in Q1 2020/21; which is an increase of 6% compared to Q4 where there was 15.
- In Q1, 3 complaint was closed and deemed to require an SI investigation.

Analysis of Claims Received Q1

Clinical Claims Received 2019/20 Q4 v 2020/21 Q1

2019/20 Q4: 31 Received
2020/21 Q1: 23 Received



There has been a **decrease** in Clinical Claims received (31 in Q4 vs 23 in Q1).
23 Claims received via:

- 1 Letter of Claim
- 1 Proceedings
- 21 Requests for notes

There has been 314 request for notes via Medico-Legal Services in Q1, down from 580 in Q4.

Non-Clinical Claims Received 2019/20 Q3 v Q4

There were no Non-Clinical Claims received Q1:
2019/20 Q4: 11
2020/21 Q1: 0

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Analysis of Claims Closed 2020/21 Q1

Clinical Claims Closed Q1 2020/2021

8 Claims closed with damages (totalling £2,234,966.00 (excluding costs))

Clinical Business Unit	Repudiated	Settled With Damages	Withdrawn	CBU Total
Digestive Diseases	1	1	3	5
Integrated Medicine and Community	1	1	0	2
Surgical Specialties	3	3	3	9
Urgent and Emergency Care	3	1	1	5
Women's and Children's	0	2	2	4
Total	**8**	**8**	**9**	**25**

Non-Clinical Claims Closed Q1 2020/21

3 Employer Liability Claims closed with damages (totalling £28,750.00 (excluding costs))

Clinical Business Unit	Details
Paediatric and Neonatology	Member of staff assaulted by a patient
Urgent and Emergency Care	Needle stick injury
Medical Care	Slip

Action taken on Clinical Claims

Surgical Specialities

Failure to diagnose deformity of hallux varus	• Since this incident member of staff involved has been on a Msc Surgical Care Practitioners course and has also completed additional learning on image interpretation. Both these areas of study have contributed to their increased understanding of the developing condition. • The member of staff involved also now ensures she compares current x-rays with the previous x-rays to help detect any change in position or concerns that there may be, changes that are not expected. These are then discussed with the consultant or the patient is brought back to clinic for consultant review. This ensures that not only that this situation is less likely to occur again, but also contributes to their ongoing continual development.
Delay in removing urological stent	• Stent register to be set up

Urgent and Emergency Care

Delay in diagnosing ulna collateral ligament injury	• Advise sought from T&O on what process to follow regarding imaging, although it is accepted that these injuries can be difficult to diagnose

Women's and Children's Health

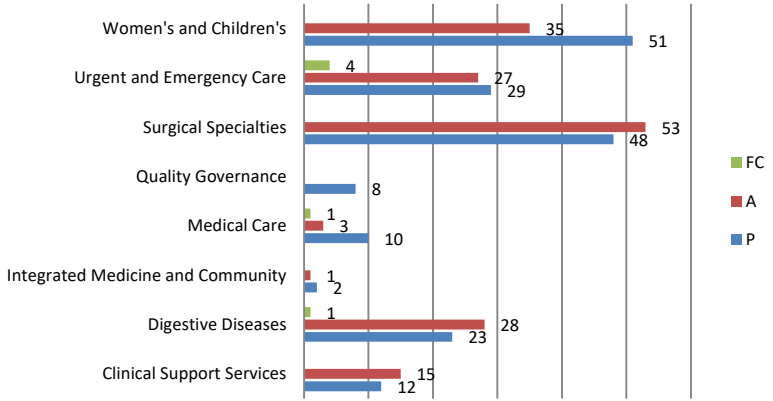
Failure to diagnose and treat pre-eclampsia	• At the time of the incident there was individual feedback with the middle grade trainees involved and the consultant on call. All of those involved were advised to perform a reflection for discussion with their educational supervisor, and for the consultant part of their appraisal.

Integrated Medicine and Community

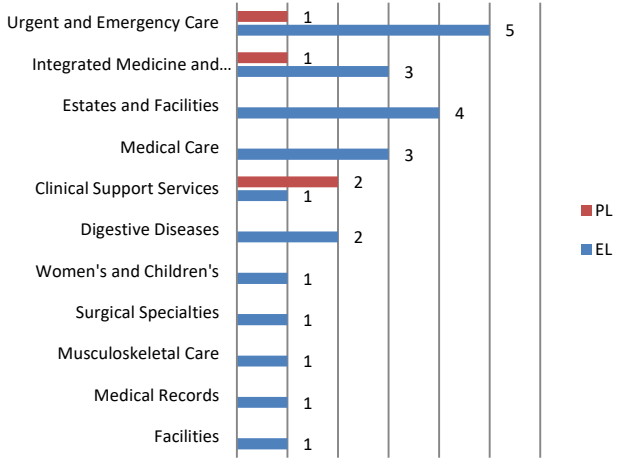
Patient fall	• Ensure that staff training is in line with Trust target • Re-introduce the SBAR (Situation, Background, Assessment, Recommendation) handover document • Ensure as an immediate action that the 'This Is Me' document completed by patient and relatives is kept together with the patient observation chart • Audit the use of stool charts

Claims Position – End of 2020/21 Q1

351 **Clinical Claims** open
162 Actual (Formal Claim) | 183 Potential (Request for notes) | 6 Coroners Funding



27 **Non-Clinical Claims** open
23 Employer Liability |4 Public Liability



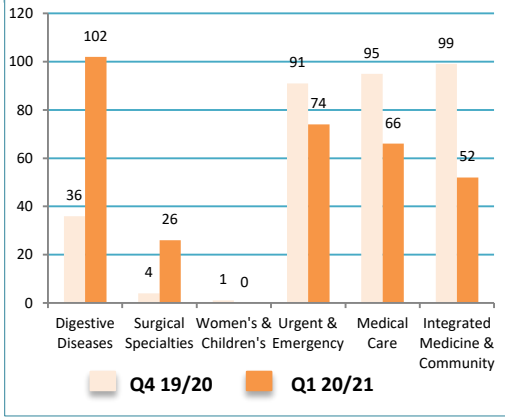
Key:
FC – Coroners Funding P – Potential = Request for notes A – Actual = (Formal Claim, Letter of Claim / Proceedings) PL – Public Liability EL – Employer Liability

Mortality Headlines

Q1 CBU Mortalities

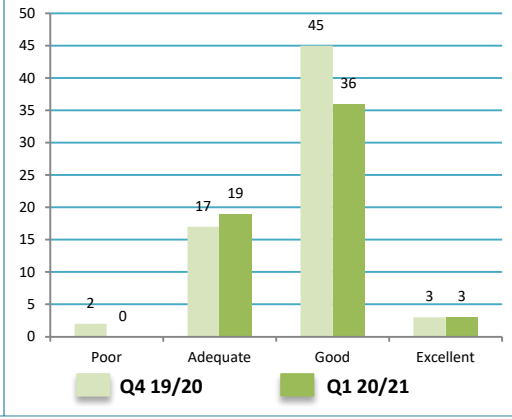
The CBU with the highest number of mortalities in Q1 was Digestive Diseases, this was due to the cohorting of COVID patients; Wards A4 and A5 were for patients requiring supportive management and enhanced palliative care.

The data below reflects deaths per CBU in accordance with the CBU structure that was in place at the start of Q1.



Q1 SJRs – Overall Care Grading

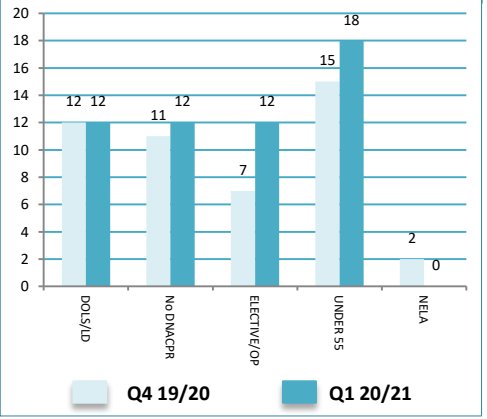
The majority of SJRs conducted have found that our overall standard of care is rated as "Good" followed by "Adequate", although "Excellent" care was also evident within the reviews.



Q1 Triggers for SJRs

Comparing to Quarter 4, patients Under 55 has become the highest trigger for an SJR.

No DNACPR still features highly as a trigger for an SJR. However, due to the COVID pandemic work has been undertaken with primary care and the Urgent & Emergency Care CBU to ensure DNACPR documentation is in place for patients.

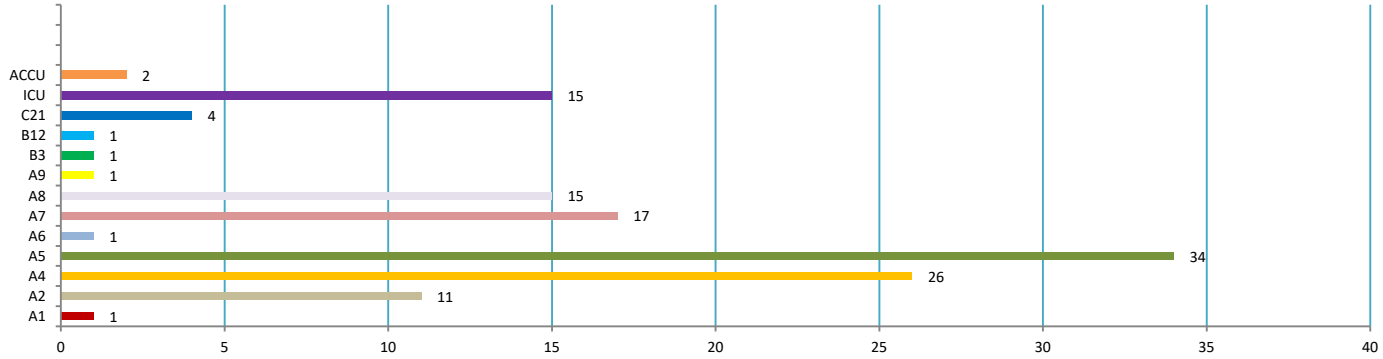


COVID Mortality Headlines

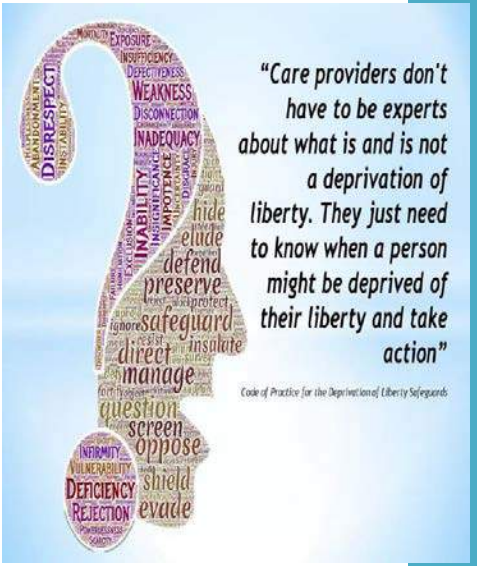
Q1 COVID Mortalities by Ward - The table below details the COVID mortalities by ward in Q1.

- The CBU with the highest number of mortalities in Q1 was Digestive Diseases, this was due to the cohorting of COVID patients as wards A4 and A5 were wards for patients for supportive management and enhanced palliative care. Ward A2 was also included as a ward for this cohort of patients but remained under the management of Urgent and Emergency Care.

- The Medical Director requested a **focused review** be conducted a review into 8 deaths between that occurred between **25th March to 31st May** on the **Trauma & Orthopaedic Ward, C21**. This focused review has been completed and actions from this review are to be included in the overarching Nosocomial Infection Review Action Plan.



Learning from Deaths – Deprivation of Liberty Safeguards (DoLS)



A case was reviewed by the Mortality Review Group and further guidance sought from the Adult Safeguarding Lead in relation to DoLS decisions for a patient in our care.

The Adult Safeguarding Lead found that the documentation was inconsistent from the medical and nursing teams. At times the patient was deemed to be capacitated and other incapacitated, however there was no rationale detailed for the decisions nor was there any evidence of capacity assessments to support the documentation.

DoLS reminders for staff:

- All staff are reminded that there is a standard operating procedure available on the Hub detailing guidance regarding the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Medical staff should observe that if a patient has an impairment of the mind or brain that is affecting a person's ability to process information then their capacity should be reviewed. They should consider that capacity is time and decision specific and that all practicable efforts must be made to ensure that a person is able to understand the information.
- If a person is unable to understand, retain or weigh up information that will enable them to make an informed choice then they do not have capacity to make a specific decision. Consider if the patient is not free to leave and unable to consent to their care and treatment and is under constant supervision, then a deprivation of liberty has happened and DoLS should be considered.

Learning from Deaths – Medical Certificate of Cause of Death (MCCD) Health and Social care government guidance

Guidance notes for doctors covering issues doctors often ask about, and clarifying best practice under current legislation, including the Coronavirus Act 2020.

Avoid physical and mental conditions which are not fatal in themselves Long-term physical disabilities, mental health problems and learning difficulties (also known as learning disabilities or intellectual disabilities) are rarely sufficient medical explanation of the death in themselves. If such a condition is considered to be relevant, the more immediate mechanism(s) or train of events leading to death must be made clear.

Example (1): A person with learning difficulties may develop aspiration pneumonia. Aspiration pneumonia should be given as the immediate cause of death; the person's learning difficulties could be included in Part 2 of the certificate if thought to be a contributory factor, but not in Part 1, as having learning difficulties does not form a direct sequence of events to having pneumonia.

Example (2): A congenital syndrome which causes learning difficulties may also cause an organ defect which can lead to premature death. The organ failure should then be included in the certificate. A description such as 'learning difficulties' should not be the only cause of death. You may give a degenerative condition such as Alzheimer's disease as the only cause of death if the mechanism by which it caused death is unclear but it is fully supported by the clinical history as the underlying cause.

Headlines of Learning from Deaths

- Mortality & Morbidity Meetings (M&M) continue to be on hold due to COVID-19.
- **SHMI and HSMR, are within the expected range at present.**
- C21 Focused Review completed and learning disseminated.
- **COVID-19 Focused Review is underway and is due for completion in November 2020.**

Learning from National Audits

Summary: Overall, the audit findings are favourable indicating high quality surgery is being delivered to NHS patients. Cataract surgery is the most frequently performed surgical procedure in the UK, a widely accepted indicator of surgical quality is the frequency of posterior capsule rupture (PCR).

Action Required
Encourage all consultants to input the data of the Surgical procedure, the Risk score and the Complications in Medisoft / Medisight. (As this is the Data collected by NOD, it would show the true figures of our performance)
To look into the possibility of standardising the Data between ORMIS and MEDISOFT with the help of IT, to create a more efficient report

Table below shows the overall national rates for Consultant Surgeons PCR and VA Loss Rate in comparison with WHH results:

Posterior Capsular Rupture (PCR) Overall Consultant Surgeon rate= **1.1%**			
No of Operations	Unadjusted PCR Rate	Case Complexity Index	Adjusted PCR Rate
1,193	0.6%	1.5%	0.4%
Visual Acuity loss Overall Consultant Surgeon VA Loss rate= **0.9%**			
No of Operations	Unadjusted VA Loss rate	Case Complexity index	Adjusted VA Loss rate
780	0.9%	0.8%	1.0%

Assurance Rating:	High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied.

Learning from Local Audits

Bone health assessment for all Rheumatoid arthritis (RA) patients (2nd cycle)

Background:

All patients with RA are at increased risk of developing osteoporosis. We wanted to assess how often we evaluate our RA patient's bone health at their annual review appointments. NICE guidance (NG100) states it should be done every year.

Key Findings:

- 73% of RA patients received bone health assessment in clinic compared to 16% in 1st cycle (+30%)
- Improvement of 57% compared to result from 1st cycle
- Improvement largely due to raised awareness amongst staffs and implementation of RA follow up proforma
- Reason for audit outcome
- Small sample size
- Short duration for change from 1st cycle audit

Recommendations:

This audit failed to achieve 100% on standards set, however did show improvement of 57% compared to the 1st cycle. Plan to continue use of RA proforma and re-education of all Rheumatology staffs. Plan to re-audit after 1 year post intervention to enable time for improvement.

Significant	There is a good system of internal control designed to meet the system objectives, and that controls are generally being consistently applied

Non-Clinical Incidents Q1

From 1st April 2020 to 30th June 2020, there were 280 non-clinical incidents reported. The top 2 categories were:

Security incidents = 56

The top sub-categories are:

- Aggressive Behaviour by patients/relatives
- Violence due to patients condition
- Threatening behaviour
- Loss
- Doors not locked

Health and Safety incidents = 104

The top sub-categories are:

- Injury to staff
- Hit by object
- Needlestick Injury
- Other Sharps issue

Risk Assessments

Since the Coronavirus pandemic, the Health and Safety Department have supported the Trust by completing a number of risk assessments. These include:

- Sessional use of gowns
- Donning and doffing of specialist PPE
- Use of reusable gowns
- Office/Ward based risk assessments
- Face shields
- Respiratory Protective Equipment
- Lack of PPE
- Social Distancing

Support has also been provided to assist Estates, Infection Control, Pharmacy, ITU, Supplies etc in compiling various risk assessments. For example Oxygen Flow and Oxygen Concentrators, ISO Shipping Container, Anticoagulant Clinic, Stress etc

Learning from Non-Clinical Incidents

We found….	We Acted….
The Trust were experiencing a number of storage issues due to the recent coronavirus pandemic. Beds were being taken out of clinical areas to maintain distancing causing excessive numbers being stored along the main corridors at Warrington Hospital	On the 4th May 2020, the Estates Team arranged delivery of a large yellow inflatable tent which is now located near to the Pharmacy Delivery bay. This is a temporary solution for the patient bed storage problem 
As well as beds, there were vast amounts of boxes of PPE being delivered and stored. Again lack of space and storage facilities was a huge issue	 The Supplies Department took delivery of a large 40 foot ISO Shipping Container which is now operational to ease the problem. This is located along the main railway line. Support has been provided in completing a risk assessment for this unit

Sharps Incidents

During Q1, there were a total of 26 sharps incidents

- Inappropriate disposal = 2
- Needlestick injury = 19
- Other Sharps issues = 5

These occurred within 19 separate areas, therefore no trends or hot spot areas. ITU had the highest number of incidents (4), two of which staff were inserting central lines and securing in place with sutures. Other areas of multiple incidents occurred on Ward A6, A7, Delivery Suite, Urgent Care and A&E. All these areas had 2 incidents whereby all others only had one each.

Sharps safety, advice and good practices are included in the Health and Safety Newsletters which is circulated to staff on a bi-monthly basis

We are WHH & We are PROUD to make a difference

The Health and Safety Department continually remind staff to complete the NSI1 form following a sharps incidents. Receipt of these are monitored as the Trust policy states these forms are to be completed and returned to Health and Safety within 48 hours of the incident occurring. Once received, the completed form is then uploaded onto Datix as additional evidence

We are WHH & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/09/107**	
SUBJECT:	**Infection Prevention and Control**	
DATE OF MEETING:	30 September 2020	
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)***	#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. #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. #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 report provides a summary of infection prevention and control activity for Quarter 4 (Q4) of the 2019/20 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. In Q4 the Trust reported:- • 13 Clostridium difficile cases • Nil return for MRSA bacteraemia cases • 3 MSSA bacteraemia cases. There is no national reduction target • 12 E. coli bacteraemia cases The Trust was over trajectory for Clostridium difficile (5 cases), MRSA bacteraemia (2 cases) and E. coli (3 cases). Action plans have been revised to reduce cases for the next financial year. Planned activity was put on hold throughout Q4 and efforts were appropriately redirected to address the coronavirus pandemic. Including surveillance, policy production, provision of clinical advice and education.	

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

RECOMMENDATION:	The Board is asked to note the contents of the report, exceptions highlighted and progress made.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/20/08/141

1

	Date of meeting	04.08.2020
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

SUBJECT	Infection Prevention and Control Q4 report 2019/20	Agenda Ref:	BM/20/09/107

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 4 (Q4) of the 2019/20 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets, learning from incidents and an update on activity for audit, education, surveillance and policy reviews and the response to the Covid-19 Pandemic.

NHSI use Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases are taken into account for regulatory purposes. The Trust is assessed for breaches of the Clostridium difficile objective using a cumulative year to date (YTD) trajectory.

The zero tolerance threshold for avoidable cases of Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia remains in place.

There is a national ambition to halve gram-negative bloodstream infections (GNBSIs). The Antimicrobial resistance 5 year plan provided a revised timescale to meet this objective and advises a systematic approach is required to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

In mid-January concerns were escalated globally about an emerging infectious disease in China. The Infection Prevention and Control Team began preparing the Trust to respond to the threat of a novel coronavirus. This situation evolved into a global pandemic and activity was appropriately redirected to managing increased healthcare demand due to Covid-19.

2. KEY ELEMENTS

HCAI data

RAG rating of Trust performance for HCAIs by month is shown in Table 1.

Table 1: HCAI data by month

Indicator	Target	Position	A	M	J	J	A	S	O	N	D	J	F	M	Total
C. difficile	≤44	Over trajectory	3	1	4	4	6	1	10	5	2	5	2	6	49
MRSA bacteraemia	Zero tolerance	Over trajectory	0	0	0	0	2	0	0	0	0	0	0	0	2
MSSA bacteraemia	No target	No target	0	0	1	2	3	5	1	2	1	2	1	0	18
E. coli bacteraemia	5% reduction ≤46	Over trajectory	4	6	5	3	2	8	4	6	1	3	4	5	51
Klebsiella spp. bacteraemia	5% reduction ≤13	Over trajectory	1	1	1	3	1	1	2	1	0	1	0	3	15
P. aeruginosa bacteraemia	5% reduction ≤4	On trajectory	0	0	1	0	0	2	0	0	0	0	0	1	4

Breakdown by ward is included at appendix 1.

Clostridium difficile

- 13 cases reported in Q4 (7 hospital onset/ healthcare associated: 6 community onset/ healthcare associated). The annual threshold was exceeded by 5 cases
- All hospital apportioned cases undergo post infection review. During the Covid-19 pandemic support was obtained from staff who are shielding to commence the investigations
- Internal review panel meetings were suspended to focus activity on Covid-19. A plan is in place to re-establish review meetings in August 2020

- The CCG also suspended review panel meetings. 7 cases from Q3 and the 13 cases from Q4 will be submitted for review. CCG meetings are scheduled to reconvene in September
- From CCG panel meetings to date for the 2019/2020 FY: 15 cases were considered unavoidable, 14 cases avoidable
- Ribotyping of all hospital onset/healthcare associated and community onset/ healthcare associated cases has not identified any links between the toxin positive cases

The change in case apportionment (reduction in one day from admission i.e. samples taken from 3rd day of admission onwards previously this was from 4th day and cases arising within 28 days of a patient discharged are now apportioned to the Trust it) is not appropriate to compare this year's data with previous years.

Themes identified from the C. difficile case reviews include: stool documentation, timely sampling and isolation. Learning from these meetings is shared with clinical teams via CBU Governance meetings.

Bacteraemia Cases

Gram positive bacteraemia

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- Nil return submitted for Q4. 2 hospital onset cases reported during the FY

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 3 hospital onset cases in Q4. Post infection reviews are in progress
- No national reduction target/threshold

Gram negative bacteraemia (GNBSI)

E coli bacteraemia

- 12 hospital onset cases in Q4: 51 hospital onset cases reported during the FY

Klebsiella Spp.

- 4 hospital onset cases in Q4: 15 hospital onset cases reported during the FY

Pseudomonas aeruginosa

- 1 hospital onset case in Q4: 4 hospital onset cases reported during the FY

The Trust registered to participate in a GNBSI reduction initiative with AQuA, supported by the Trust's Quality Academy. This work was halted in Q4 due to Covid-19. An Action plan is in place aligned to findings from GNBSI case reviews. This focuses on urinary catheter care, timely blood culture sampling and education on the UTI pathway. The national Safety Thermometer reporting has ceased and alternative methods of carrying out Catheter Associated UTI surveillance are under review. Due to change in some ward profiles, a review of innovation wards for phase 1 of the GNBSI reduction collaborative has been undertaken.

Comparative data on HCAI cases and rates from April 2019 to March 2020 across the Northwest is included in appendix 2. Appropriate comparison with other similar sized Trusts (local delivery system partners), shows a slightly higher number (1) of MRSA bacteraemia cases. However the Trust has a significantly lower number of C. difficile cases and MSSA. Similar numbers of E.coli are noted and less cases of Klebsiella spp. and Pseudomonas aeruginosa bacteraemia cases than one of our Local Delivery System partners.

Outbreaks/Incidents

Viral Gastroenteritis

There was 1 ward with 2 confirmed cases of norovirus in Q4.

Table 2: Viral Gastroenteritis incidents by month

	A	M	J	J	A	S	O	N	D	J	F	M
Outbreaks	6	4	0	0	0	0	0	0	4	1	0	0

Wards with confirmed cases of norovirus are reviewed twice daily by the Infection Prevention and Control Nurses. Surveillance for additional cases is carried out and infection control standards are monitored. The Communications Team have provided support by use of social media messages to members of the public advising members of the local population not to visit if unwell.

Influenza

During Q4, 42 positive influenza results were confirmed and acted upon. The Infection Control Team worked closely with operational management to support safe placement of patients to prevent outbreaks. The majority of samples (28) were taken in ED. The introduction on seasonal in-house testing (7 day service) has significantly contributed to timely patient review and implementation of infection control precautions.

Covid-19 Pandemic

A vast amount of activity was undertaken in Q4 in response to the evolving situation of the pandemic. Surveillance of the international and national situation was in place from mid-January. The Trust responded to the directive to set up Coronavirus Priority Assessment Pods and took referrals from NHS 111 for suspected cases in returning travellers. Demand for swabbing was managed by setting up an appointment system. To support the additional demand on ED, a senior nursing team rota was put in place. Almost 100 samples were taken prior to detecting the first positive case (ED attender only) on 9 March 2020.

The first inpatient case was detected in ICU on 13 March 2020 and outside of ICU on a medical ward on 17 March 2020. In addition to the assessment pods, a review of the estate was undertaken to determine the most suitable location to accept suspected coronavirus cases. This was agreed as A7 due to having side rooms with ante rooms for safe doffing of Personal Protective equipment (PPE) and en-suite facilities. Additional handwashing facilities were installed in the ante rooms. A further review of the Estate resulted in additional doors being installed in ED Majors and partitions in ED minors.

A draft policy with all essential infection prevention and control advice was developed by 23 January 2020 and updated throughout Q1 in response to changing national guidance. A Standard Operating Procedure on waste management including disposal into yellow bag and quarantine was implemented. Standalone guidance on decontamination of the Coronavirus Priority Assessment Pods was developed and distributed.

A huge amount of activity was focussed on education. Two Grand Rounds were delivered on 7th February and 13th March, which were well attended. Simulation exercises were set up with support from the Trust Simulation Lead and carried out in ED, Critical Care, Maternity and ward A7 (respiratory) including safe transfer of patients through the Trust.

The Trust implemented a system of PPE Champions to support the Infection Prevention & Control Team in education on donning and doffing of PPE. The Clinical Education Team were key members alongside senior members of nursing and allied healthcare staff.

Face to Face training was provided to all wards and departments by PPE champions. This education was further supported by individual PPE training booklets and Public Health England (PHE) posters on donning and doffing displayed in all ward areas. A dedicated telephone line and later e-mail was set up to support staff with PPE queries. Training videos were produced on donning and doffing of PPE, supported by the Communications Team. Consultant Microbiology roadshows were put in place with visits and presentations about evidence for PPE, in particular respiratory protection to ED, A7, Critical Care and Theatres.

The Infection Prevention and Control Team worked closely with the Emergency Planning Officer and participated in teleconferences/webinars with Public Health England, NHSE/I and local system assurance meetings. Education was provided to senior managers on call and a series of briefings held for all heads of service. Planning meetings were converted into Tactical Meetings and held daily from 18 March 2020.

Tactical meetings included review of PPE stock levels. Media coverage of shortage was noted to be fuelling staff anxieties. This was addressed by centralising PPE stock and sharing information on availability of PPE. An in and out of hours process for accessing stock was put in place. A number of local organisations and schools began to offer supplies. All donated items were reviewed to ensure essential safety standards were met (e.g. CE marked and with corresponding EN numbers). The national pandemic stock was released on 3 March 2020 and the Trust put in place a system to ensure receipt of stock at short notice. Mutual aid from other Trust was also put in place at a later date. Scrub Suits were offered as an alternative to home laundering of uniforms.

The declaration of a level 4 incident put the Trust under full command and control from central government. Services were reviewed and some virtual clinics implemented. The Operational Team, Emergency Planning Team and Infection Prevention and Control Team participated in Novus Coronet (an emergency planning exercise) with possible scenarios for pandemic development.

Fit Testing of staff for appropriate respiratory protection was in place pre-pandemic. The programme of Fit Testing, a legal requirement was stepped up to ensure all staff had access to a successfully fit tested FFP3 respirator. A number of difficulties were experienced as one size does not fit all and in some instances, re-usable respirators were issued with appropriate advice on decontamination and filter change.

In the early stages of the pandemic access to virology testing was limited. All specimens were being referred to one central laboratory in London and there were significant delays in turnaround of results. Testing moved locally to Manchester on 11 February 2020 with a slight improvement on turnaround times. By end of March 2020 over 100 positive results had been identified, with just over 30 inpatient cases. A medical on-call Covid Consultant rota was established to provide advice to clinical teams and the Patient Safety Nurses provided additional support to the Infection Prevention and Control Team.

Surveillance

Set up of the IT surveillance system has been paused due to the Coronavirus pandemic and will recommence as part of the recovery schedule.

Infection Prevention and Control Training

Overall compliance with Mandatory training was 89% in February 2020. Face to Face mandatory infection control training was halted due to the coronavirus pandemic and will recommence as part of the recovery schedule.

Table 3 Infection Control Training compliance

Infection Control Training	A	M	J	J	A	S	O	N	D	J	F	M
Overall % of staff trained	91%	91%	89%	90%	90%	89%	91%	88%	87%	88%	89%	-

Infection Prevention and Control Audits

The IPCN audits were halted due to the coronavirus pandemic and will recommence as part of the recovery schedule.

Environmental Hygiene

Cleanliness monitoring was halted due to the coronavirus pandemic. A system was in put in place to escalate concerns about environmental hygiene to Domestic supervisors for timely action. Activity in place pre pandemic to implement the recommendations of the draft National Standards of Healthcare Cleanliness document will recommence as part of the recovery schedule.

Infection Control Policies

The following documents were approved by the Infection Control Sub-Committee in January 2020:-

- Specimen Collection Guidelines
- Urinary Catheter Passport
- Insertion of Urinary Catheters (Male) Policy
- Critical Care Infection Screening SOP
- Critical Care Positive/Negative Pressure Isolation SOP

The Sub-Committee meeting was cancelled in March.

Antimicrobial Stewardship

There was a reduction in Antibiotic Ward Round during Q4 due to a reduction in Consultant Microbiology staffing and to focus of activity on the coronavirus pandemic. Daily review of critical care patients took place virtually.

Awareness raising events

The Infection Prevention and Control Team have focussed awareness raising activity throughout Q4 on coronavirus.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Develop the Infection Prevention and Control Service recovery plan
- Publish the Infection Prevention and Control Strategy revision
- Continue to provide expert advice throughout the pandemic

4. IMPACT ON QPS

- Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes
- P: Improved attendance at training assists staff in fulfilling mandatory training requirements
- S: Reduction in HCAIs supports sustainability by avoidance of contractual financial penalties

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to Public Health England
- Conduct surveillance on Covid-19 cases
- The Infection Prevention and Control Team meet weekly to monitor cases of HCAI. Action is implemented in response to increased incidences of HCAIs and infection control related incidents
- The Infection Control Sub-Committee will meet monthly (12 times per annum) and discusses HCAI surveillance data and learning from HCAI incidents
- Meetings will take place weekly to review HCAI incident investigation reports and agree actions to support care improvements
- Healthcare Associated Infection data is included in the Ward Dashboard data

6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2020/2021 is yet to be confirmed
- The Trust threshold for E. coli bacteraemia is yet to be confirmed. There is a national target for a 25% reduction by 2021/2022 and the full 50% reduction by 2024. A 5% GNBSI reduction target has been set as a priority within the Quality Strategy
- The zero tolerance to avoidable MRSA bacteraemia cases remains in place

Work streams will continue to:-

- Progress GNBSI reduction
- Reduce the incidence of Clostridium difficile infection and implement learning from incidents
- Promote Antimicrobial Stewardship and challenge inappropriate prescribing
- Partnership working with Urgent and Emergency Care CBU to support timely blood culture sampling
- Monitor invasive device management/bacteraemia reduction
- Recommence ANTT competency assessor training
- Implement an infection control surveillance systems including Catheter Associated UTI
- Support staff training in Infection Prevention and Control where CBU compliance is lower than 85%
- Promote excellent standards in uniform/workwear and the Bare Below the Elbows campaign
- Promote excellence in adherence to Covid-19 PPE guidance
- Support assessment of decontamination standards
- Set up a surgical site infection surveillance programme
- Implement a recovery plan to review overdue policies

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 Integrated Performance Report.

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

Exception reports will be submitted to the Quality and Assurance Committee when increased incidences of infection are identified.

8. TIMELINES

2019/20 Financial Year

9. ASSURANCE COMMITTEE

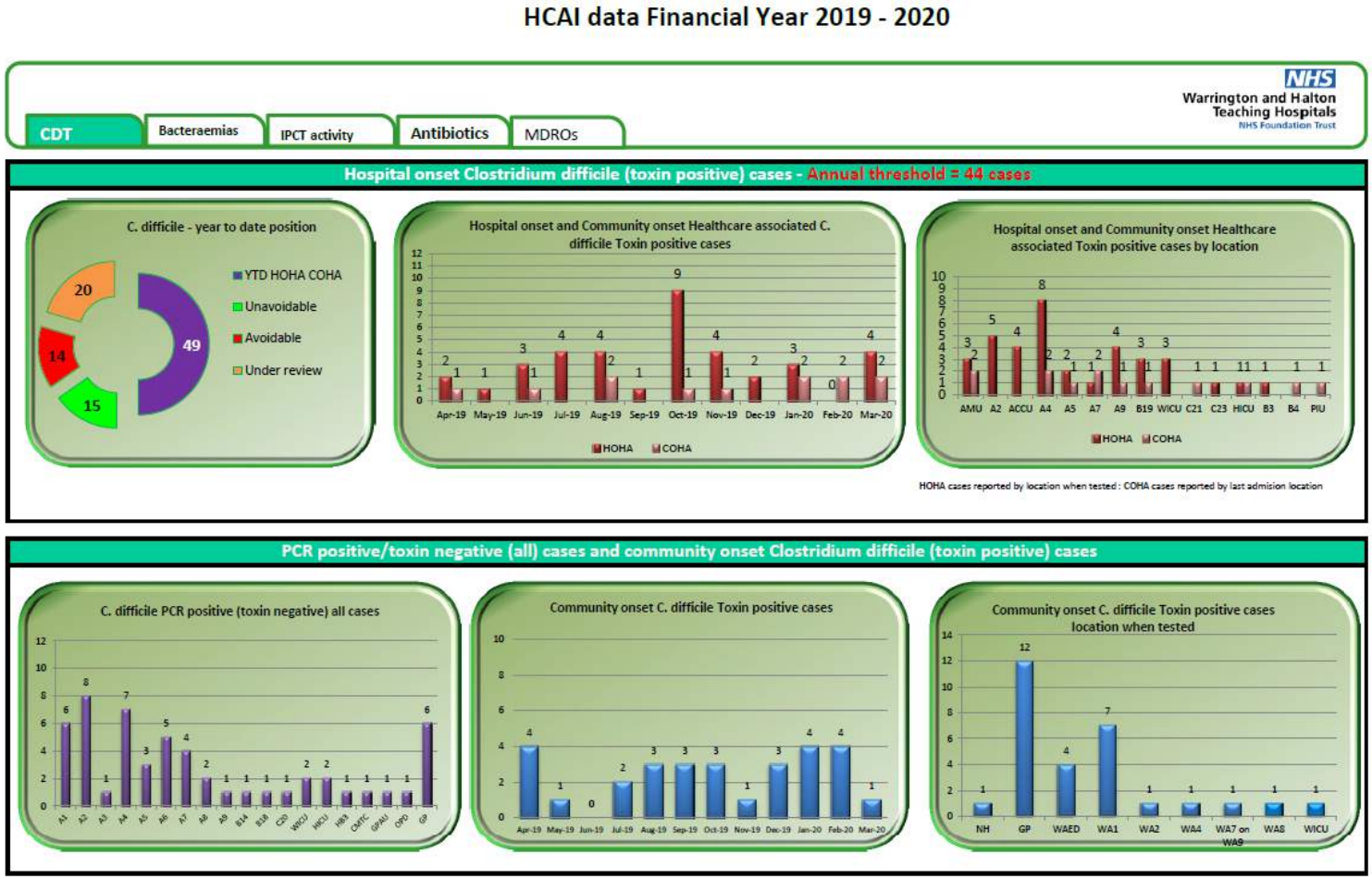
- Infection Control Sub-Committee

10. RECOMMENDATIONS

The Board is asked to: note the content of the report; the exceptions reported and the progress made.

APPENDIX 1 Healthcare Associated Infection Data April 2019 – March 2020

Clostridium difficile Cases



Hospital onset/Healthcare associated = HOHA
Community onset/Healthcare assocaiated = COHA
Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

April 2019 - March 2020

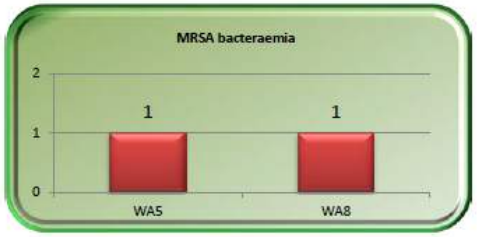
Gram Positive Bacteraemia Cases

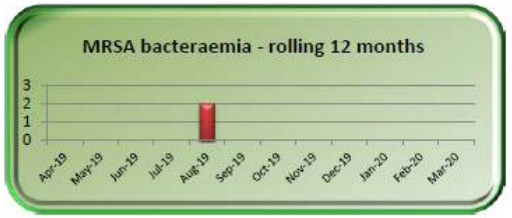
HCAI data Financial Year 2019 - 2020

CDT | Bacteraemias | IPCT Activity | Antibiotics | MDROs

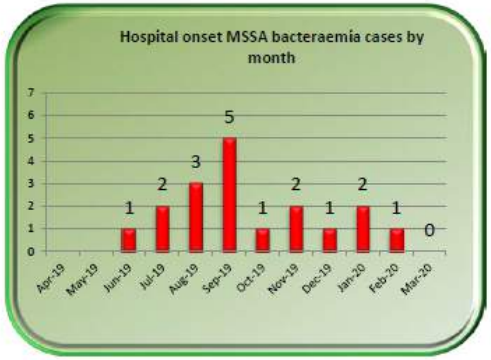
NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

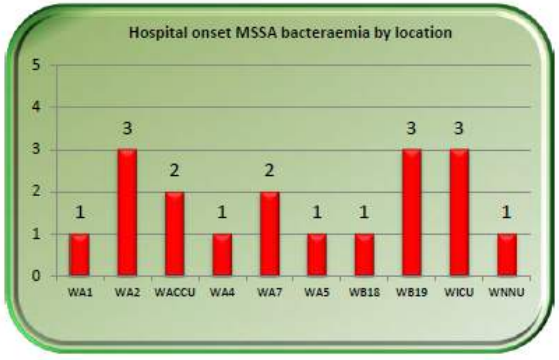
Hospital onset MRSA bacteraemia data Zero tolerance

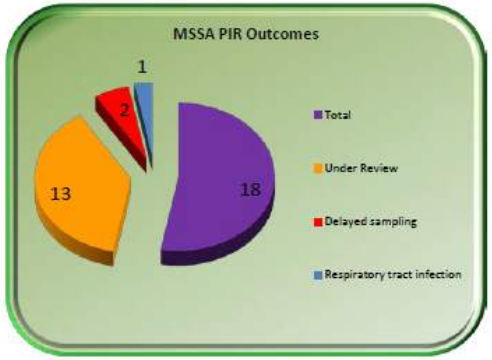




MSSA bacteraemia data (no thresholds set)

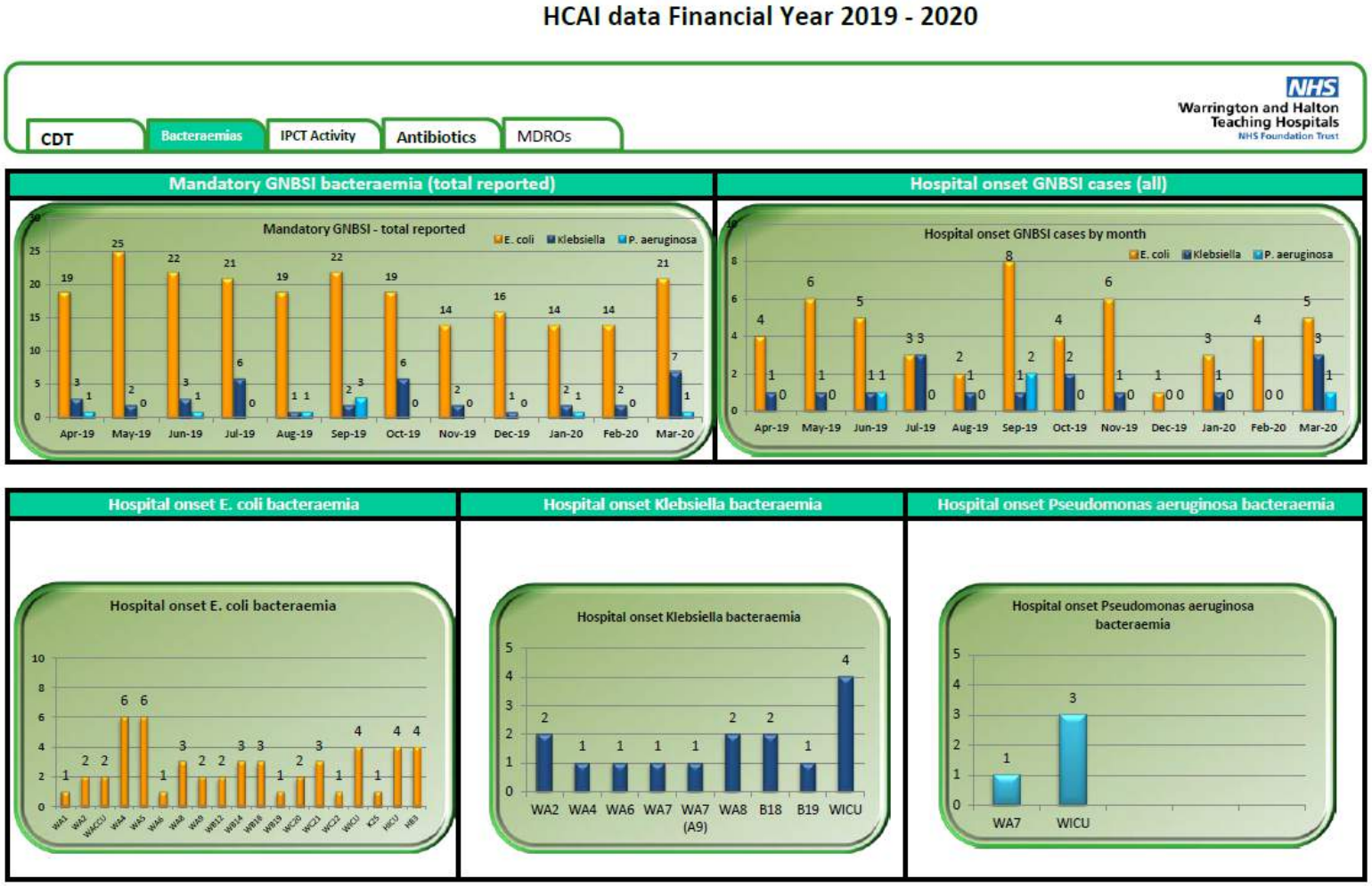






April 2019 - March 2020

Gram Negative Bacteraemia Cases



April 2019 - March 2020

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APPENDIX 2 COMPARISION OF HEALTHCARE ASSOCIATED INFECTION DATA ACROSS THE NORTHWEST

Clostridium difficile (April 2019 – March 2020)

Public Health England

C. difficile quarterly tables

***C. difficile* by Trust: Hospital Onset Healthcare Associated & Community Onset Healthcare Associated**

	Counts				Rates*			
Organisation Name	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0	2	3	0.0	0.0	12.7	19.3
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	6	12	11	12	13.9	27.9	24.2	26.7
EAST CHESHIRE NHS TRUST	2	0	3	5	7.4	0.0	10.5	17.7
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	3	2	1	1	26.8	18.9	9.8	9.9
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0	0	0	0.0	0.0	0.0	0.0
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	24	49	43	37	17.8	37.4	31.8	27.6
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	9	7	6	7	20.6	16.1	12.5	14.7
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	8	6	10	9	23.2	18.7	29.5	26.8
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	18	14	15	13	29.1	22.5	23.8	20.8
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	4	2	2	47.1	63.9	32.4	32.8
THE WALTON CENTRE NHS FOUNDATION TRUST	2	2	1	1	16.5	16.6	8.7	8.8
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	8	11	17	13	18.3	25.0	36.8	28.5
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	37	18	21	11	57.5	27.8	31.8	16.8
Cheshire & Merseyside	**120**	**125**	**132**	**114**	**32.5**	**34.0**	**25.5**	**22.3**

MRSA – Annual rolling rate (April 2019 – March 2020)

Public Health England

MRSA annual tables: Trust cases & rates (hospital onset)

Organisation Name	April 2019 to March 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	2	0.9	
BOLTON NHS FOUNDATION TRUST	3	1.5	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	3	1.6	
EAST CHESHIRE NHS TRUST	2	1.8	
EAST LANCASHIRE HOSPITALS NHS TRUST	1	0.3	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	1	0.3	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	2.3	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.5	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4	0.8	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	8	1.2	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0	0.0	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	0	0.0	
PENNINE ACUTE HOSPITALS NHS TRUST	1	0.3	
SALFORD ROYAL NHS FOUNDATION TRUST	1	0.4	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1	0.7	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	1	0.4	
STOCKPORT NHS FOUNDATION TRUST	0	0.0	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	0	0.0	
THE CHRISTIE NHS FOUNDATION TRUST	0	0.0	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1	3.9	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	1	0.5	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	2	1.1	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	1	0.4	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	0	0.0	
North West	35	0.7	

MSSA – Annual rolling rate (April 2019 – March 2020)

Public Health England

MSSA annual tables: Trust cases & rates (hospital onset)

Organisation Name	April 2019 to March 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	9	14.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	20	8.7	
BOLTON NHS FOUNDATION TRUST	14	7.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	12	6.4	
EAST CHESHIRE NHS TRUST	5	4.6	
EAST LANCASHIRE HOSPITALS NHS TRUST	28	9.1	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	26	9.1	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	11	24.8	High (0.025)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	4	14.1	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	45	8.6	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	13	1.9	Low (0.001)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	16	9.0	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	21	11.6	
PENNINE ACUTE HOSPITALS NHS TRUST	16	4.2	Low (0.001)
SALFORD ROYAL NHS FOUNDATION TRUST	26	9.8	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	15	11.1	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	25	10.2	
STOCKPORT NHS FOUNDATION TRUST	15	6.9	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	18	12.4	
THE CHRISTIE NHS FOUNDATION TRUST	11	19.8	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	11.6	
THE WALTON CENTRE NHS FOUNDATION TRUST	6	11.7	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	29	14.1	High (0.025)
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	18	9.7	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	24	9.2	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	10	6.6	
North West	506	9.4	

E. coli bacteraemia – Annual rolling rate (April 2019 – March 2020)

Public Health England

E. coli annual tables: Trust cases & rates (hospital onset)

Organisation Name	April 2019 to March 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	10	15.5	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	60	26.2	
BOLTON NHS FOUNDATION TRUST	41	20.4	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	35	18.6	
EAST CHESHIRE NHS TRUST	26	23.9	
EAST LANCASHIRE HOSPITALS NHS TRUST	70	22.7	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	68	23.7	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	3	6.8	Low (0.025)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	8	28.3	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	134	25.5	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	157	22.8	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	31	17.4	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	49	27.0	
PENNINE ACUTE HOSPITALS NHS TRUST	77	20.1	
SALFORD ROYAL NHS FOUNDATION TRUST	46	17.4	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	24	17.8	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	51	20.9	
STOCKPORT NHS FOUNDATION TRUST	48	22.0	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	16	11.0	Low (0.001)
THE CHRISTIE NHS FOUNDATION TRUST	31	55.8	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	8	31.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	15	29.2	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	40	19.4	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	51	27.5	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	61	23.4	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	28	18.5	
North West	1188	22.2	

Klebsiella bacteraemia - Annual rolling rate (April 2019 – March 2020)

Public Health England

Klebsiella annual tables: Trust cases & rates (hospital onset)

Organisation Name	April 2019 to March 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	11	17.1	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	27	11.8	
BOLTON NHS FOUNDATION TRUST	15	7.5	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	13	6.9	
EAST CHESHIRE NHS TRUST	6	5.5	
EAST LANCASHIRE HOSPITALS NHS TRUST	16	5.2	Low (0.025)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	21	7.3	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	6	13.5	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2	7.1	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	51	9.7	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	81	11.8	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	6	3.4	Low (0.025)
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	14	7.7	
PENNINE ACUTE HOSPITALS NHS TRUST	29	7.6	
SALFORD ROYAL NHS FOUNDATION TRUST	25	9.5	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	10	7.4	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	16	6.5	
STOCKPORT NHS FOUNDATION TRUST	17	7.8	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	7	4.8	
THE CHRISTIE NHS FOUNDATION TRUST	9	16.2	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	4	15.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	4	7.8	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	12	5.8	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	15	8.1	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	22	8.4	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	10	6.6	
North West	449	8.4	

Pseudomonas aeruginosa - Annual rolling rate (April 2019 – March 2020)

Public Health England

Pseudomonas aeruginosa annual tables: Trust cases & rates (hospital onset)

Organisation Name	April 2019 to March 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2	3.1	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	5	2.2	
BOLTON NHS FOUNDATION TRUST	2	1.0	Low (0.025)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	5	2.7	
EAST CHESHIRE NHS TRUST	1	0.9	
EAST LANCASHIRE HOSPITALS NHS TRUST	7	2.3	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	12	4.2	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	3	6.8	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.5	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	15	2.9	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	31	4.5	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	7	3.9	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	8	4.4	
PENNINE ACUTE HOSPITALS NHS TRUST	7	1.8	
SALFORD ROYAL NHS FOUNDATION TRUST	3	1.1	Low (0.025)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	11	8.2	High (0.025)
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	6	2.5	
STOCKPORT NHS FOUNDATION TRUST	2	0.9	Low (0.025)
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	3	2.1	
THE CHRISTIE NHS FOUNDATION TRUST	9	16.2	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	8	31.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	1	1.9	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	2	1.0	Low (0.025)
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	4	2.2	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	9	3.4	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	3	2.0	
North West	167	3.1	

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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/09/107**			
SUBJECT:	**Infection Prevention and Control**			
DATE OF MEETING:	30 September 2020			
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):	#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. #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. #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 report provides a summary of infection prevention and control activity for Quarter 1 (Q1) of the 2020/21 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. In Q1 the Trust reported:- • 11 Clostridium difficile cases • Nil return for MRSA bacteraemia cases • 3 MSSA bacteraemia cases. There is no national reduction target • 9 E. coli bacteraemia cases Healthcare associated infection reduction targets have not yet been published for 2020/21.			
PURPOSE:	Information √	Approval	To note √	Decision
RECOMMENDATION:	The Board is asked to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/20/08/141		
	Date of meeting	04.08.2020		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

1

SUBJECT	Infection Prevention and Control Q1 report 2020/21	Agenda Ref:	BM/20/09/107

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 1 (Q1) of the 2020/21 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets and an update on activity for audit, education, surveillance and policy reviews and the response to the Covid-19 Pandemic.

NHSE/I use Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases are taken into account for regulatory purposes. The Trust is assessed for breaches of the Clostridium difficile objective using a cumulative year to date (YTD) trajectory.

The zero tolerance threshold for avoidable cases of Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia remains in place.

There is a national ambition to halve gram-negative bloodstream infections (GNBSIs). The Antimicrobial resistance 5 year plan provided a revised timescale to meet this objective and advises a systematic approach is required to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

In June NHSE/I published a Standing Operating Procedure (SOP) for investigation of hospital onset Covid-19. Categorisation of cases is based on time between admission to a hospital Trust and first positive specimen. The first day of admission counts as day one. Case definitions are as follows:

- Community-Onset – First positive specimen date <=2 days after admission to Trust
- Hospital-Onset Indeterminate Healthcare-Associated – First positive specimen date 3-7 days after admission to Trust
- Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Definite Healthcare-Associated – First positive specimen date 15 or more days after admission to Trust

A cluster of cases is defined as 2 cases arising within the same ward/department over a 14 day period.

2. KEY ELEMENTS

HCAI data

RAG rating of Trust performance for HCAIs by month is shown in Table 1. Breakdown by ward is included at appendix 1.

Table 1: HCAI data by month

Indicator	Target	Position	A	M	J	Total
C. difficile	TBC		5	4	2	11
MRSA bacteraemia	Zero tolerance	On Trajectory	0	0	0	0
MSSA bacteraemia	No target	No target	1	2	0	3
E. coli bacteraemia	TBC		2	2	5	9
Klebsiella spp. bacteraemia	TBC		0	1	0	1
P. aeruginosa bacteraemia	TBC		0	0	1	1

Clostridium difficile

- 11 cases reported in Q1 (8 hospital onset/ healthcare associated: 3 community onset/ healthcare associated), national objective yet to be advised
- All hospital apportioned cases undergo post infection review. During the Covid-19 pandemic support was obtained from staff who are shielding to commence the investigations
- Internal review panel meetings were suspended in Q1 to focus activity on Covid-19. A plan is in place to re-establish review meetings in August 2020
- The CCG also suspended review panel meetings. The outstanding cases from the 2019/20 FY will be submitted for review when meetings reconvene in September 2020
- Ribotyping of all hospital onset/healthcare associated and community onset/ healthcare associated cases has not identified any links between the toxin positive cases

Bacteraemia Cases

Gram positive bacteraemia

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- Nil return submitted for Q1

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 3 hospital onset cases in Q1. Post infection reviews are in progress
- No national reduction target/threshold

Gram negative bacteraemia (GNBSI)

E coli bacteraemia

- 9 hospital onset cases in Q1

Klebsiella Spp.

- 1 hospital onset cases in Q1

Pseudomonas aeruginosa

- 1 hospital onset case in Q1

The Trust registered to participate in a GNBSI reduction initiative with AQuA, supported by the Trust's Quality Academy. This work was halted in Q1 due to Covid-19. An Action plan is in place aligned to findings from GNBSI case reviews. This focuses on urinary catheter care, timely blood culture sampling and education on the UTI pathway. The national Safety Thermometer reporting has ceased and alternative methods of carrying out Catheter Associated UTI surveillance are under review. Due to change in some ward profiles, a review of innovation wards for phase 1 of the GNBSI reduction collaborative has been undertaken.

Comparative data on HCAI cases and rates from June 2019 to May 2020 across the Northwest is included in appendix 2. Appropriate comparison with other similar sized Trusts (local delivery system partners), shows a slightly higher number (1) of MRSA bacteraemia cases. However the Trust has a significantly lower number of C. difficile cases and MSSA. A lower numbers of E.coli and Klebsiella spp. cases and less cases of and Pseudomonas aeruginosa bacteraemia are noted than one of our Local Delivery System partners.

Outbreaks/Incidents

Viral Gastroenteritis

There were no reports of viral gastroenteritis outbreaks in Q1.

Table 2: Viral Gastroenteritis incidents by month

	A	M	J
Outbreaks	0	0	0

Wards with confirmed cases of norovirus are reviewed twice daily by the Infection Prevention and Control Nurses. Surveillance for additional cases is carried out and infection control standards are monitored. The Communications Team have provided support by use of social media messages to members of the public advising members of the local population not to visit if unwell.

Covid-19 Pandemic

A vast amount of activity was undertaken in Q1 in response to the evolving situation of the pandemic. Patient testing extended from returning travellers and patients with respiratory illness in ICU, to include admission screening of all patients admitted by the emergency route on 24 April 2020. Discharge to Care Home screening was also introduced on 16 April 2020. In house testing commenced on 16th June 2020.

Covid-19 cases peaked in April (appendix 3) 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 A8, A5 and A4. Critical Care expanded its bed base into theatres as per the pandemic plan.

Text message alerting of confirmed results was put in place with alerts to the Infection Prevention and Control Nurses and the Covid Consultant on call. Additional support was provided from medical staff that were redeployed from front line working. The Infection Control Nurses provide a 7 day and on call service. A business case was developed and approved to increase Infection Control Nurse staffing.

The following documents were developed by the Infection Prevention and Control Team to provide guidance to staff on Covid-19:

- Coronavirus Assessment Pod Decontamination SOP
- Novel Coronavirus Policy
- Patient Placement SOP
- Qualitative Fit Testing SOP
- Reusable PPE Decontamination SOP
- Hospital Onset Covid-19 Investigation and Outbreak Management Plan

The Infection Prevention and Control Team members continued to provide education and roadshows were delivered where staff raised concerns about PPE guidance. A number of Royal and Chartered Societies produced PPE guidance that differed from Public Health England. Consultant Microbiology and Infection Control roadshows 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 FFP3 respirators was expanded during Q1. Additional testing equipment was purchased (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, guidance on maintenance and decontamination was provided.

Visiting restrictions have been 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 restrictions. Compassionate visiting arrangements remain in place and visitors are supported with training on use of PPE.

Public Health England 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 coronavirus (COVID-19) because of an underlying health condition. All healthcare workers that required shielding were supported to work from home.

During April the Secretary of State for Health advised the risk of shortages of fluid resistant gowns. Guidance on sessional use of gowns was published on 02 April 2020. Alternative choices including reusable fluid repellent theatre gowns and coveralls were put in place by the Chief Nurse/DIPC and Associate Chief Nurse for IPC on 3 April 2020 as per the contingency plan for gown shortage. PPE stock levels remains under constant review. Mutual aid from other Trust is in place. Scrub Suits continue to be offered as an alternative to home laundering of uniforms.

Recovery Board meetings began 07 May 2020 to establish plans for return of elective activity. The Infection Control Team provided advice on setting up Covid Protected Pathways. Ward B18 was set up for urgent cases. Visits also took place to the Halton site. A number of areas have been visited and patient pathways reviewed and agree. All Clinical Business Units have been asked to estimate PPE usage rates as part of service redevelopment plans.

Further guidance introduced 15 June 2020, stipulated use of face masks in all areas. An Environmental Action Plan has been developed jointly with the Associate Director of Estates and Facilities and the Deputy Chief Nurse for Patient Safety. This action plan incorporates a number of other actions including: reduction of entrances/exits, signage promoting social distancing, Perspex barriers at reception desks, ensuring high standards of cleanliness and risk assessments to create Covid secure areas for staff. A risk assessment tool has been implemented across the Trust.

NHSE/I have published definitions of hospital onset cases of Covid-19. At the time of the draft consultation, a cluster of cases (4 patients over 14 days), where specimen was obtained more than 15 days after admission, was noted on ward C21. An Outbreak Control Team was established and the situation reported to Public Health England (PHE).

The draft guidance developed by NHSE/I was followed including notification to the Northwest Incident Control Centre. The Trust supported trial of the NHSE/I draft 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 summary of activity to address the cluster of cases was provided. Root Cause Analysis of all cases is in progress and learning will be shared once the concise investigation has been completed. All Patients were discharged from the ward and the situation formally declared over 12/06/2020.

A Covid-19 PPE audit tool has been developed to monitor standards of compliance.

NHSE/I have published a Board Assurance Framework linked to the Code of Practice on prevention of Healthcare Associated Infections. This document was populated and submitted to Trust Board in May. Additional evidence has been added to the framework in advance of submission to the CQC and an action plan has been developed to support minor gaps in assurance.

Surveillance

Set up of the IT surveillance system has been paused due to the Coronavirus pandemic and will recommence as part of the recovery schedule.

Infection Prevention and Control Training

Overall compliance with Mandatory training was 84% in May 2020.

Table 3 Infection Control Training compliance

Infection Control Training	A	M	J
Overall % of staff trained	-	84%	

Overall compliance with mandatory training is 84%. Level 2 (clinical training) is 73%. Face to Face mandatory infection control training was halted due to the coronavirus pandemic and will recommence as part of the recovery schedule. All Clinical Business Units have been requested to set an improvement trajectory.

Infection Prevention and Control Audits

The IPCN audits were halted due to the coronavirus pandemic and will recommence as part of the recovery schedule.

Environmental Hygiene

Cleanliness monitoring was halted due to the coronavirus pandemic. A system was in put in place to escalate concerns about environmental hygiene to Domestic supervisors for timely action. Activity in place pre pandemic to implement the recommendations of the draft National Standards of Healthcare Cleanliness document will recommence as part of the recovery schedule. Hydrogen peroxide vapour has been used to support deep cleaning of vacant wards.

Infection Control Sub-Committee

The Sub-Committee meeting is scheduled to reconvened from July 2020. Terms of Reference have been revised and meeting timescales changed to monthly.

Antimicrobial Stewardship

There was a reduction in Antibiotic Ward Round during Q1 to focus of activity on the coronavirus pandemic. Daily review of critical care patients took place virtually.

Awareness raising events

The Infection Prevention and Control Team have focussed awareness raising activity throughout Q1 on coronavirus.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Develop the Infection Prevention and Control Service recovery plan
- Publish the Infection Prevention and Control Strategy
- Continue to provide expert advice throughout the pandemic

4. IMPACT ON QPS

- Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes
- P: Improved attendance at training assists staff in fulfilling mandatory training requirements
- S: Reduction in HCAIs supports sustainability by avoidance of contractual financial penalties

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to Public Health England
- Surveillance of hospital onset Covid-19 cases
- The Infection Prevention and Control Team meet weekly to monitor cases of HCAI. Action is implemented in response to increased incidences of HCAIs and infection control related incidents
- The Infection Control Sub-Committee will meet monthly (12 times per annum) and discusses HCAI surveillance data and learning from HCAI incidents
- Meetings will take place weekly to review HCAI incident investigation reports and agree actions to support care improvements
- Healthcare Associated Infection data is included in the Ward Dashboard data

6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2020/2021 is yet to be confirmed
- The Trust threshold for E. coli bacteraemia is yet to be confirmed. There is a national target for a 25% reduction by 2021/2022 and the full 50% reduction by 2024. A 5% GNBSI reduction target has been set as a priority within the Quality Strategy
- The zero tolerance to avoidable MRSA bacteraemia cases remains in place

Work streams will continue to:-

- Progress GNBSI reduction
- Launch the revised Urinary Catheter Passport
- Reduce the incidence of Clostridium difficile infection and implement learning from incidents
- Promote Antimicrobial Stewardship and challenge inappropriate prescribing
- Partnership working with Urgent and Emergency Care CBU to support timely blood culture sampling
- Monitor invasive device management/bacteraemia reduction
- Recommence ANTT competency assessor training
- Implement an infection control surveillance systems including Catheter Associated UTI
- Support staff training in Infection Prevention and Control where CBU compliance is lower than 85%
- Promote excellent standards in uniform/workwear and the Bare Below the Elbows campaign

- Promote excellence in adherence to Covid-19 PPE guidance
- Support assessment of decontamination standards
- Set up a surgical site infection surveillance programme
- Implement a recovery plan to review overdue policies

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 Integrated Performance Report.

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

Exception reports will be submitted to the Quality and Assurance Committee when increased incidences of infection are identified.

8. TIMELINES

2020/21 Financial Year

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

The Board is asked to: note the content of the report; the exceptions reported and the progress made.

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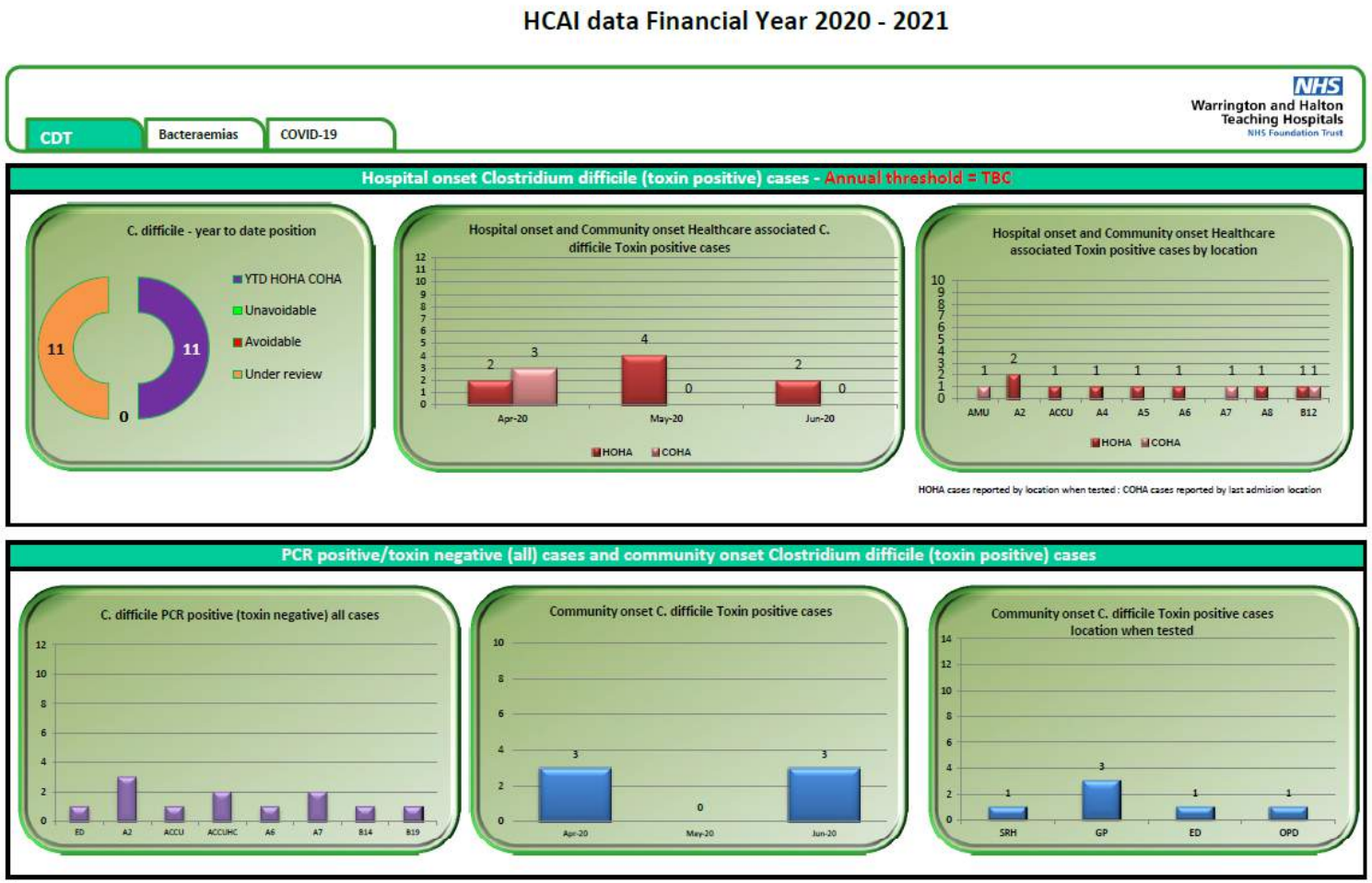
NHS Foundation Trust

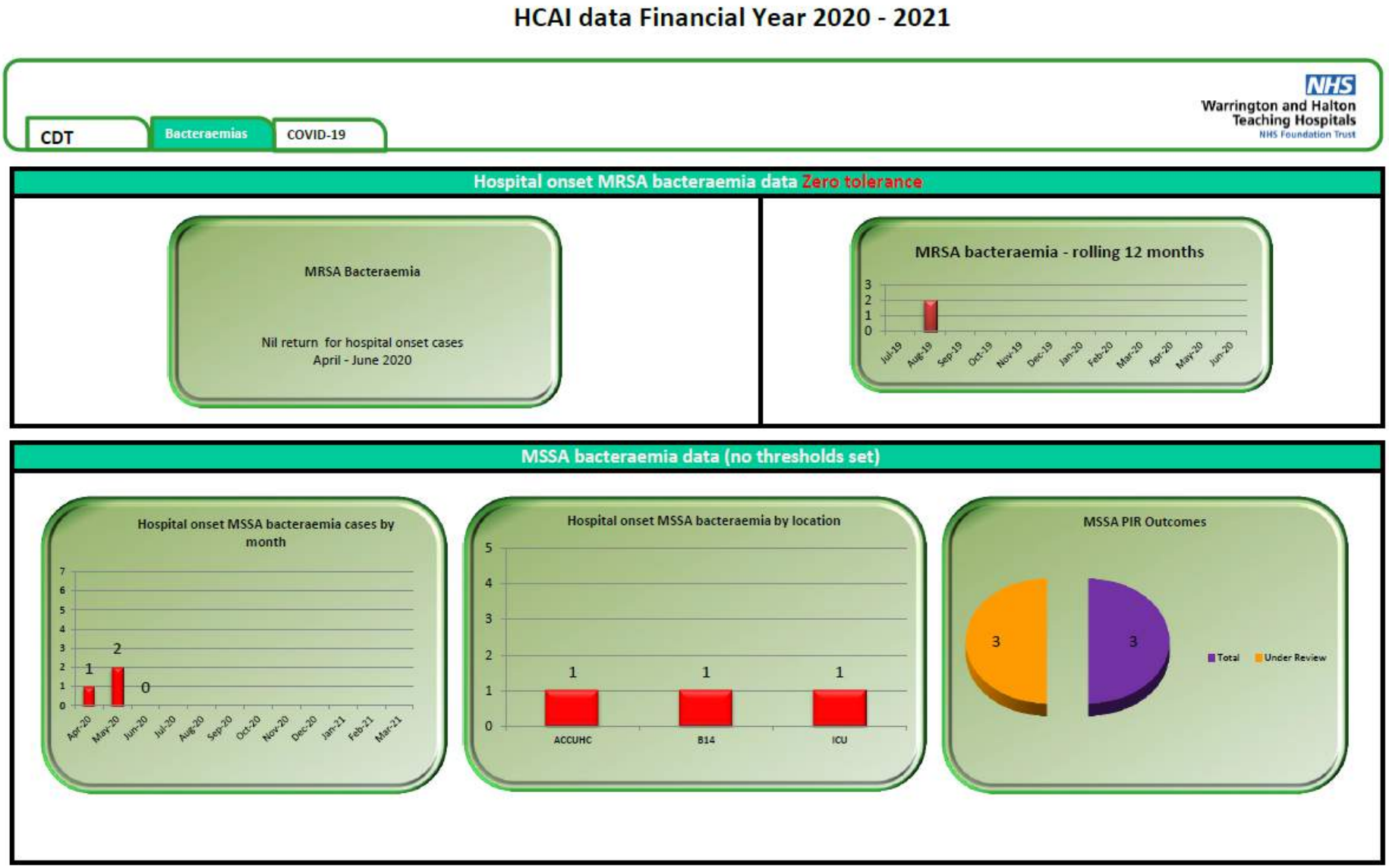
APPENDIX 1 Healthcare Associated Infection Data April – June 2020

Clostridium difficile Cases



Hospital onset/Healthcare associated = HOHA
Community onset/Healthcare assocaiated = COHA
Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

Gram Positive Bacteraemia Cases



Gram Negative Bacteraemia Cases

HCAI data Financial Year 2020 - 2021

APPENDIX 2 COMPARISION OF HEALTHCARE ASSOCIATED INFECTION DATA ACROSS THE NORTHWEST

Clostridium difficile (June 2019 – May 2020)

Public Health England

C. difficile annual tables: healthcare associated cases & rates by Trust (hospital onset & community onset)

Organisation Name	June 2019 to May 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	6	9.3	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	122	53.3	High (0.001)
BOLTON NHS FOUNDATION TRUST	52	25.9	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	38	20.2	
EAST CHESHIRE NHS TRUST	13	11.9	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	73	23.6	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	125	43.6	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	5	11.3	Low (0.025)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	151	28.7	Low (0.025)
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	156	22.7	Low (0.001)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	24	13.5	High (0.025)
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	65	35.9	
PENNINE ACUTE HOSPITALS NHS TRUST	94	24.6	Low (0.001)
SALFORD ROYAL NHS FOUNDATION TRUST	36	13.6	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	34	25.3	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	57	23.3	
STOCKPORT NHS FOUNDATION TRUST	53	24.3	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	39	26.8	High (0.001)
THE CHRISTIE NHS FOUNDATION TRUST	36	64.8	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	9	34.9	Low (0.001)
THE WALTON CENTRE NHS FOUNDATION TRUST	4	7.8	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	52	25.2	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	54	29.1	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	73	28.0	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	47	31.0	
North West	1418	26.5	

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MRSA – Annual rolling rate (June 2019 – May 2020)

Public Health England

MRSA annual tables: Trust cases & rates (hospital onset)

Organisation Name	June 2019 to May 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	1	0.4	
BOLTON NHS FOUNDATION TRUST	3	1.5	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	3	1.6	
EAST CHESHIRE NHS TRUST	3	2.8	
EAST LANCASHIRE HOSPITALS NHS TRUST	1	0.3	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	1	0.3	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	2.3	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.5	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3	0.6	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	9	1.3	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0	0.0	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	0	0.0	
PENNINE ACUTE HOSPITALS NHS TRUST	1	0.3	
SALFORD ROYAL NHS FOUNDATION TRUST	1	0.4	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	2	1.5	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	1	0.4	
STOCKPORT NHS FOUNDATION TRUST	1	0.5	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	2	1.4	
THE CHRISTIE NHS FOUNDATION TRUST	0	0.0	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1	3.9	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	1	0.5	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	2	1.1	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	2	0.8	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	0	0.0	
North West	40	0.7	

MSSA – Annual rolling rate (June 2019 – May 2020)

Public Health England

MSSA annual tables: Trust cases & rates (hospital onset)

Organisation Name	June 2019 to May 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	8	12.4	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	20	8.7	
BOLTON NHS FOUNDATION TRUST	16	8.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	12	6.4	
EAST CHESHIRE NHS TRUST	5	4.6	
EAST LANCASHIRE HOSPITALS NHS TRUST	26	8.4	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	22	7.7	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	11	24.8	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	4	14.1	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	38	7.2	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	78	11.3	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	7	3.9	Low (0.025)
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	14	7.7	
PENNINE ACUTE HOSPITALS NHS TRUST	24	6.3	
SALFORD ROYAL NHS FOUNDATION TRUST	23	8.7	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	15	11.1	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	25	10.2	
STOCKPORT NHS FOUNDATION TRUST	15	6.9	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	16	11.0	
THE CHRISTIE NHS FOUNDATION TRUST	10	18.0	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	2	7.7	
THE WALTON CENTRE NHS FOUNDATION TRUST	4	7.8	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	26	12.6	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	21	11.3	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	21	8.0	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	11	7.3	
North West	474	8.8	

E. coli bacteraemia – Annual rolling rate (June 2019 – May 2020)

Public Health England

E. coli annual tables: Trust cases & rates (hospital onset)

Organisation Name	June 2019 to May 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	10	15.5	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	57	24.9	
BOLTON NHS FOUNDATION TRUST	41	20.4	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	38	20.2	
EAST CHESHIRE NHS TRUST	25	23.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	60	19.4	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	64	22.3	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	3	6.8	Low (0.025)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	5	17.7	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	111	21.1	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	144	20.9	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	27	15.2	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	50	27.6	
PENNINE ACUTE HOSPITALS NHS TRUST	76	19.9	
SALFORD ROYAL NHS FOUNDATION TRUST	40	15.2	Low (0.025)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	24	17.8	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	49	20.0	
STOCKPORT NHS FOUNDATION TRUST	43	19.8	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	16	11.0	Low (0.025)
THE CHRISTIE NHS FOUNDATION TRUST	29	52.2	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	8	31.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	14	27.2	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	44	21.4	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	45	24.2	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	61	23.4	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	22	14.5	
North West	1106	20.6	

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Klebsiella bacteraemia - Annual rolling rate (June 2019 – May 2020)

Public Health England

Klebsiella annual tables: Trust cases & rates (hospital onset)

Organisation Name	June 2019 to May 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	13	20.2	High (0.025)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	25	10.9	
BOLTON NHS FOUNDATION TRUST	16	8.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	11	5.8	
EAST CHESHIRE NHS TRUST	7	6.4	
EAST LANCASHIRE HOSPITALS NHS TRUST	13	4.2	Low (0.025)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	17	5.9	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	3	6.8	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2	7.1	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	52	9.9	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	86	12.5	High (0.001)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	5	2.8	Low (0.001)
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	12	6.6	
PENNINE ACUTE HOSPITALS NHS TRUST	29	7.6	
SALFORD ROYAL NHS FOUNDATION TRUST	28	10.6	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	14	10.4	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	21	8.6	
STOCKPORT NHS FOUNDATION TRUST	15	6.9	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	8	5.5	
THE CHRISTIE NHS FOUNDATION TRUST	7	12.6	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	4	15.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	6	11.7	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	8	3.9	Low (0.025)
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	13	7.0	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	16	6.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	8	5.3	
North West	439	8.2	

Pseudomonas aeruginosa - Annual rolling rate (June 2019 – May 2020)

Public Health England

Pseudomonas aeruginosa annual tables: Trust cases & rates (hospital onset)

Organisation Name	June 2019 to May 2020 Counts	Rates	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2	3.1	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	4	1.7	
BOLTON NHS FOUNDATION TRUST	4	2.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	4	2.1	
EAST CHESHIRE NHS TRUST	2	1.8	
EAST LANCASHIRE HOSPITALS NHS TRUST	7	2.3	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	13	4.5	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	3	6.8	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.5	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	13	2.5	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	32	4.6	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	6	3.4	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	9	5.0	
PENNINE ACUTE HOSPITALS NHS TRUST	6	1.6	
SALFORD ROYAL NHS FOUNDATION TRUST	4	1.5	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	7	5.2	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	5	2.0	
STOCKPORT NHS FOUNDATION TRUST	2	0.9	Low (0.025)
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	4	2.7	
THE CHRISTIE NHS FOUNDATION TRUST	7	12.6	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	7	27.1	
THE WALTON CENTRE NHS FOUNDATION TRUST	1	1.9	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	1	0.5	Low (0.001)
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	5	2.7	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	8	3.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	4	2.6	
North West	161	3.0	

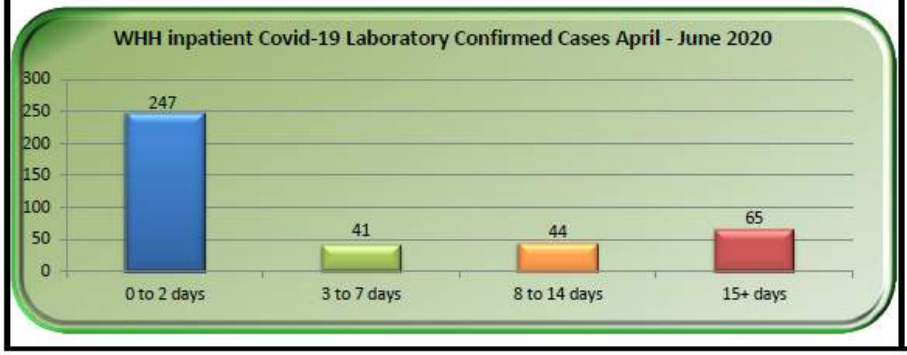
APPENDIX 3 COVID-19 Cases

HCAI data Financial Year 2020 - 2021

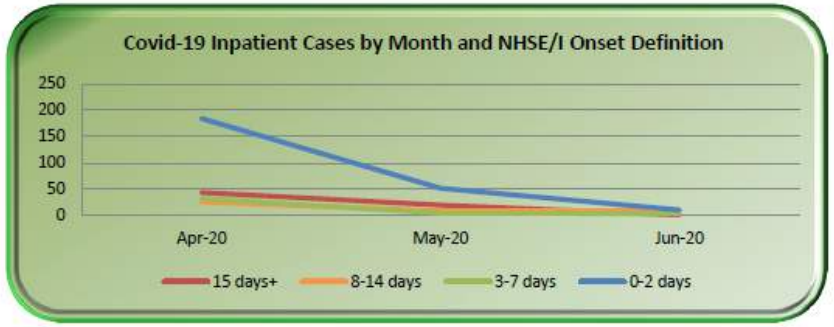
CDT | Bacteraemias | COVID-19

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

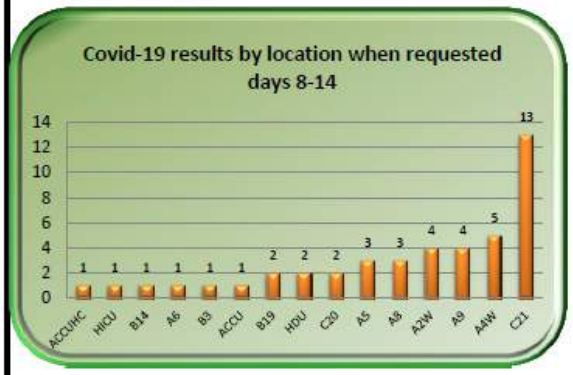
COVID-19 - Total inpatient cases from start of pandemic



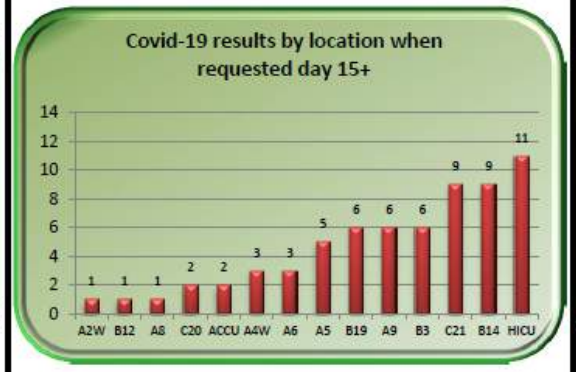
Covid-19 Cases by Month



Admission Day 8-14 (probable hospital acquired)



Admission Day 15+ Definite Hospital acquired



Day 8-14 and 15+ combined

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/09/108**			
SUBJECT:	**Freedom To Speak Up**			
DATE OF MEETING:	30 September 2020			
AUTHOR(S):	Jane Hurst, Deputy DoF & Commercial Development			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO			
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.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***				
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an update to Trust Board on the activity of the Freedom To Speak Up (FTSU) Team.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the work of the FTSU Team and the lessons learnt.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/20/09/108		
	Date of meeting	23 September 2020		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Freedom To Speak Up	AGENDA REF:	BM/20/09/108

1. BACKGROUND/CONTEXT

This paper provides an update to Trust Board on the activity of the Freedom To Speak Up (FTSU) Team.

2. KEY ELEMENTS

In 2020/21 (April to 31 August 2020) the FTSU team received the following disclosures.

Table 1 Disclosures in 2020/21

Quarter 1	8
July & August	7
Total	**15**

The cases can be grouped as follows:-

Table 2 Types of disclosures in 2019/20

Behaviour and relationships	14
Patient safety	1
Total	**15**

Nearly half of the issues raised have related to Women's and Children's CBU. The issues are being managed with support from HR, OD and escalation to the Executive and Non-Executive Directors responsible for FTSU. A FTSU questionnaire has been circulated to W&C staff and over 2 weeks 79 replies were received, these have been collated and reported back to the Executive lead and will be included in a report to the Trust Board in September 2020.

The questionnaire feedback has been reviewed and as a result the OD team have produced an action plan with the support of FTSU and Management.

The questionnaire results showed that 60% of the respondents do not believe there is a positive speak up culture and that 59% of respondents felt they would suffer detriment if they spoke up.

A simple visual/ infographic of 'you said we did' will be produced for maternity services based on the recent anonymous survey to support communication across the area that actions are being taken on the staff voice.

There has been 1 patient safety concern raised relating to the Women's and Children's CBU, which was investigated by the Deputy Chief Nurse and Head of Midwifery and was included in the review.

3. LESSONS LEARNT

The importance of involving our Organisational Development (OD) team in the FTSU process has been highlighted in two cases:-

One where several members of staff raised issues regarding team working. The OD Team worked with the department to identify their needs and developed a structure training and development programme, whilst sensitively listening to their concerns.

The second case links to the Women's and Children's CBU as work with the OD Team had already commenced.

It is hoped that increased involvement with the BAME, LGBTQ+ and disability groups will enable more staff to feel comfortable in speaking up about their concerns.

4. ACTIVITY

Face to face training has been limited during 2020/21 due to Covid19. The team is working with the Medical Education team to ensure FTSU slides are available for online induction when face to face is not possible. FTSU presented at the Student Physician Associates induction in June and feedback was scored as "good" by 95%. FTSU Guardian spoke to the final year volunteers about FTSU and wellbeing on the 31 March 2020. The team also held a drop in day in July and the FTSU Guardian attended and introduced FTSU to the newly formed the BAME and LGBTQA+ groups. During September FTSUG has presented to Year 3, 4 and 5 Medical Student inductions.

5. FTSU INDEX SCORES

The Freedom to Speak Up (FTSU) Index, first published in 2019, is a key metric for organisations to monitor their speaking up culture. The index has risen nationally from 75.5 per cent in 2015 to 78.7 per cent in 2019. When compared with other sectors, a score of 70 per cent is perceived as a healthy culture. Within this national average there continues to be variation, both within and between organisations. For example, in one trust only four in 10 responders believe that the organisation treats staff who are involved in an error, near miss or incident fairly. This can act as a barrier to speaking up, which could have devastating consequences for patient and worker safety and wellbeing. Fostering a positive speaking up culture sits firmly with the leadership, and correlation can be seen with organisations that have higher FTSU Index scores tend to be rated as Outstanding or Good by CQC. The annual NHS staff survey contains several questions that are helpful indicators of speaking up culture. The FTSU index was calculated as the mean average of responses to the following four questions from the NHS Staff Survey:

• % of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)

• % of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)

• % of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)

• % of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

This year's index is based on the results from the 2019 NHS Staff Survey.

Warrington and Halton FTSU Index score is 79.4%, the highest score is 86.6% and lowest 68.5%.

6. RECOMMENDATION

The Trust Board is asked to note the FTSU activity and the lessons learnt.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/09/109**			
SUBJECT:	**Safe Staffing Escalation Audit May – June 2020**			
DATE OF MEETING:	30 September 2020			
AUTHOR(S):	Ellis Clarke Clinical Informatics Matron			
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 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)***	#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):*				
PURPOSE: *(please select as appropriate)*	Information x	Approval	To note x	Decision
RECOMMENDATION:	**To note the finding of the report and approve the recommendations**			

PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	SPC/20/09/78
	Date of meeting	23 September 2020
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Staffing Escalation Audit	AGENDA REF:	BM/20/09/

Staffing Escalation Process Audit

0062
8th July 2020
Ellis Clarke, Informatics Matron
Ellis Clarke
Lead Nurses for staffing
Assurance Level - Significant

Contents

Clinical Audit Report

Background:

The Trust has a duty to ensure that all wards and departments are staffed with the appropriate number and skill mix of nurses. Nurse staffing levels have been set using nationally recognised methodologies and the Trust is committed to ensuring that there are the right number and skill mix to care for our patients safely, and to effectively utilise our workforce through efficient resource allocation.

Where shortfalls in nurse staffing are identified, the Trust has a staffing escalation process for assessing and managing and recording nurse staffing levels across the Trust on a shift by shift basis. The National Quality Board paper, Safe Sustainable and Productive Staffing (2018) recommends that organisations should ensure that they have appropriate staffing escalation processes in place as part of their expectations and framework for nurse staffing in adult inpatient wards in acute hospitals.

Aim:

The aim of the audit is to ensure that the staffing escalation plans are utilised effectively, are fit for purpose and determine the awareness and impact of the current Trust process at ward and departmental level.

Objective(s):

An action identified by the Care Quality Commission (CQC) in their 2017 inspection of the Trust was to ensure that there were staffing escalation plans in place across the Trust and that these are audited to assess effectiveness and compliance.

Methodology:

This is the 5th staffing escalation audit, the 2nd report indicated that the questions in the audit needed to be reviewed and updated to better reflect the process as well as to minimise the variability of response. The senior nursing team devised a Microsoft Excel based proforma for the data collection, using the standards and expectations identified in the Trust Nurse Staffing Escalation Plan of Safe staffing across wards and departments.

The data was collected over a 2 week period, between the 25th May & 7th June 2020. The audit was undertaken daily, by the senior nurse for staffing that day. The data was collected using a range of information, the daily staffing template on the P: drive, the information in the staffing meeting, the plan and mitigation records and the handover process.

The information for both was recorded on individual Excel spreadsheets and returned to the Clinical Audit Department for analysis.

Results:

Please see an example table below for a breakdown of the standards with results- show comparison with previous audits if applicable for example re-audits.

	Compliance Scores				
Standard	Yes	No	N/A	Total	Compliance RAG
Where are the staffing levels recorded?	14 100%	0 0%		14	100%
Has the proforma been completed by all wards/depts?	14 100%	0 0%		14	100%
Wards with Amber & Red levels have a documented plan?	14 100%	0 0%		14	100%
Have shortages been escalated to NHSP?	14 100%	0 0%		14	100%
Have ward requiring enhanced care escalated to Matron/Lead Nurse?	14 100%	0 0%		14	100%
Night team to daytime staffing lead	14 100%	0 0%		14	100%
Daily staffing meeting attendance	14 100%	0 0%		14	100%
Daytime staffing lead to night team	14 100%	0 0%		14	100%
Number of Red Flags raised	14 100%	0 0%		14	100%
Red Flag responses in time?	14 100%	0 0%		14	100%

Red Flags:

During the audit we kept a record of the Red Flags that were entered onto the SafeCare system for escalation to the Staffing Lead of the day.

Red flags were raised on just 1 of the 14 days and the response was seen as acceptable. The reason for low numbers of Red Flags was that there was extra vigilance with nurse staffing due to the COVID-19 response, so the number of issues was reduced by the employment of extra staff and Matrons/Lead Nurses dealing with any issues before they became reportable.

Key Findings:

The results of the audit have all improved against all standards providing significant assurance. Staffing concerns are escalated via the Site Manager and the audit confirms that this happened despite the Red Flag issue.

The audit was undertaken during the COVID-19 Pandemic response, during this time there was a senior nurse on duty to support with staffing 8am until 8pm 7days a week. This senior support provided oversight and responsive action to the nurse staffing processes across the Trust at this time.

Recommendations:

- It is recommended that the audit is repeated in 6 months' time.
- Share the report at the Safe Staffing Group and the Workforce Committee

Audit Action Plan:

Compulsory section of report- Refer to appendix B for SMART actions. If NO actions are identified please state.

Project Title	Staffing Escalation Audit
Audit ID	167
Service & Directorate	Corporate

Action Plan Lead	Name: Ellis Clarke	Title: Matron	Contact: 2290

Standard	**Actions required**	**Action by Date**	**Person responsible** *(Name and job title)*	**Comments** *(state any problems encountered in facilitating change, reasons for delay etc)*
Red Flag Responses	Discuss with Lead Nurses and Matrons with view to improve the position	February 2020	Ellis Clarke	

Presentation and Dissemination

- Presentation: Safe Staffing Meeting Tuesday 21st July 2020 and Workforce Committee Thursday 23rd July 2020 by Ellis Clarke
- Dissemination: Matrons & Lead Nurses will share with their teams following the meeting

APPENDIX A - Assurance levels for Clinical Audit

Step 1: Each standard is given a rating of red, amber or green depending on how high, or low, it measured

Calculation of individual ratings against standard	
Colour	**Standard % measure**
Green	90% and above
Amber	80% to 89%
Red	79% and below

Step 2: Once each standard has been rated an overall level of assurance for the audit project can be determined using the matrix below.

Level	Assurance
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied.
Significant	There is a good system of internal control designed to meet the system objectives, and that controls are generally being consistently applied .
Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.
Limited	There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts achievement of the system objectives at risk.
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.

The appropriate level of assurance will be decided following a discussion between the clinical audit lead, or leads, and the clinical audit department.

APPENDIX B – Setting SMART actions

Once you have completed your project, turn your attention to developing actions that will enable you to make successful changes.

Actions should be **SMART** - specific, measurable, achievable, realistic and time-based.

SPECIFIC	✓ Be clear in what you want to achieve
MEASURABLE	✓ What will be different ✓ What will you have started doing ✓ What will you have stopped or be doing ✓ How will you know you have achieved your aim
ACHIEVABLE	✓ Ensure your goals are realistic ✓ Set smaller goals towards achieving the bigger picture
REALISTIC	✓ Do I have the resources to achieve the aim ✓ Are there any limitations, what can I do to minimise these
TIME BASED	✓ Set a reasonable time scale to achieve the aim