TRUST BOARD - 25 November 2020

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

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NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/123**	
SUBJECT:	**Director of Infection Prevention and Control Annual Report**	
DATE OF MEETING:	25th November 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: **(*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)***	#1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2019 to March 2020 financial year. Good progress was made against the annual action plan with activity redirected in Q4 in response to the Covid-19 pandemic. All members of the Infection Prevention and Control Team responded proactively providing education, briefings, development of policies and standard operating procedures and participation in contingency planning to ensure a high level of preparedness and access to appropriate personal protective equipment. The Infection Control Team structure has been revised and strengthened by the addition of an additional whole time equivalent nurse. • Improvements were noted in compliance with the Code of Practice on Prevention of Healthcare Associated Infections from upgrades to patient care environments. The Trust scored above national average in the Patient Led Assessments of the Care Environment (PLACE) reports on both sites for cleanliness. The National Inpatient Survey for 2019 included a question on cleanliness and the Trust scored highly with the result comparable to other Trusts	

	• There was a reduction in planned activity (audits and mandatory training) due to the Covid-19 pandemic as activity was appropriately redirected • 49 C. difficile cases (data is not directly comparable to previous years due to changes to apportionment algorithm). 5 cases over threshold with the CCG review panel concluded 18 cases from Q1-Q3 were unavoidable. Q4 cases are awaiting review • 2 MRSA bacteraemia cases (as per previous year) and 1 case considered unavoidable • 51 E. coli bacteraemia cases (increase by 3 cases) • 15 Klebsiella bacteraemia cases (increase by 1 cases) • 18 MSSA bacteraemia cases (increase by 3 cases) • 4 Pseudomonas cases (decrease by 1 case) Case numbers are comparable with similar sized Trusts. Action plans, which focus on learning from incidents, are in place. A 10% reduction target has been set as a priority in the Quality Strategy for 2019/20. The low incidence of surgical site infection in mandatory Orthopaedic surveillance has been maintained. Antimicrobial Stewardship has been strengthened with a 20% (n=12) increase in ward round activity. Point prevalence audits show 90% compliance with the Trust formulary. This report builds on previous annual reports submitted to the Board to give a full year account of infection prevention and control activity.

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

RECOMMENDATION:	The Board is asked to receive and approve the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	**QAC/20/10/192**
	Date of meeting	6th October 2020
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Assurance Committee

SUBJECT	Director of Infection Prevention and Control Annual Report	AGENDA REF:	BM/20/11/123

1. BACKGROUND/CONTEXT

Executive Summary

Organisation

Warrington and Halton Teaching Hospitals NHS Foundation Trust is a secondary care organisation providing healthcare services across the towns of Warrington, Runcorn, Widnes and surrounding areas. The Trust has 3 hospitals across two sites and operates within the mid-Mersey Health Economy. The Trust has circa 680 beds, an annual budget in the region of £246 million, employs over 4,200 staff and delivers 500,000 individual appointments, procedures and inpatient stays.

The Trust's mission is 'To be outstanding for our patients, our communities and each other', with a vision that 'We will be the change we want to see in the world of health and social care'. We always put our patients first through high quality, safe care and an excellent patient experience.

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

Infection Prevention Annual Work Plan

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

A robust work plan (appendix 1) has been devised for the 2020/21 financial year. The work plan includes attendance at other committees to ensure integration of infection prevention and control across the organisation; compliance with all mandatory surveillance requirements; monitoring of environmental cleanliness standards; audits of practice/policies; policy/guideline reviews and a programme of education and awareness raising events.

The work plan will link to the Infection Prevention and Control Strategy which is being revised in 2020 and progress will be monitored by the Infection Prevention and Control Sub-Committee.

Covid-19 Pandemic

A vast amount of activity was undertaken in Q4 in response to the evolving situation of the pandemic. This included surveillance of the international and national situation and Coronavirus Priority Assessment Pods were established for testing suspected cases in returning travellers. 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.

The Trust estate was reviewed to determine the most suitable location to accept suspected coronavirus cases. This was agreed as Ward 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. Review of the estate also resulted in additional doors being installed in ED Majors and partitions in ED Minors.

A novel coronavirus policy was developed by 23 January 2020 and updated throughout Q4 in response to changing national guidance. A number of other documents were developed as national guidance emerged. A huge amount of activity was focussed on education including two Grand Rounds delivered on 7th February and 13th March, which were well attended. Simulation training proved invaluable to review processes around patient admission, transfer and clinical procedures.

Education of staff included use of PPE Champions (58) to deliver face to face training on donning and doffing, a training booklet was developed and given to all members of staff, Public Health England (PHE) posters on donning and doffing were displayed in all ward areas and Consultant Microbiologist roadshows were put in place with presentations on evidence for PPE.

The Infection Prevention and Control Team worked closely with the Emergency Planning Office. Education was provided to senior managers on call and a series of briefings held for all heads of service. PPE stock levels were kept under close review to ensure no outages or access issues and scrub suits were offered as an alternative to home laundering of uniforms.

Fit Testing of staff for appropriate respiratory protection was in place pre-pandemic and this was stepped up to ensure all staff had access to a successfully fit tested FFP3 respirator as per legal requirements.

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. By end of March 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 Nursing Team.

Code of Practice on Prevention of Healthcare Associated Infections

Good progress has been made to achieve the requirements of the Health and Social Care Act (2008) Code of Practice on prevention of healthcare associated infections (2015) which is directly linked to Regulation 12 of the Health and Social Care Act 2008. A number of improvements have been made to patient care environments and outpatient waiting areas. The Trust is working towards full compliance with the 10 criterion:-

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

These relate to old estate i.e. lower number of side room facilities than current recommendations, lower ratio of hand washing sinks to patient number than current guidance. Additional handwashing facilities have been installed as part of the Covid-19 response.

The annual Patient Led Assessment of the Care Environment (PLACE) took place in November 2019 and the Trust scored above national average at both sites for cleanliness, food and condition/appearance. A

vast amount of activity to improve the Trust estate has been undertaken and additional inpatient bed capacity created. The National Inpatient Survey for 2019 included a question on cleanliness and the Trust also scored highly with the result comparable to other Trusts.

Healthcare Associated Infections

There are 3 healthcare associated infection reduction action plans, linked to mandatory reporting requirements which were reviewed on a quarterly basis. Results for mandatory reported healthcare associated infections compared to the previous financial year are detailed below.

- *Staphylococcus aureus* (Meticillin resistant/Meticillin sensitive) bacteraemia
    - 2 hospital onset MRSA bacteraemia case - as per previous year
    - 18 hospital onset MSSA bacteraemia cases – increase by 3 cases

- Gram Negative Bloodstream Infection (GNBSI)
    - 51 hospital onset cases of Escherichia coli (E. coli) – increase by 3 cases
    - 15 hospital onset cases of Klebsiella spp. – increase by 1 cases
    - 4 hospital onset cases of Pseudomonas aeruginosa – decrease by 1 case

There was a slight increase in both E. coli and Klebsiella spp. cases. Nationally reported data shows E. coli bloodstream infections continue to increase. The national target to reduce GNBSI published in the Tackling Antimicrobial Resistance 5 year plan (January 2019) remains in place. This publication recommends a systematic approach to preventing infections and delivering a 25% reduction by 2021-2022 and 50% by 2023-2024.

As part of the Quality Strategy a pledge: 10% reduction in Hospital Acquired Infections – particularly focusing on safe catheter care and implementation of the Trust's Urinary Tract Infection (UTI) pathway, was made. There was a decrease in targeted work due to Covid-19 and plans are in place to recommence targeted activity within the Trust and with partners across the health economy in September 2020.

- Clostridium difficile

Changes to the reporting and apportionment algorithm in 2019/20 resulted in some cases that in previous years were apportioned to the community being apportioned to the Trust. There was a reduction in the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) following admission and therefore the data is not directly comparable with previous years.

    - 37 hospital onset healthcare associated cases
    - 12 community onset healthcare associated cases – previously community apportioned cases

All hospital apportioned C. difficile cases undergo root cause analysis (RCA) investigation. Cases considered unavoidable are submitted to the Clinical Commissioning Group (CCG) review panel. There

was a delay in completing RCA reviews for Q4 due to the Covid-19 pandemic and a recovery plan is in place to ensure completion. Actions in place to reduce the risk of Clostridium difficile focus on hand hygiene (staff and patients), environmental cleanliness and antimicrobial stewardship.

This report outlines the arrangements, activities and achievements during 2019/20. The report builds on previous annual reports submitted to the Board to give a whole year account of infection prevention and control activity.

Kimberley Salmon-Jamieson
Chief Nurse & Deputy Chief Executive
Director of Infection Prevention and Control (DIPC)
August 2020

Acknowledgements

Marcia Anthony	Facilities Manager
Allen Hornby	Lead Nurse Critical Care
Julie McGreal	Facilities Manager
Lesley McKay	Associate Director of Infection Prevention and Control
Dr Zaman Qazzafi	Consultant Medical Microbiologist
Olwyn Wainwright	Surgical Care Practitioner Surgical Specialities Clinical Business Unit
Jacqui Ward	Lead Pharmacist in Antimicrobial Stewardship

2. KEY ELEMENTS

Description of Infection Control Arrangements

Infection Prevention and Control Team

The Infection Prevention and Control Team meet fortnightly. Membership includes:-

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

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

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

- Audit and Surveillance Nurse
  - Joanne Oldfield

- Lead Pharmacist in Antimicrobial Stewardship
  - Jacqui Ward

- Infection Control Administrator:-
  - Amanda Millington

- Operational Estates Manager
  - Darren Wardley

Infection Control Sub-Committee

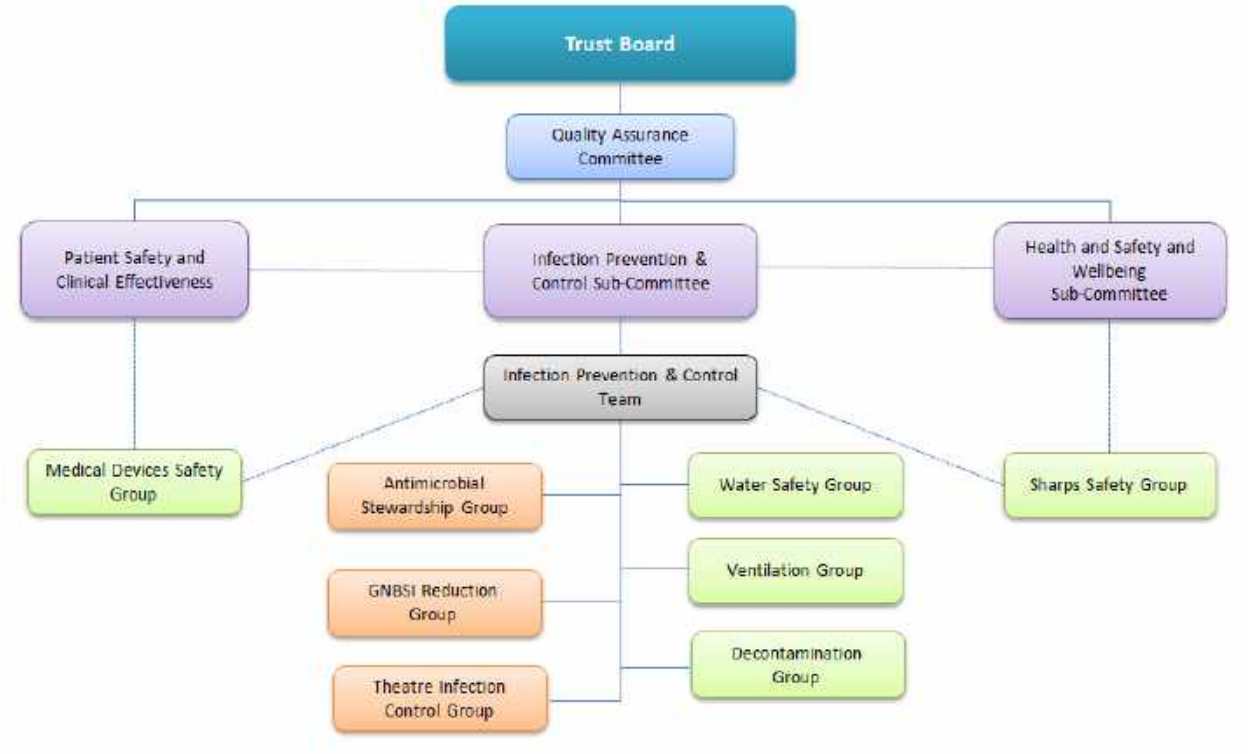
The Infection Control Sub-Committee is chaired by the Consultant Medical Microbiologist/Deputy DIPC/Infection Control Doctor. The committee met bimonthly with the exception of March 2020. At this time a Coronavirus Management Board was established. Infection Prevention and Control operated as a cell within the coronavirus structure with responsibility for providing Trust-wide advice and education. Daily tactical meetings were implemented. These meetings and subsequently Recovery Board meetings were attended by the DIPC, Associate Chief Nurse for IPC and Consultant Microbiologists.

Membership comprises of the DIPC, Infection Prevention and Control Team, Lead Nurses from each Clinical Business Unit, Estates and Facilities Managers, Lead Allied Health Professional and the Occupational Health and Wellbeing Manager.

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

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

Figure 1 Reporting Line to Trust Board



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

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

DIPC Reports to Trust Board

Reports and High level Briefing Papers, which included key performance indicators, HCAI surveillance data, outbreak/incident details and root cause analysis/post infection review findings were submitted to the Quality and Assurance Committee with onward reporting to Trust Board in:-

- May 2019

- July 2019
- July 2019 (Annual Report on previous years activity)
- October 2019
- February 2020 Covid-19 Briefing Paper

Annual work plan

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

This work plan is underpinned by action plans for key performance indicators/mandatory healthcare associated infections and a programme of audit that provides evidence of policy/guideline compliance. Progress against planned activity was good throughout quarter 1 -3.

Covid-19

In quarter 4 the Infection Prevention and Control Team redirected efforts to address the Covid-19 pandemic. The Infection Prevention and Control Nurses seamlessly adapted to provide a seven day service, on call advice and supported the Trust's Incident Control Room.

Education and Training was provided at Grand Round presentations on 7 February and 13 March and the Consultant Microbiologists delivered a number of roving and educational roadshows. Links to the Department of Health donning and doffing videos were distributed to support staff education. PPE Champions were trained in donning and doffing and provided education to clinical teams at ward and department level. A PPE enquiry advice line and email address was set up. An in and out of hours process was put in place to ensure access to PPE at all times. Simulation exercises were carried out with support from the Trust Simulation Lead in ED, Critical Care, Maternity, paediatrics and ward A7 (respiratory). These included safe transfer of patients through the Trust and directed improvements in processes.

A novel coronavirus policy was developed by 23 January 2020 prior to the declaration of a public health emergency of international concern by the World Health Organisation (WHO) on 30 January 2020. This policy included information on diagnostic and testing criteria in addition to infection prevention and control. This policy was updated frequently in response to changes in national guidance. A Standard Operating Procedure (SOP) was used to support patient placement that complimented the clinical guidelines for assessing suspected coronavirus cases.

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

Health and Social Care Act (2008) compliance assessment

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

The Care Quality Commission (CQC) uses this code to judge registered provider compliance with the cleanliness and infection control requirement set out in the regulations. Compliance with the Code of Practice at the end of January 2020 and areas requiring further action are detailed in table 1.

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

Criterion	Assessment	Action required/in progress
1. *Systems to manage and monitor the prevention and control of infection.*	*Compliant*	*Training required on surveillance software. Report templates to be developed*
2. *Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.*	*Partially compliant*	*Upgrades to some hand washing sinks required (design and location). Re audit of handwashing facilities scheduled with Estates Team*
3. *Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.*	*Compliant*	*Implementation of electronic prescribing in progress*
4. *Provide suitable accurate information on infections to service users and their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.*	*Compliant*	
5. *Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.*	*Compliant*	
6. *Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.*	*Compliant*	
7. *Provide or secure adequate isolation facilities.*	*Partially compliant*	*Continuous liaison with the Patient Flow Team to optimise use of side rooms for appropriate patient isolation*
8. *Secure adequate access to laboratory support as appropriate.*	*Compliant*	
9. *Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.*	*Compliant*	
10. *Providers have a system in place to manage the occupational health needs of staff in relation to infection.*	*Compliant*	

Healthcare Associated Infection Statistics

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

Clostridium difficile

For the financial year 2019/20 changes were made to the Clostridium difficile reporting algorithm. This included:-

- adding a prior healthcare exposure element
- reducing the number of days to apportion hospital-onset healthcare associated cases from three or more days (day 4 onwards) to two or more days (day 3 onwards) following admission

Cases reported to the healthcare associated infection data capture system are now assigned as follows:-

- **hospital onset healthcare associated (HOHA):** cases that are detected in the hospital three or more days after admission (included in contractual count)
- **community onset healthcare associated (COHA):** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks (included in contractual count)
- **community onset indeterminate association:** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous 12 weeks but not the most recent four weeks (not included in contractual count)
- **community onset community associated:** cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the Trust reporting the case in the previous 12 weeks (not included in contractual count)

The Trust reported 78 Clostridium difficile toxin positive cases:

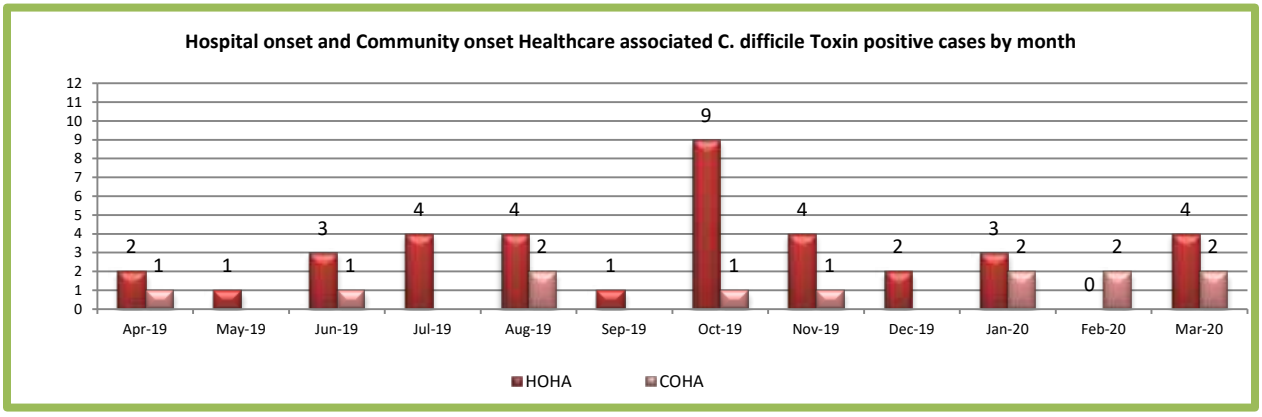
- hospital onset healthcare associated = 37
- community onset healthcare associated = 12

} 49 Trust apportioned cases

- community onset indeterminate association = 8
- community onset community associated = 21

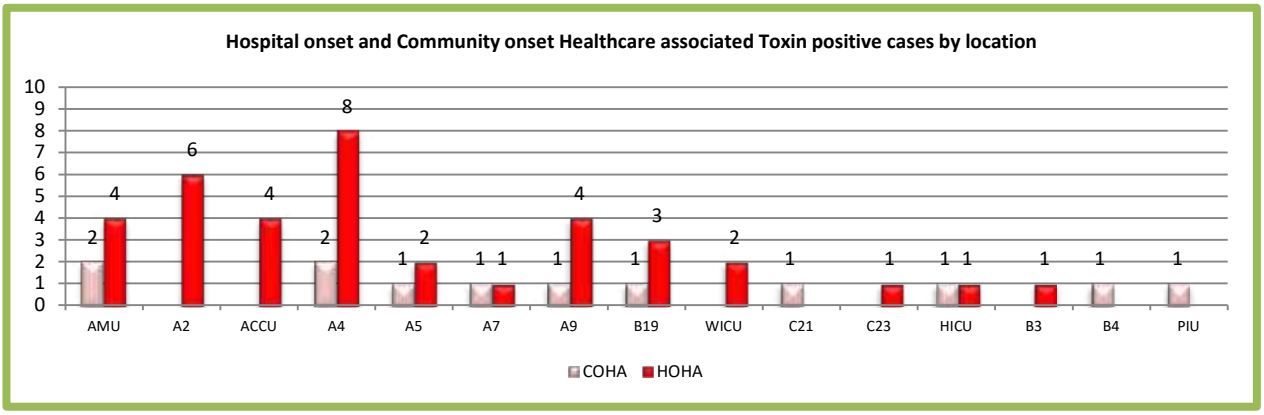
The Trust Clostridium difficile objective for the 2019/20 financial year was 44 or less hospital apportioned cases. The Trust was 5 cases over threshold with a total of 49 cases. Changes to the apportionment algorithm do not support direct comparison to previous year's data. The number of hospital onset healthcare associated and community onset healthcare associated cases reported by month is displayed in figure 2.

Figure 2 Hospital onset/Community onset Healthcare associated C. difficile toxin positive cases by month



Hospital apportioned cases by location when the sample was taken is displayed in figure 3. The location the specimens were obtained from is not necessarily where the infection was acquired as patients may have been on the ward/department for less than 48 hours when tested.

Figure 3 Hospital onset and Community onset Healthcare associated C. difficile toxin positive cases by location when tested



All hospital apportioned C. difficile cases undergo root cause analysis (RCA). The investigations are completed by Ward Managers with input from the patients' consultants'. Completed investigations are reviewed internally and if considered unavoidable are submitted to the Clinical Commissioning Group (CCG) review panel. There was a delay in completing RCA reviews for Q4 due to the Covid-19 pandemic. A recovery plan is in place to ensure completion. Cases reviewed from Q1 –Q3 resulted in 18 cases being assessed as unavoidable (and removed from those counted for contractual purposes) and 18 cases assessed as avoidable infections. The 13 cases from Q4 are awaiting review by the CCG.

Table 2 depicts the Clostridium difficile toxin positive case review outcomes by month. An action plan is in place linked to learning from these incidents that sets out the work required to reduce the risks of Clostridium difficile infection. This focuses on hand hygiene (staff and patients), environmental cleanliness and antimicrobial stewardship.

Table 2 Outcome of CCG review panel decisions by month

2019/20	A	M	J	J	A	S	O	N	D	J	F	M	Total
Total C difficile	3	1	4	4	6	1	10	5	2	5	2	6	49
No lapses in care	2	0	4	2	4	0	4	1	1	Under review			Total TBC
Lapses in care	1	1	0	2	2	1	6	4	1	Under review			Total TBC
Not reviewed	0	0	0	0	0	0	0	0	0	Under review			13

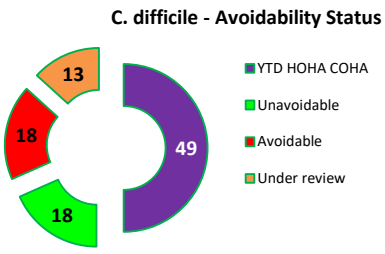
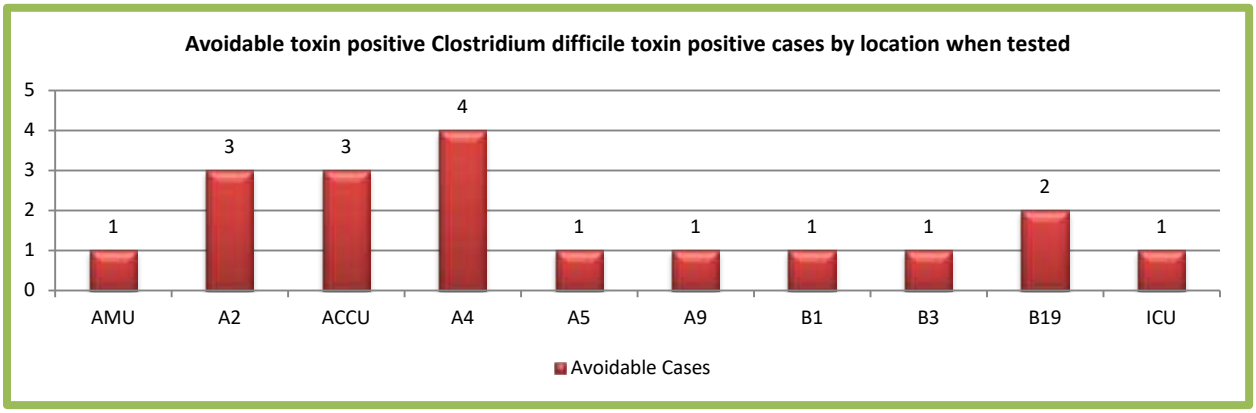


Figure 4 provides data on the 18 cases from Q1 – Q3 considered avoidable by location at the time of testing.

Figure 4 Avoidable Hospital onset (HO) Clostridium difficile toxin positive cases by location



The avoidable cases related to choice antibiotic prescribed and some missed sampling opportunities. Wards with higher numbers of avoidable cases are being prioritised for targeted support. A4 provides care for patients with gastroenterological conditions and is reviewed on the weekly antibiotic ward round. A number of antibiotic stewardship initiatives have been implemented include additional training for nursing staff to support challenge on antibiotic choice, ward based pharmacist support and strengthening inclusion of junior doctors on antibiotic ward rounds.

Feedback of investigation findings for shared learning has taken place and additional education provided to areas where the Clostridium difficile policy was not followed. Action plans are in place to address these findings.

There were no periods of increased incidence of Clostridium difficile during the reporting period and Ribotyping of all hospital apportioned cases demonstrated no cross infection.

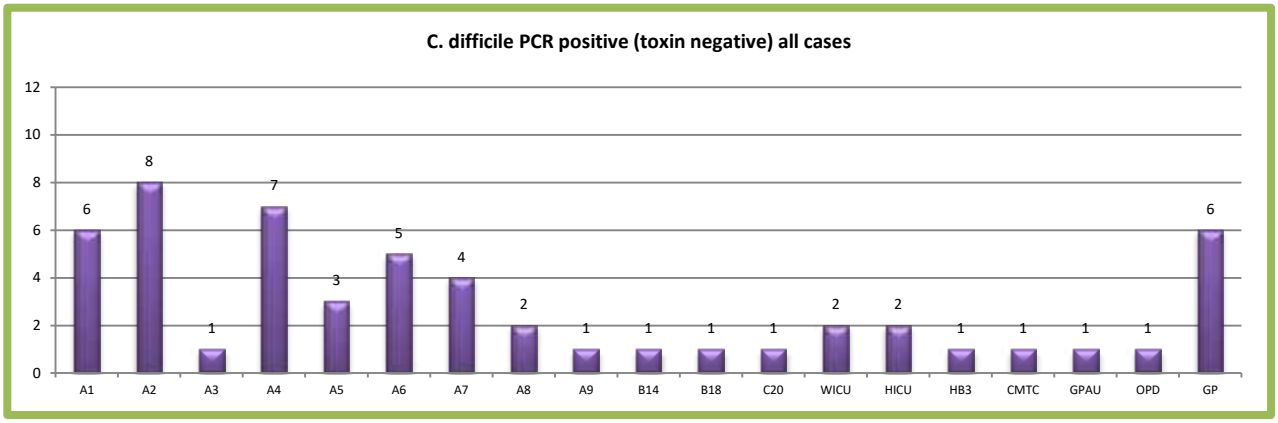
Clostridium difficile (toxin negative/PCR positive)

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

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

Figure 5 shows the results for all patients (no apportionment) who were Clostridium difficile toxin negative/PCR positive and location at the time of testing.

Figure 5 Clostridium difficile PCR positive/toxin negative cases (all) by location when tested



The Infection Prevention and Control Team focussed activity on Clostridium difficile reduction by:-

- Surveillance of cases/monitoring for increased incidences (2 or more cases in a 28 day period)
- Antimicrobial Stewardship Group
- Hand hygiene awareness raising events
- Ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of PPE
- Weekly multi-disciplinary team review of patients with Clostridium difficile
- Promoting improvements to standards of environmental hygiene
- Use of hydrogen peroxide vapour for environmental decontamination

The Clostridium difficile objective for 2020/21 has not been published. An internal threshold of 44 cases has been set as per last year's objective.

Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia

The Trust reported five cases of MRSA bacteraemia, two of which were hospital apportioned. Hospital apportioned case numbers are the same as the previous financial year. Data for comparison with earlier financial years is shown in figure 6.

Figure 6 MRSA bacteraemia cases (all) 2021 – 2020

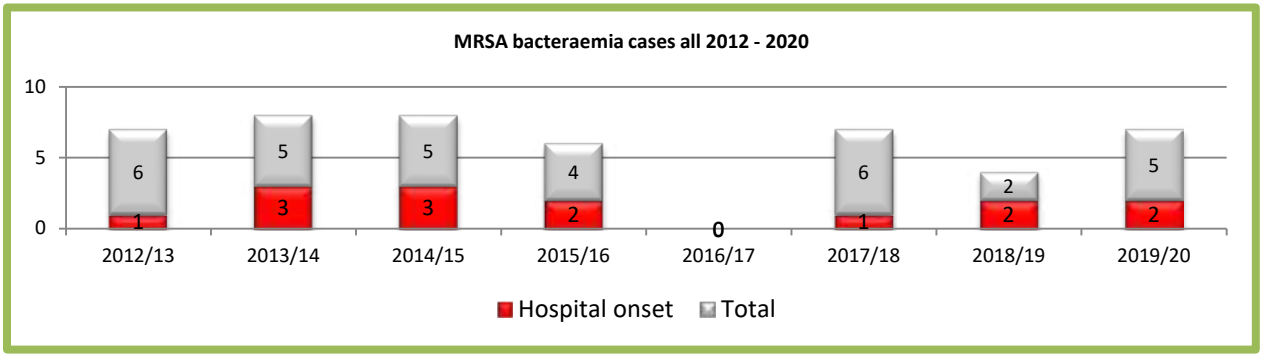
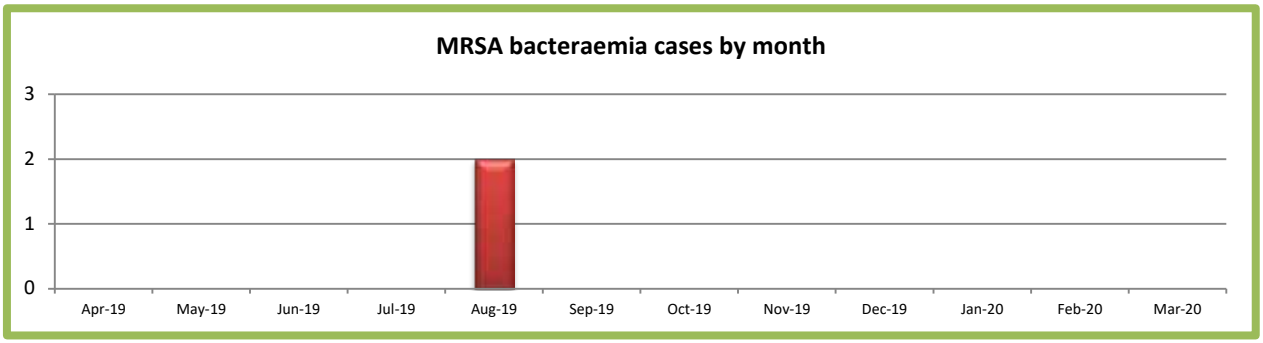


Figure 7 shows the hospital onset MRSA bacteraemia cases identified within the Trust by month. Both cases occurred in August.

Figure 7 Hospital onset MRSA bacteraemia cases by month



Case 1 occurred on ward A8. The patient had a long term history of MRSA colonisation and presented with bilateral leg cellulitis. A comprehensive incident investigation was completed and the case was considered unavoidable. Some learning points were identified that were not related to the development of the bacteraemia. These included ensuring all the required admission screening samples for MRSA are taken, completing documentation for cannula site monitoring and blood culture sampling.

Case 2 occurred on ward A5. The patient did not have any prior history of MRSA and presented with urology problems. A comprehensive incident investigation was completed and the case was considered avoidable. Learning from the review included: documentation of urinary catheter care and blood culture sampling, timely microbiological sampling on suspicion of sepsis/elevated NEWS2.

MRSA screening

The Trust continues to provide MRSA screening for patients in line with the Department of Health guidance. Approximately 26, 884 patients were screened for MRSA. This figure is consistent with previous years. Work is in progress with the data warehouse team to provide a more robust screening compliance report against the MRSA policy screening requirements.

Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia

The Trust reported 49 cases of MSSA bacteraemia (31 community onset and 18 hospital onset). This was an increase of 3 hospital onset cases compared to the previous financial year.

The Department of Health has not set targets for the reduction of MSSA bacteraemia. Data for comparison with previous financial years is shown in figure 8.

Figure 8 MSSA bacteraemia cases (all) April 2012 – March 2020

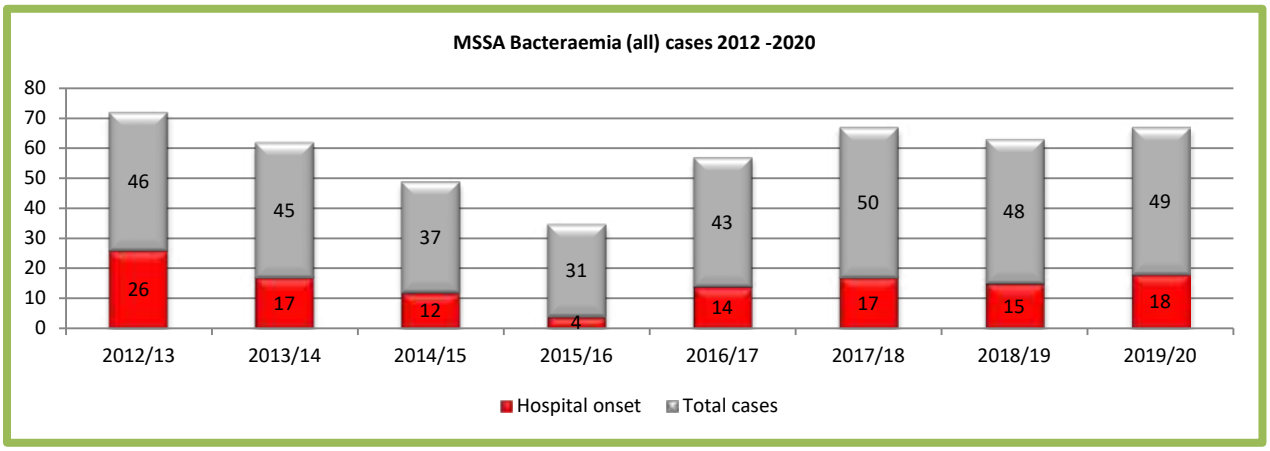


Figure 9 shows the hospital onset MSSA bacteraemia cases identified within the Trust by month.

Figure 9 Hospital onset MSSA bacteraemia cases by month

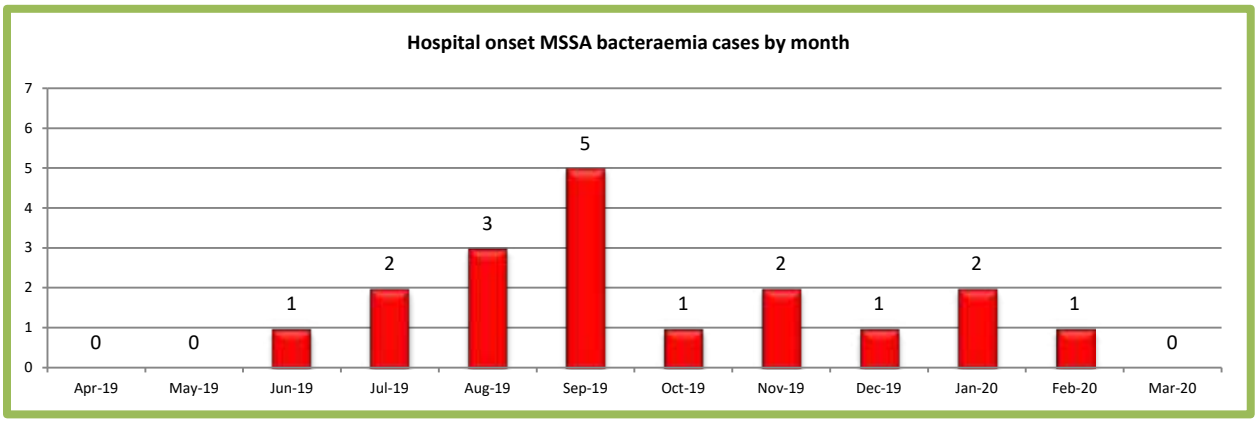
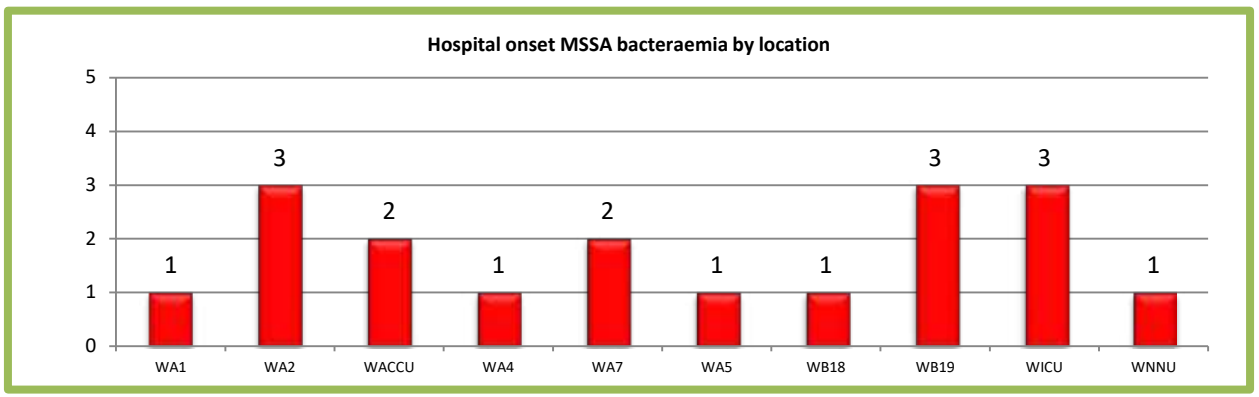


Figure 10 shows the patients location at the time the specimen was obtained.

Figure 10 Hospital onset MSSA bacteraemia cases by location detected



The post infection reviews identified a number of different sources for infection including deep seated endocarditis, osteomyelitis, pneumonia, septic arthritis, skin and soft tissue infection and ventilator associated pneumonia. An action plan is in place linked to learning from these incidents that sets out the work required to reduce the risks of MRSA/MSSA bacteraemia cases.

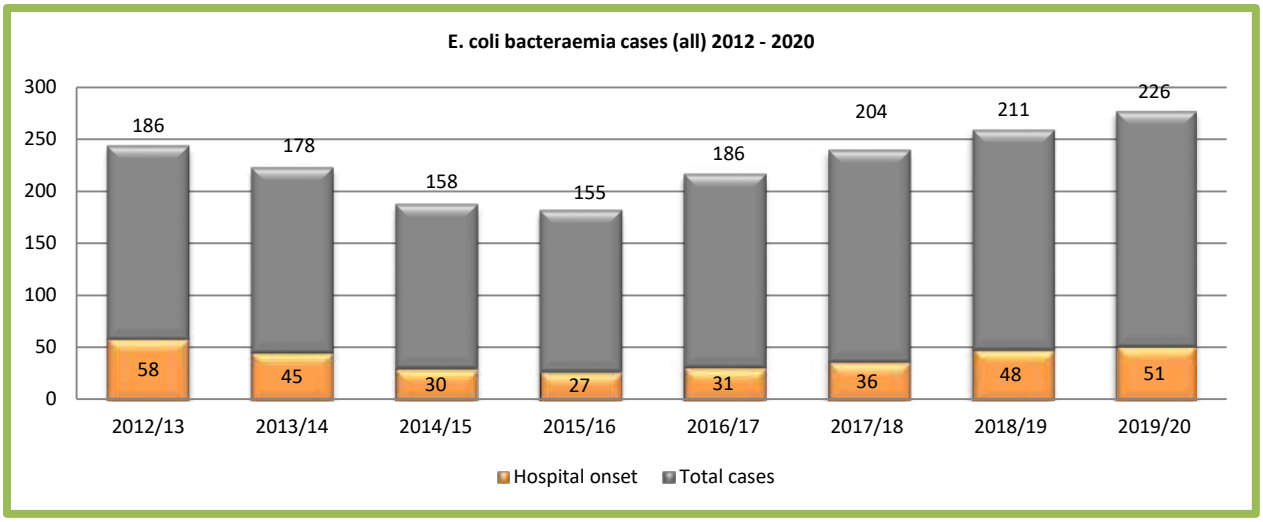
Gram Negative Bloodstream Infection (GNBSI)

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

E. coli bacteraemia

Mandatory reporting of E. coli bacteraemia commenced in June 2011. In order to show whole year figures for comparison, data is shown in figure 11 from April 2012.

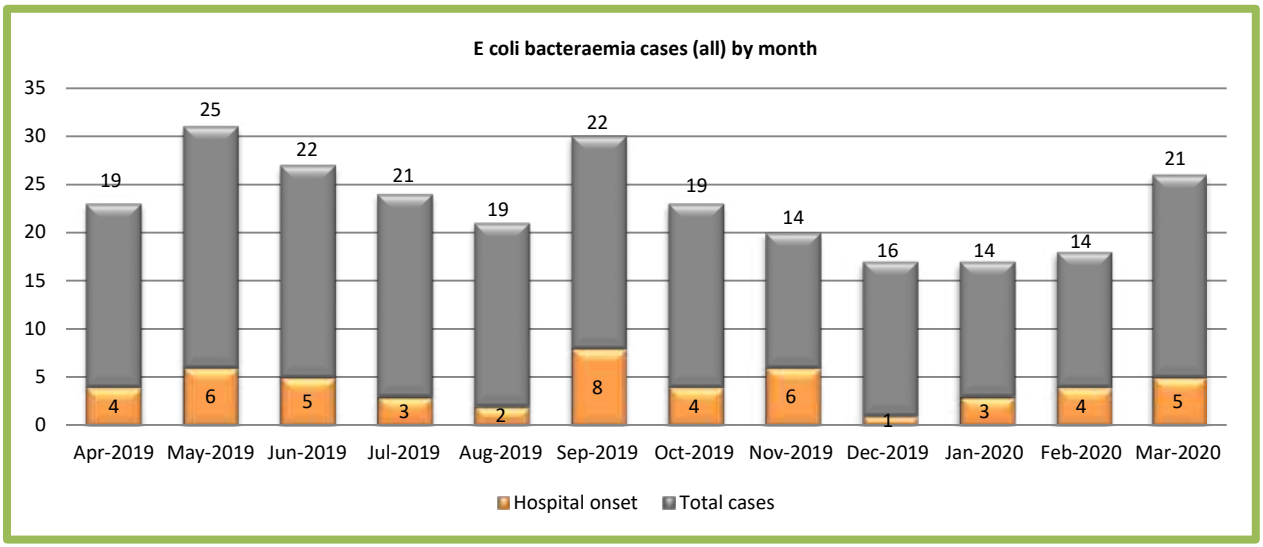
Figure 11 E. coli bacteraemia cases (all) April 2012 – March 2020



During in 2019/20 financial year the Trust reported a total of 226 E. coli bacteraemia cases, 51 of these were hospital onset cases. There was an increase of 3 hospital onset cases and an overall increase of 15 cases across the health economy compared to the previous financial year.

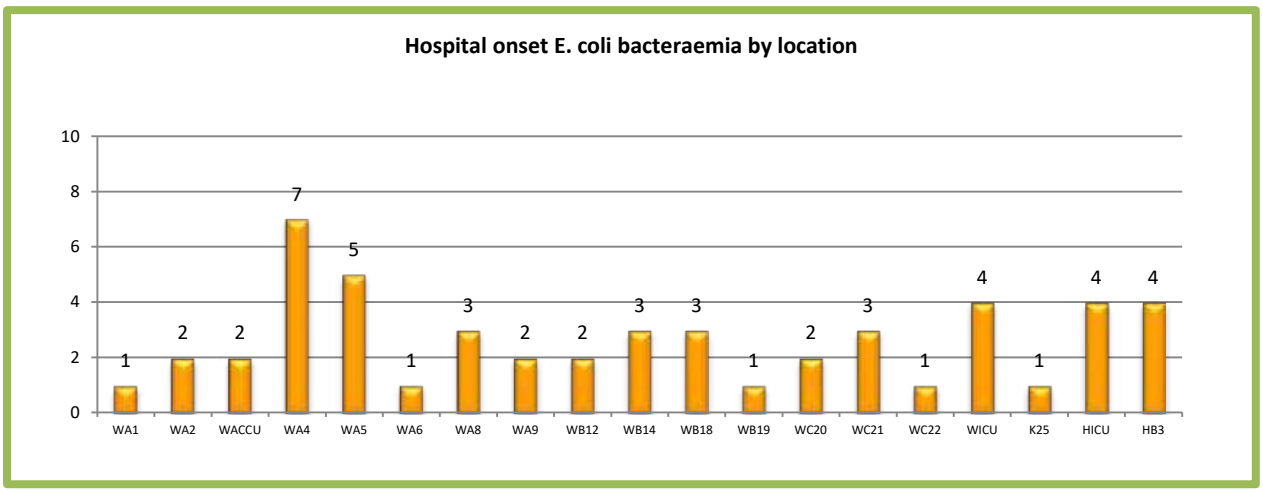
Figure 12 displays the total number of cases reported each month against the number of hospital onset cases during the financial year.

Figure 12 E. coli bacteraemia cases (all) by month



The hospital onset E. coli bacteraemia cases by ward when specimen was taken are shown in figure 13.

Figure 13 Hospital onset E.coli bacteraemia cases by location when tested

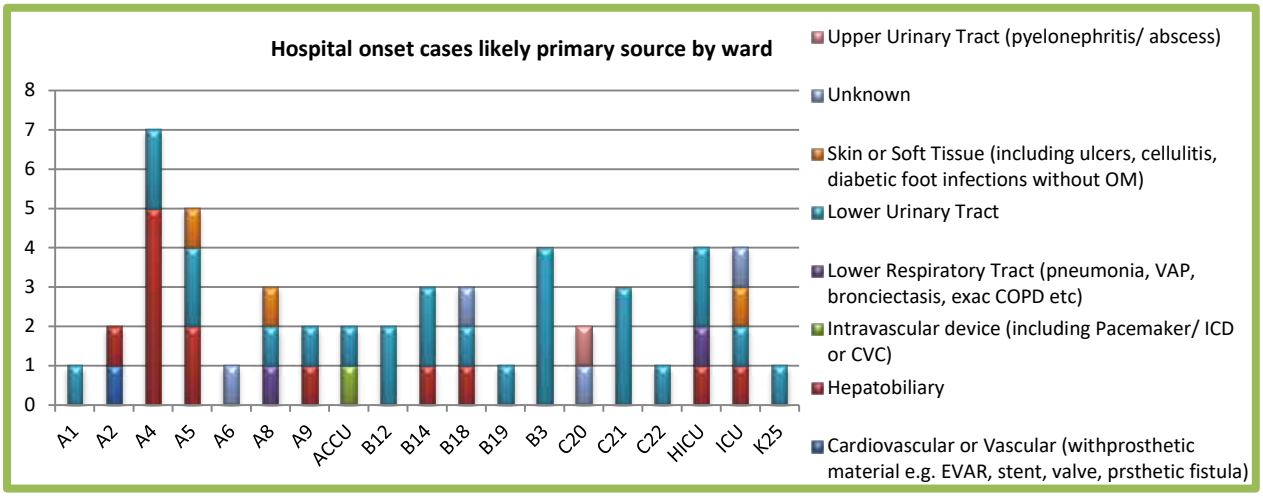


Of the 51 hospital onset cases the likely primary focus was assessed as being associated with:-

- urinary tract - 27 cases
- hepatobiliary - 13 cases
- unknown source - 4 cases
- skin/soft tissue – 3 cases
- respiratory tract - 2 cases
- cardiovascular – 1 case
- IV device/implanted device – 1 case

A breakdown of hospital onset cases to show likely primary source by ward is shown in figure 14.

Figure 14 Hospital onset cases likely primary source by ward



Completed investigations identified a number of opportunities for care improvement including antibiotic treatment choice for urinary tract infection. The Infection Prevention and Control Team are working with the Quality Academy and commenced work with the Advancing Quality Alliance (AQuA). A collaborative across the health economy was established with community partners including: Warrington and Halton CCG, 3 Boroughs Public Health Infection Control Team, Bridgewater Community Trust and Warrington Borough council. This was put on hold due to Covid-19.

Meetings recommenced in August 2020 and focussed activity to reduce the risk of catheter associated urinary tract infection will resume in September 2020. The Associate Chief Nurse for Infection Prevention and Control is representing acute Trusts on the Cheshire and Merseyside Programme Board for GNBSI reduction.

Klebsiella spp. bacteraemia

Reporting of Klebsiella spp. bacteraemia became mandatory from April 2017. A comparison with previous year's data is shown in figure 15.

Figure 15 Klebsiella spp. bacteraemia (all) April 2017 – March 2020

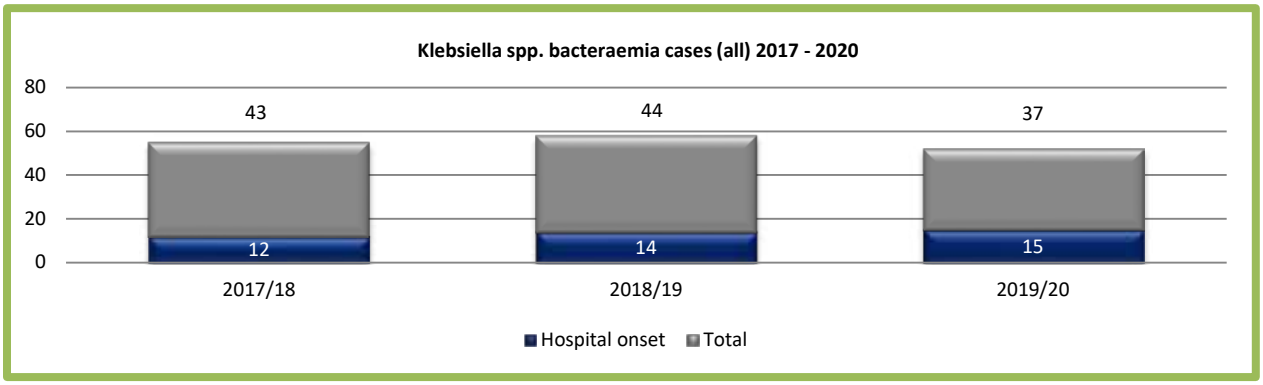


Figure 16 displays the total number of cases and the number of hospital onset cases reported each month during the 2019/20 financial year.

Figure 16 Klebsiella spp. bacteraemia (all) cases by month

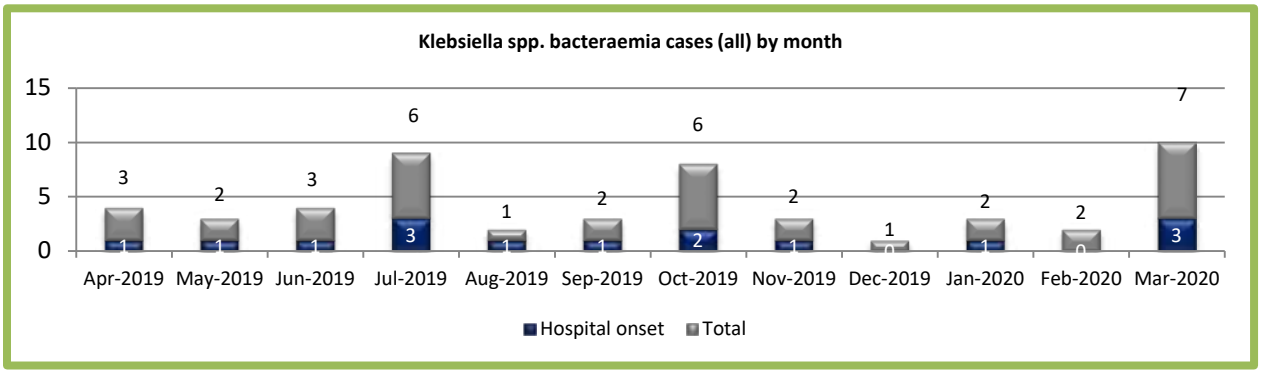
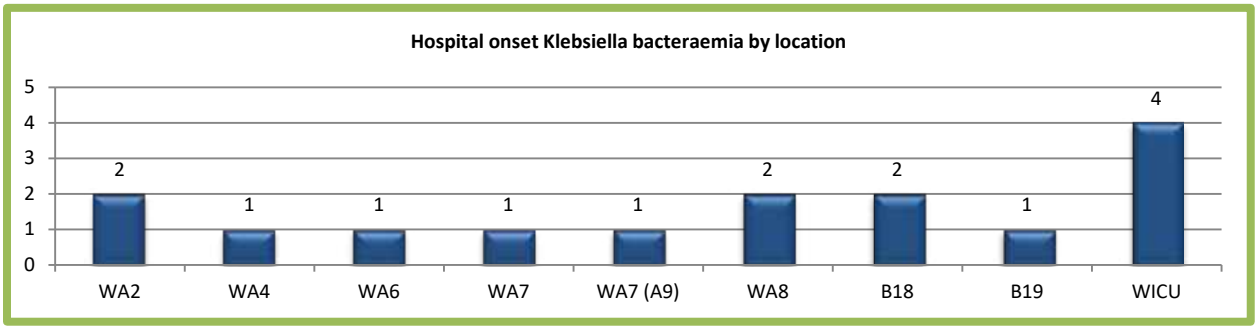


Figure 17 show Hospital onset Klebsiella bacteraemia cases by ward location when tested.

Figure 17 Hospital onset Klebsiella bacteraemia cases by ward location when tested



Pseudomonas aeruginosa bacteraemia

Reporting of Pseudomonas aeruginosa bacteraemia was made mandatory from April 2017. A comparison with previous year's data is shown in figure 18.

Figure 18 Pseudomonas aeruginosa bacteraemia cases April 2017 – March 2020

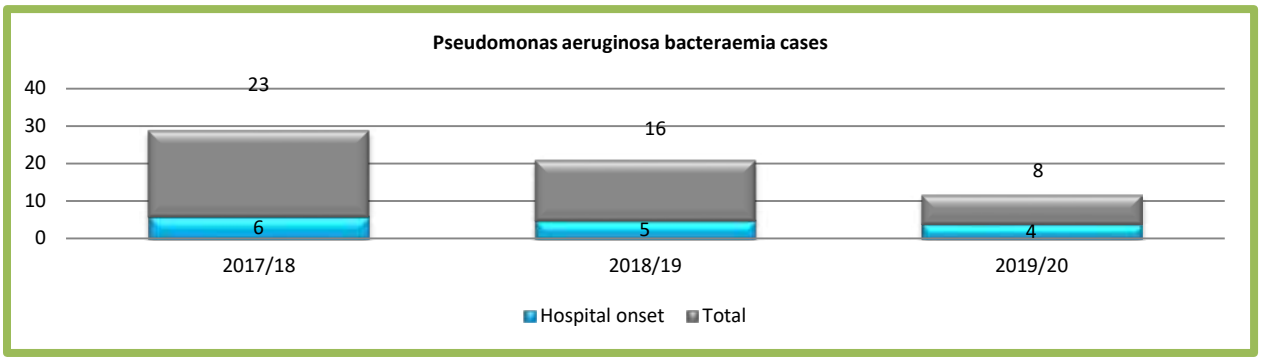


Figure 19 displays the total number of cases and the number of hospital onset cases reported each month.

Figure 19 Pseudomonas aeruginosa bacteraemia cases (all) by month

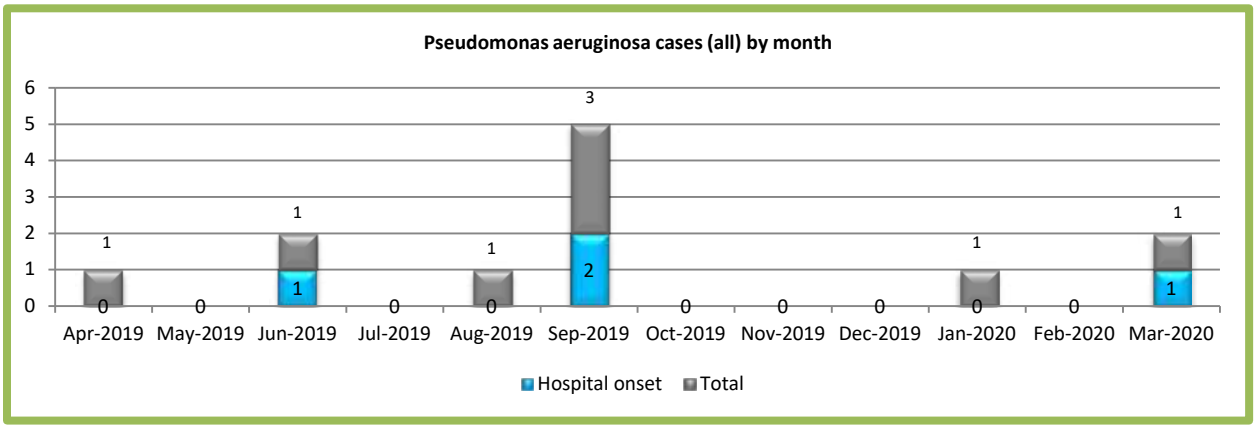
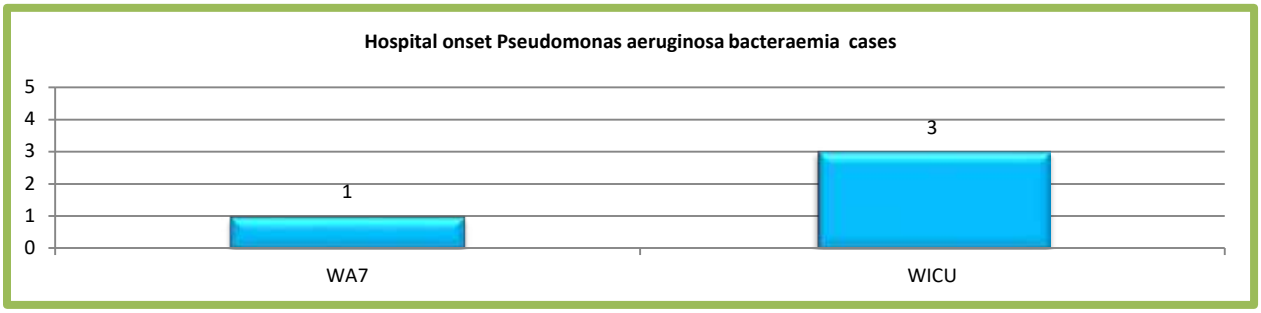


Figure 20 show Hospital onset Pseudomonas aeruginosa bacteraemia cases by ward location when tested.

Figure 20 Pseudomonas aeruginosa bacteraemia cases by ward loaction



The Pseudomonas aeruginosa bacteraemia cases were associated with lower respiratory tract infections. Tracheostomy tubes with subglottic suctioning ports have been implemented in ICU to reduce the risk of ventilator associated pneumonia.

The Trust registered to participate in an Advancing Quality Alliance (AQuA) programme for action on antimicrobial resistance and reduction of GNBSI. Expert Faculty Meetings were established and change ideas generated both in the Trust and in partnership with members of the Health Economy. There was a reduced focus on this activity due to Covid-19. Meetings will recommence in September 2020 and activity will be strengthened on:-

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

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

Incidents/outbreak reports

Pseudomonas

Surveillance identified an increase in Pseudomonas isolates on the Critical Care Unit (4 cases over 3 months). The programme of water testing was brought forward and results showed presence of Pseudomonas in water from 2 of the hand wash basins and high counts (Pseudomonas not confirmed) in 1 other hand wash basin. Typing of the isolates (from patients and water outlets) was undertaken and results were all unique indicating no cross infection patient to patient or from water to patient.

Scabies

In October a patient was admitted to ward B18 with a prior diagnosis of scabies. Pre-admission treatment wasn't completed and a small number of staff complained of rash illness. Two members of staff were treated for scabies. Surveillance was carried out and a further suspected patient case was identified. After discussion with Public Health England (PHE) a mass treatment exercise was carried out. Surveillance of the ward was carried out for the following 3 months and no further cases identified.

Pertussis

The Women's Health CBU reported three cases of Pertussis in members of staff. The first two cases were out of the infectious period at the time of reporting and shared an office. Nil significant contact with patients was identified. The third case had not worked whilst infectious. PHE was notified. A programme of Pertussis vaccination is being implemented for staff working with patients in high risk groups.

Chickenpox

In January 2020 a healthcare worker was identified with serology confirmed chickenpox. The member of staff works in an area of the Trust with high patient throughput. Significant Contact (less than 15 minutes in the same room or face to face conversation) resulted in a high number of staff and patients to contact trace. Public Health England was notified who agreed with the actions being taken. The contact tracing exercise identified a small number of high risk patients and staff who were confirmed to have immunity and no harm was caused.

Influenza

The Trust saw high numbers of patients admitted with influenza over the winter months (>380 cases). A background rise of influenza both in the Northwest and nationally was noted. In-house testing supported management of suspected cases. The Workplace Health and Wellbeing Team, using a peer vaccinator approach, vaccinated just over 85% of frontline staff and the trust was in the top 5 Trust nationally with highest vaccine uptake.

During this time the Infection Prevention and Control Nurses worked over and above expected levels of performance to support the Trust in maximizing bed capacity whilst simultaneously maintaining safe infection prevention and control practice.

Viral gastroenteritis (Norovirus)

Hospital outbreaks of viral gastroenteritis can have a significant impact on patient care as both patients and staff can be affected. This can lead to ward and sometimes hospital closures. Early recognition of an outbreak and instituting control measures can greatly reduce the adverse operational impact on the Trust.

The Trust carries out in-house testing for viral gastroenteritis pathogens. This assists operational management as suspected outbreaks have been ruled out on the basis of negative test results and areas reopened for patient use. Previously suspected outbreaks would have been managed on clinical symptoms with results only being made available after the outbreak had been declared over (when all symptoms had been settled for 48 hours).

Closure of beds, bays and wards places significant pressure on operational teams. There has not been any hesitation in accepting the Infection Prevention and Control Team's recommendations on bed closures, which has substantially enhanced the overall management of outbreaks. Table 3 provides details of the number of outbreaks by month.

Table 3 Viral gastroenteritis incidents

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Outbreaks	6	4	0	0	0	0	0	0	4	0	0	0

The Infection Prevention and Control Team take a pragmatic and escalatory approach to diarrhea and vomiting outbreak management as detailed in national guidance documents. This involves closing affected bays and escalating to full ward closures only when appropriate. During the year norovirus was detected on 10 occasions.

Decontamination Incidents

One incident was reported by the orthopaedic theatre team where a single use item had been left in a speed stich device. This was identified during a procedure. Duty of Candour was completed with the patient and no harm occurred.

One incident was reported by the Neonatal Unit where an examination instrument was accidentally reused on another patient. Learning from the incident investigation has been shared with all team members and a Local Safety Standard for Invasive Procedures developed.

Carbapenemase Producing Enterobacteriaceae screening

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

The Infection Prevention and Control Team implemented national guidance to isolate and conduct CPE screening for all patients admitted by inter hospital transfer. During the reporting period just over 1660 patients were screened for CPE carriage with 1 positive case identified. A further 3 cases were identified for urine samples. The Infection Prevention and Control Nurses visit wards daily, where patients with

multi-drug resistant organisms are cared for, to support staff with high standards of practice to prevent transmission and no additional cases were identified.

Vancomycin Resistant Enterococci (VRE)

Screening for VRE is performed for patients admitted by inter hospital transfer. Additional screening is undertaken when patients are identified with VRE in clinical isolates. Surveillance data identified:-

- VRE detected on 221 rectal screening specimens
- VRE detected in 106 clinical specimens (some patients may have more than 1 clinical site specimen)
  - 2 bile fluid
  - 3 blood culture specimen
  - 83 urine specimens
  - 4 fluid/enrichment culture
  - 13 wound/pus/tissue swabs
  - 1 sputum sample

The number of VRE isolates has remained comparable to the last financial year. All patients were reviewed by the Infection Prevention and Control Team and advice on Infection Control precautions provided.

Orthopaedic surgical site infection surveillance

The Trust conducts continuous surveillance on both total hip and knee surgery. Due to Covid-19, data was not collected in Quarter 4.

There are 3 classifications for Surgical Site Infection: Superficial infections, those involving the skin or subcutaneous tissue of the incision; deep infection involving the facial and muscle layer of the incision; and organ or space infections, involving any other areas other than the incision opened or manipulated during the procedure. Stitch abscess are not classified as surgical site infections.

The surveillance data demonstrates there were 8 reported cases of surgical site infection (2 associated with hip surgery and 6 associated with knee surgery). Due to the nature of implant surgery infections can manifest themselves beyond this surveillance period.

Table 4 Hip Surgery surveillance April – December 2019

Type of Surgery	Number of surveillance forms completed (previous year data)	No. of SSI's detected during initial surveillance (previous year data)	Type of SSI & micro-organisms identified
Cemented	96 (132)	2 (3)	Deep incisional; Proteus Mirabilis VRE, E coli Perioperative samples: Staphylococcus hominis
Uncemented	10 (12)		
Hybrid	86 (81)		
Revision	7 (9)		
Total	**190 (318)**		

Table 5 Knee surgery surveillance

Type of Surgery	Number of surveillance forms completed (previous year data)	No. of SSI's detected during initial surveillance (previous year data)	Type of SSI & micro-organisms identified
Cemented	201 (293)	6 (2)	Superficial: Staphylococcus aureus Organ space: Staphylococcus aureus Perioperative samples: Staphylococcus aureus and Staphylococcus epidermis Superficial: Staphylococcus aureus Organ space: Streptococci Pneumoniae Superficial: Staphylococcus aureus and E coli
Uni compartmental	22 (96)		
Revision	9 (16)		
Bilateral	1 (8)		
Total	**232**		

The surveillance information collected during 2019/20 indicates Orthopaedic joint replacement infections have remained minimal with a slight increase from 5 cases in 2018/19 to 8 cases in 2019/20.

Hand Hygiene and Aseptic Protocols

Audits of compliance with the Hand Hygiene Policy are undertaken weekly at ward and department level. The average compliance rate for the year was 98%. Overall results by month are shown in table 6.

Table 6 Trust wide hand hygiene audit results by month

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Compliance	98%	98%	97%	98%	98%	98%	97%	98%	98%	98%	97%	98%

Decontamination

The Decontamination Group was established to provide assurance that the Trust has the appropriate policies and training in place to be compliant with the Health and Social Care Act (2008) and Care Quality Commission standards.

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

Cleaning Services

Management Arrangements

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

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

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

Budget Allocation

The budget allocation for domestic services was £3.765m with 153.52 whole time equivalent (WTE) staff.

Cleaning Arrangements

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

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

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

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

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

Monitoring Arrangements

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

The monitoring of ward kitchens is undertaken by the Catering Department, who monitor cleanliness and food hygiene standards. A schedule is in place to routinely monitor ward kitchens. Any serious

breaches of food hygiene are dealt with immediately. An annual inspection of ward kitchens is also carried out by the Local Authority Environmental Health Team.

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

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

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

Copies of the monitoring reports are circulated to the Lead Nurses, Matrons, Ward Managers, Domestic and Portering Managers and Estates, to address any remedial action required. If there are any specific areas of concern, this is reviewed and focus is given to address the issue. When necessary, the frequency of monitoring is increased to address any problem areas.

In order to closely monitor the cleanliness standards in the Main Outpatients and X-Ray Departments, the risk and frequency of cleanliness monitoring has been revised from significant risk (three monthly) to high risk (monthly).

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

Infection Control Operational Group

This group was set up in 2018 led by the Associate Chief Nurse for Infection Prevention and Control. The group is part of an assurance framework aimed at strengthening infection prevention and control throughout the organisation. The group promotes clean and safe environments that minimise the risk of healthcare associated infections to patients, staff and/or visitors to hospital premises. The group includes; an Estates Manager, Facilities Manager, Domestic Manager, Matrons, Ward Housekeepers and therapy staff.

Terminal Cleaning

Terminal cleaning is carried out by the Task team on request by a Ward when there is an infection or when a patient has been discharged outside normal working domestic hours.

Table 7 Terminal cleans

Terminal cleans	A	M	J	J	A	S	O	N	D	J	F	M	Total
Terminal Cleans 2015/16	278	281	235	254	224	212	236	199	235	208	233	306	**2901**
Terminal cleans 2016/17	222	272	259	307	286	267	289	340	351	292	318	287	**3490**
Terminal cleans 2017/18	217	281	386	346	352	352	349	257	311	419	368	499	**4137**
Terminal cleans 2018/19	322	394	363	408	335	305	344	317	351	388	484	335	**4346**
Terminal cleans 2019/20	433	463	359	426	485	290	221	402	612	393	341	790	**5215**

Table 8 Curtain changes

Curtain changes	A	M	J	J	A	S	O	N	D	J	F	M	**Total**
Curtain changes 2015/16	179	188	151	167	124	123	175	114	178	134	157	184	**1874**
Curtain changes 2016/17	144	190	168	202	195	167	177	203	239	195	200	171	**2251**
Curtain changes 2017/18	149	171	262	303	252	252	237	208	235	317	267	308	**2961**
Curtain Changes 2018/19	308	270	251	251	237	101	208	217	226	293	301	225	**2888**
Curtain Changes 2019/20	332	302	239	323	256	183	363	276	420	230	191	547	**3662**

In 2019/20 staff responded to 5215 terminal clean requests and 3662 curtain changes. There was an increase in terminal cleans and curtain changes during March 2020 owing to the Covid-19 pandemic. A review of curtains has been completed and all areas converted to disposable curtains.

Cleanliness Scores

The 2019/20 cleanliness monitoring scores for clinical areas were as follows:

- Warrington: 96%
- Halton: 96%

Table 9 Cleaning scores - Warrington

WARRINGTON 2019/20	A	M	J	J	A	S	O	N	D	J	F	M
Cleanliness Scores	97%	96%	97%	93%	96%	96%	98%	96%	97%	97%	96%	97%

Table 10 Cleaning scores - Halton

HALTON 2019/20	A	M	J	J	A	S	O	N	D	J	F	M
Cleanliness Scores	98%	98%	96%	99%	97%	98%	95%	93%	96%	94%	96%	95%

PLACE (Patient Led Assessments of the Care Environment)

In 2019 there was a large scale national review of the PLACE Assessments with changes in the set questions therefore the results are not comparable with previous assessments.

In autumn 2019 the PLACE assessments were undertaken at this Trust by a team of external patient assessors, Trust Governors and also representatives from Warrington and Halton Health Watch Organisations. There was also representation from the Trust's Infection Prevention and Control Team, Matrons, Estates and Facilities Management Team and an External Validator.

PLACE Results

The results from the WHH assessments are detailed in figure 21 and table 11, along with the North West and National averages.

Figure 21 PLACE scores

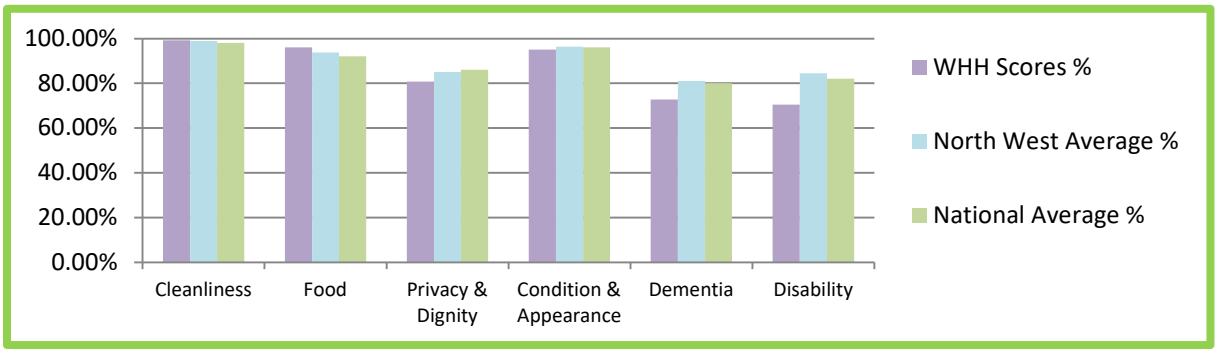


Table 11 PLACE Assessment Results

Assessment	WHH Scores %	North West Average %	National Average %
Cleanliness	99.22%	98.99%	98.06%
Food	96.01%	93.74%	92.02%
Privacy & Dignity	80.71%	85.05%	86.01%
Condition & Appearance	95.06%	96.36%	96.04%
Dementia	72.76%	81.05%	80.07%
Disability	70.43%	84.47%	82.05%

The Trust scored above national average at both sites for cleanliness and food. Following publication of the PLACE results, specific focus was given to the domains that have scored below the national average, with the aim to improve these scores by putting the following measures into place:

Privacy & Dignity

- Provision of Personal Lockers for Patients
- Hearing Loops available on all Reception Areas
- Improve confidentiality and data protection on Wards

Condition and Appearance

- 10 year capital plan
- Annual capital funding allocation – risk based allocation
- Mandated by statute/legislation
- Business Critical
- Recommended by statute/legislation
- Clinical Safety (Patients)
- Non Clinical Safety (Patients, Staff and Visitors)

- Business Growth/Expansion
- Business invest to save/cost improvement programme
- Maintains and/or Improves quality
- Maintains and/or Improves experience

Disability

- Improve access to handrails
- Ensure sufficient space in all areas for wheelchairs
- Ensure all seating meets a range of patient needs

Next Steps:

- Produce a PLACE Action Plan
- Share the results with CBUs for appropriate action
- Share the results with Patient Experience and Dementia Leads
- Identify funding and include on Capital Plan
- Monthly review and update of PLACE Action Plan and report through Trust Operational Board and Patient Experience Sub-Committee
- Benchmark scores against future PLACE Assessments

Corporate Reporting

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

Training

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

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

Clinical Access/Responsibility

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

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

There are cleanliness standards notices displayed in wards, departments, public corridors and sanitary areas highlighting the frequency of cleaning in that area and also giving details of who to contact with any issues relating to cleanliness. There is a plan to display cleanliness standards using a star rating in all wards and departments.

NHSE/I published a revised Draft of the National Standards of Healthcare Cleanliness. The document has been jointly reviewed by the Facilities and Infection Prevention and Control Teams and actions identified to revise current ways of working. Agreement has been reached to implement the Commitment to Cleanliness Charter.

National inpatient survey 2019

The Trust National Inpatient Survey 2019 included a question on cleanliness. Responses were received from 480 patients and the Trust scored 9.0/10. This is reported as about the same as other Trusts.

Infection Control Audit

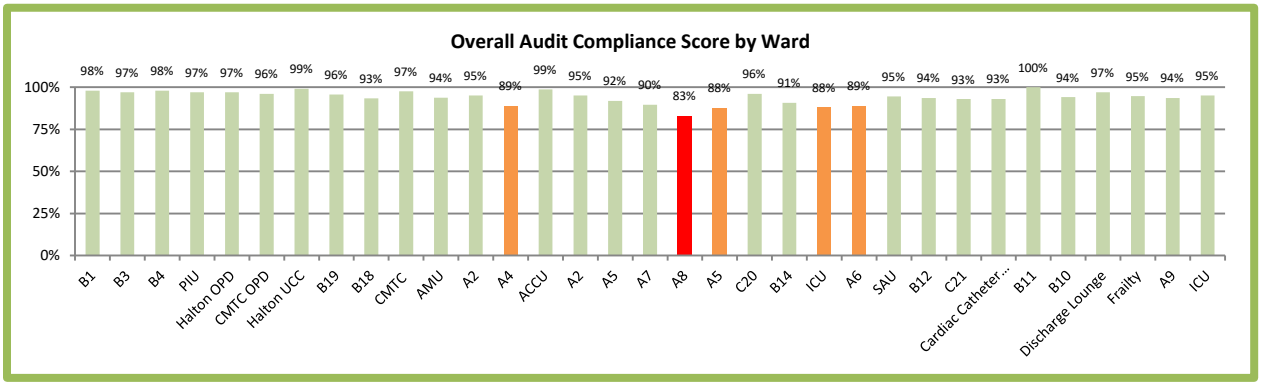
The aim of the audit programme is to measure compliance with Trust polices/guidelines and standards in the patient care environment. This audit programme contributes to providing assurance that infection control policies are followed and risks are effectively managed within the Trust.

The audits are carried out by the Infection Prevention and Control Nurses using an approved Infection Prevention and Control audit tool. The audit tool has a total of 14 components however these are not all relevant in all areas of the Trust. A rolling programme of audit is in place to cover all in-patient areas. The audit plan was halted to redirect activity during the Covid-19 pandemic. Additional audits are completed outside of the rolling programme when infection incidents occur.

Results

A total of 33 areas were audited. The majority of areas attained above 90% compliance. The exception to this was A4, A5, A6, A8 and ICU. Results are shown in figure 21.

Figure 22 Infection Control audit results by ward/department



The total percentage compliance for each of the audit components is detailed in table 7.

Table 12 Audit Summary for each component

Ward	All
Environment	82%
Ward Kitchens	85%
Handling/Disposal of Linen	92%
Departmental Waste	97%
Safe Handling Disposal of Sharps	95%
Patient Equipment (General)	92%
Patient Equipment (Specialist)	100%
Personal Protective Equipment	96%
Short Term Catheter Management	96%
Enteral Feeding	95%
Care of Peripheral Intravenous Lines	96%
Non-Tunnelled Central Venous Catheters	100%
Isolation Precautions	98%
Hand Hygiene	95%
Overall Compliance	**94%**

Reports on findings are fed back to the nurse in charge of the clinical area at the time of the audit. This is followed up by a written report within one week of the audit. The manager of the clinical area is responsible for producing an action plan to address areas of non-compliance. The action plan is added to the Matron's report to the Infection Control Sub-Committee where it will remain for monitoring until all actions are completed. The compliance results from all audits are compiled to provide an overall compliance score for the Trust of 94%.

The lowest scoring components were general environment and ward kitchens. A vast amount of work has been undertaken to improve the patient environments and there is an upgrade and deep cleaning programme in place to improve standards of ward kitchens.

Other areas of concern identified from the audits include:-

- Sharps disposal: 5 areas with less than 90% compliance
- Care of patient equipment: equipment: 9 areas with less than 90% compliance
- Handling and disposal of linen: 15 areas with less than 90% compliance

Partnership working with the Health and Safety Team and Workplace Health and Wellbeing is in place to address concerns about sharps safety. This work was instigated in response to the reported numbers of exposure incidents identified at Infection Control Sub-Committee meetings.

The Infection Prevention and Control Nurses attend Housekeeper meetings and work closely with the Medical Devices Co-ordinator to drive improvements in care of equipment.

A single point lesson on safe handling of linen has been shared to support practice improvement.

Areas that were audited have received their audit results to: confirm good practice and identify where improvement is needed to minimise infection risks and enhance the quality of the patient care

environment. The success of the audit programme relies on having robust action plans that are followed through to completion to ensure improvement actions have been taken.

Combined Walkabouts with Matrons and Infection Prevention and Control Nurses are in place to provide a programme of continuous monitoring.

The programme of audit will be reinstated in September 2020 so that assurance on compliance with Trust polices/guidelines and the care environment can be provided. The approaches to targeting audits in areas with hospital apportioned infection will continue.

Sharps audit

An external audit of compliance with good practice in relation to sharps management is conducted annually. The sharps bin supplier was invited (May 2019) into the Trust to conduct a Trust wide sharps safety audit. The object of the audit was to establish whether or not sharps are disposed of in a safe manner. The method used was to visit wards and departments and observe existing practices.

Results

Ninety (90) clinical areas were visited during the audit and three hundred and sixty (360) sharps containers were reviewed. The sharps containers were mainly supplied by the company conducting the audit. The audit results showed:-

- 4 sharps containers with protruding sharps
- 10 that were not properly assembled
- 1 that was more than three quarters full
- 0 sharps container had the wrong lid on the wrong base
- 0 sharps containers were sited on the floor or at an unsuitable height
- 7 sharps containers were unlabelled whilst in use
- 15 sharps containers had significant inappropriate non sharp contents
- 2 sharps containers did not have the temporary closure in place

The audit recommendations included:-

- Train staff in the assembly of sharps containers
- Train staff not to overfill sharps containers
- Train staff to fill in labels at assembly
- Train staff not to put non sharps in sharps containers
- Train staff to put the temporary closure in place when unattended or when moved
- Use a one-brand system
- Re-audit within one year

Compared to the previous year's audit there was a slight increase in sharps bins with protruding items. There was a decrease in incorrectly assembled bins, a significant decrease in temporary closure devices being left open. Each area has received a copy of the audit and been asked to improve compliance where standards were not met.

The Health and Safety Team have provided Sharps Management Packs to all Wards and Departments with individual action plans. The management of sharps is being monitored via the Patient Safety and Clinical Effectiveness Sub Committee as well as the Health and Safety Sub Committee.

High Impact Interventions

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

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

Antibiotic Prescribing

From April 2019 to March 2020, there were 71 joint Consultant Microbiologist and Antibiotic Pharmacist ward rounds carried out at Warrington hospital. This year saw a 20% increase in the number of ward rounds carried out compared to the previous year when there were 59 ward rounds carried out.

The appointment of an additional Consultant Medical Microbiologist (0.6WTE) in February 2019 has ensured Antimicrobial Stewardship (AMS) work has been strengthened. In addition to the increase in ward round activity within the Trust, this appointment has allowed for the development and implementation of a weekly Outpatient Parenteral Antimicrobial Therapy (OPAT) multidisciplinary team meeting.

Joint Consultant Medical Microbiologist and Antibiotic Pharmacist Ward Rounds

Two joint Consultant Microbiologist and Pharmacist ward rounds are carried out each week at Warrington hospital. These ward rounds target patients who are prescribed specific "target antibiotics", wards with higher rates of antibiotic prescribing or wards where there are concerns about compliance with the Trust antibiotic formulary or higher incidence of healthcare associated infections (HCAIs).

"Target antibiotics" are antibiotics that require closer monitoring than other antibiotics because they are either:

- broad-spectrum antibiotics that should be reserved for more difficult infections that are not responding to first line antibiotics or,
- antibiotics that are more commonly associated with the development of Clostridium difficile infection

The "target antibiotics" within the Trust are:

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

- quinolones

The ward rounds are seen as a way of gaining assurance that the "target antibiotics" are being prescribed appropriately and that patients are receiving the most appropriate microbiological investigations/sampling. Microbiological sampling is a vital part of antimicrobial stewardship and the ward round is used to promote and reinforce this as it allows for timely review of the antibiotics and de-escalation to a narrower spectrum agent when culture and sensitivity results become available or it is clinically appropriate to do so.

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

- Patient is deteriorating despite antibiotics and clinical team have requested a review
- Patient is prescribed antibiotics that are non-compliant with the antibiotic formulary and clinical team are reluctant to change antibiotics despite advice provided
- Culture and sensitivity results available to allow rationalisation of antibiotics but not yet actioned by the clinical team
- Patient appears clinically well and suitable for oral step down or cessation of antibiotic therapy but the team with clinical responsibility for the patient are not undertaking this or are requesting Consult Medical Microbiologist advice

Summary of Antibiotics Reviewed

A total of 739 patients and 919 antimicrobials were reviewed on the ward rounds between April 2019 and March 2020.

Table 13 Total Number of Antibiotics Reviewed

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

Summary of Ward Round Interventions

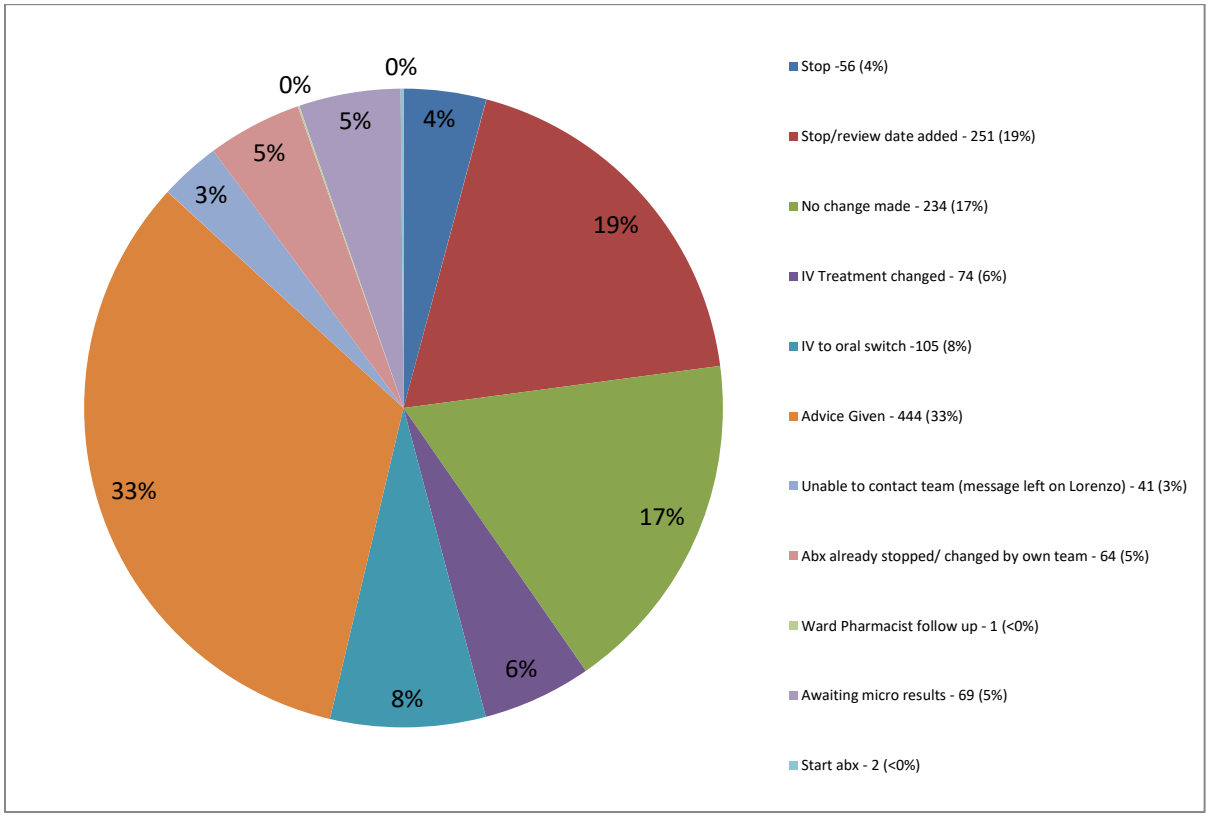
Of the 919 antibiotics reviewed, it was possible to stop 4% of antibiotics on the ward round and a stop/review date was added to a further 19% of prescriptions. 14% of antibiotics were changed to a more appropriate antibiotic – this could be a change in IV antibiotic regimen or an IV to oral step down. Changes were only made if the team looking after the patient could be contacted and the proposed changes were discussed and agreed.

Advice was provided in a further 33% of cases. Examples of the advice given include:

- Escalation in antibiotic plan in case of clinical deterioration. This plan will include the need for further investigations or microbiological sampling as required
- Advice on duration of therapy and oral stepdown options when clinically appropriate
- The need for additional investigations or microbiological sampling
- Patient to be considered for referral to the OPAT team for completion of antibiotics in the community

Figure 22 summarises the outcome of the antibiotic reviews in more detail.

Figure 23 Summary Outcome of Antibiotic Reviews



Benefits of the ward round

Patient Safety

During or prior to each ward round a review is undertaken of each patient's recent microbiology samples to see if any micro-organisms have been isolated which will allow the spectrum of activity of antimicrobial cover to be narrowed down. Other factors are also considered that influence prescribing decisions such as; history of multi-drug resistant organisms or Clostridium difficile infection. The interventions made on the ward rounds ensure that patients are exposed to fewer days of antibiotic treatment or changed to more appropriate antibiotic treatment in a timelier manner. This improves patient safety because if patients are exposed to fewer days of unnecessary broad spectrum

antimicrobial therapy then the risk of the patient going on to develop a HCAI such as Clostridium difficile infection is reduced. The ward rounds also have other patient safety benefits; they allow a review of patients with complex histories who specifically need input from a Consultant Medical Microbiologist i.e. patients with infective endocarditis and patients who are prescribed antibiotics with a narrow therapeutic window, providing specific advice on dosage adjustment and duration of treatment.

Junior Doctors

The Consultant Medical Microbiologists and Pharmacist use the ward rounds as an opportunity to build up relationships with ward teams and provide education to junior doctors. The antibiotic formulary is actively promoted on each ward round and the junior doctors are reminded of the importance of Antimicrobial Stewardship (AMS) and their vital role in slowing down antimicrobial resistance (AMR). Junior doctors are encouraged to participate in the ward rounds and they are informed of the reasons for any suggested changes to antimicrobial therapy which develops their knowledge of microbiology. The need for appropriate investigations and microbiological sampling is also promoted. It is hoped that the education provided during the ward rounds will influence their prescribing practice as they progress in their career and develop their confidence around diagnosis and management of different infections.

Financial benefits

Cost savings are made through the ward rounds by stopping unnecessary antibiotics, changing antibiotics to more appropriate treatment and adding stop dates to courses of antibiotics. Nursing time can also be saved by the appropriate stopping of antibiotics, particularly intravenous antibiotics. Referring patients to the OPAT team to complete their antibiotics in the community also has financial savings by reducing bed days.

Compliance with NICE Guidance

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

Other benefits

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

Future developments

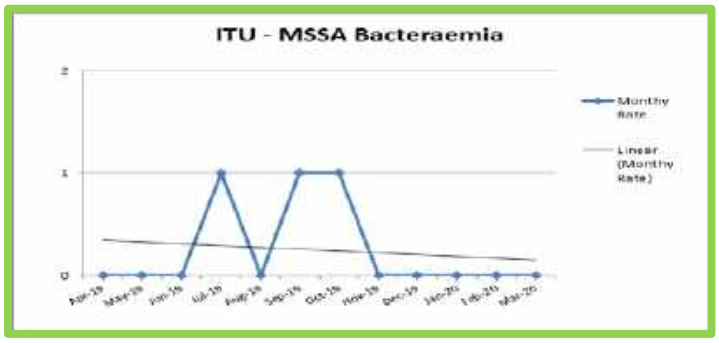
Ideally the antimicrobial ward rounds could be expanded so that more patients on antibiotics are reviewed. The Trust switched over to electronic prescription and medication administration (EPMA) in November 2019, it is hoped that this electronic system may be able to generate reports which will flag up patients who require a review and reduce the preparation time required for a ward round to ultimately allow more time for reviewing patients. Unfortunately, the ongoing global COVID-19 pandemic meant that work on developing these reports was put on hold. This is something that will be looked at going forward.

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

Critical Care Surveillance

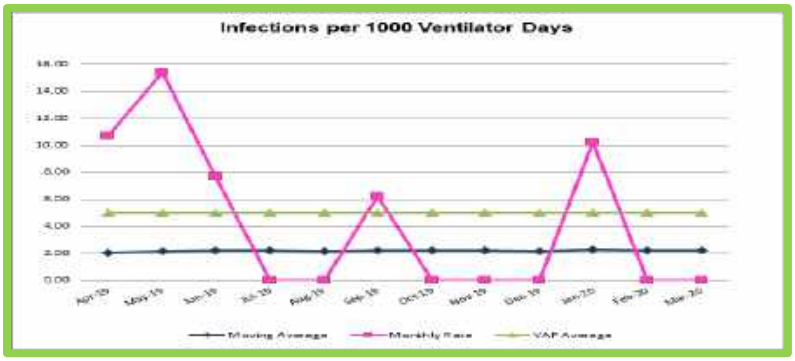
The Critical Care Unit conducts enhanced surveillance of bloodstream infections and ventilator associated pneumonias. During 2019/20 Meticillin sensitive Staphylococcus (MSSA) bacteraemia cases were monitored and three cases were observed. Data is shown in figure 24.

Figure 24 MSSA bacteraemia cases



The Critical Care Unit also collates data on ventilator associated pneumonias (VAP). This facilitates identification of trends of bacterial pneumonia in ICU patients who are mechanically ventilated. Data for the 2019/20 year is displayed in figure 25. The unit has implemented use of tracheal tubes with subglottic suction ports in a bid to further reduce the incidence of VAP.

Figure 25 VAP data



Targets and Outcomes

Activities

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

- Hand hygiene awareness raising events
- Unannounced spot checks

- Matron/Facilities Walkabouts
- World Antibiotic Awareness Week
- Response to complaints
- Response to FOI requests

Updated policies and guidelines

The following documents were revised during the financial year and approved by the Infection Control Sub-Committee:-

- Multi-Drug Resistant Organism Guidelines
- Insertion of Male Catheter Policy
- Decontamination Policy
- Mattress Inspection and Cleaning SOP
- Meningitis and Invasive Meningococcal Disease Guidelines
- Positive/Negative Pressure Isolation in Critical Care SOP
- Animals in Healthcare Guidelines
- Laundry Policy
- Specimen Collection Guidelines
- Critical Care Admission Screening SOP

Other documents

- Urinary Catheter Passport – adapted from the National Catheter Passport
- Clostridium difficile – toolkit for case investigation
- MSSA bacteraemia - post infection review toolkit
- MRSA bacteraemia - post infection review toolkit
- Gram Negative Bacteraemia post infection review toolkit
- Assurance framework – Infection Prevention and Control Team reporting structure
- Infection Control Sub-Committee Work Plan 2019/20

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

Contribution to other initiatives

Capital Projects

The Infection Prevention and Control Team participated in Estates Safety and Risk Meetings. All areas that have undergone upgrade work have been reviewed and signed off by the Infection Prevention and Control Team prior to re-occupation by patients.

Estates projects

- Upgrade to ward A9

Group documents

- Terms of Reference Decontamination Group

- Terms of Reference Infection Control Sub-Committee
- Terms of Reference GNBSI Reduction/ Expert Faculty Group

External groups

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

- North West Boroughs Partnership Mental Health Trust Infection Control Committee
- 3 Boroughs Public Health Infection Control Committee
- Public Health Forum (Public Health England)
- Health Protection Forum – Warrington Borough Council
- Multi-agency C difficile Review meeting
- Cheshire and Mersey Programme Board for GNBSI/Sepsis/HCAI

Training Activities

The Infection Prevention and Control Team continue to provide a structured annual programme of education. This includes an Infection Control E-Learning package for clinical staff. Overall attendance at mandatory infection prevention and control training was just below 85% across the Trust at the end of the financial year. Attendance was affected by face to face training being halted. Additional sessions are being provided including virtual to recover training levels.

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

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

Additional training sessions were provided to support areas where compliance with mandatory training attendance was low.

Other training was provided to:

- Student Nurses – including Collaborative Learning in Practice
- Newly Registered Nurses - Preceptorship
- Trainee Nursing Associates
- Trainee Assistant Practitioners
- F1/F2 Doctors
  - Induction and updates
  - Blood culture specimens (indications; aseptic technique and performance management)
  - Prudent use of antibiotics

Grand Round Presentations

- Covid-19 - 7 February 2020
- Covid-19 – 13 March 2020

Medical Students

- Infection Prevention and Control
- Various infection/microbiology topics

Consultant

- Mandatory Infection Prevention and Control Training

Ad hoc clinical based teaching

Single point lessons in response to incidents on:-

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

Training attended/ provided by Infection Prevention and Control Team Members

Dr Zaman Qazzafi - Consultant Microbiologist

15 May 2019	Gram negative Bloodstream infection conference in Leeds
19 June 2019	Don't Panic Conference (Infection Control and Microbiology) in Manchester
30 October 19	Medical Cabinet Leadership Development programme
5 November 2019	BSAC Educational Programme: Partnership of AMS and IPC – Stewarding New Antimicrobials and IPC
18 November 2019	Advancing Quality – Action on AMR (NHSI led event)

Dr Toong Chin

06 December 2019	DIPC Study Day in London

Dr Janet Purcell

02 July 2019	Epidemiology Study Day in Manchester
26 September 2019	Surgical Site Infection Training Day in London

Lesley McKay – Associate Chief Nurse for Infection Prevention and Control

15 May 2019	Gram negative Bloodstream infection conference in Leeds
19 June 2019	Don't Panic Conference (Infection Control and Microbiology) in Manchester
20 June 2019	DIPC Development Day in Manchester
25 September 2019	FFP3 Fit Testing Training
21 November 2019	Audit and Surveillance Study Day in Manchester
06 December 2019	DIPC Study Day in London
23 January 2020	QI Practitioner Programme

13 February 2020 IPC and AMR Study Day in Birmingham

Charlene Liptrot – Infection Prevention and Control Nurse

02 July 2019 Epidemiology Study Day in Manchester
23 September 2019 Infection Control Conference in Liverpool
30 September 2019 FFP3 Fit Testing Training
21 November 2019 Audit and Surveillance Study Day in Manchester

Katherine Summers – Infection Prevention and Control Nurse

23 September 2019 Infection Control Conference in Liverpool
25 September 2019 FFP3 Fit Testing Training

Joanne Oldfield

23 September 2019 FFP3 Fit Testing Training
26 September 2019 Surgical Site Infection Training Day in London

Jacqui Ward – Antibiotics Pharmacist

Quarterly North West Antimicrobial Pharmacist Group educational session
13 February 2020 IPC and AMR Study Day in Birmingham

Conclusion

The Infection Prevention and Control Team have worked at an exemplar level throughout the year to deliver the annual work plan. This includes provision of clinical advice, education and training, audit, policy development/review, surveillance, and input into complaints, FOI requests and Estates and Facilities issues.

The Covid-19 pandemic created additional challenges this year on top of an already demanding role. The experience, skills and vast knowledge of Infection Control Team members resulted in a high output of education, guidance and positive outcomes for the Trust. It is to their great credit that all team members stepped up to meet the additional requirements for education, production of policy documents, service reviews and meeting attendance alongside a proactive agenda to address Clostridium difficile and bloodstream infections from MRSA/MSSA and GNBSI.

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

High level briefing papers submitted to the Patient Safety and Clinical Effectiveness Committee and Quality Assurance Committee and Board reports, these documents give the Trust Board assurance about infection control activities and outcomes.

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. IMPACT ON QPS?

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

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

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

5. MEASUREMENTS/EVALUATIONS

Monitor:-

Progress against the Infection Control Sub-Committee work plan

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

- Progress against action plans
    - *Staphylococcus aureus* bacteraemia reduction (MRSA/MSSA)
    - Clostridium difficile infection reduction
    - Gram negative bloodstream infection reduction

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

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

Compliance assessment against the Health and Social Care Act (2008), Code of practice on preventing infections and related guidance (2015). This will include the IPC Board Assurance Framework, published in May 2020 and updates thereafter, assessments.

6. TRAJECTORIES/OBJECTIVES AGREED

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

7. MONITORING/REPORTING ROUTES

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

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

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

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

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

8. TIMELINES

Financial year 2019/20

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

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

Kimberley Salmon-Jamieson
Chief Nurse & Deputy CEO
Director of Infection Prevention and Control (DIPC)
August 2020

Appendix 1 ANNUAL WORK PROGRAMME 2020/21

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

GOVERNANCE													
	Target date	**Leads**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Monitor action plan following external review	3 / annum	ADIPC	D			✓	Completed							
Review of ICSC Terms of Reference	Annual	Deputy DIPC				✓								✓
Review of IPCT infrastructure	Annual	ADIPC				✓								✓
DIPC annual report	Annual	ADIPC				✓								
Quarterly reports to Quality and Assurance Committee	Quarterly	ADIPC	D			✓ ✓			✓			✓		
Quarterly DIPC reports to Trust Board	Quarterly	ADIPC				✓			✓			✓		
Risk register review	Monthly	ADIPC			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HLBP submission to PSCE; QA; and H and S committees	Bimonthly	ADIPC			✓		✓		✓		✓		✓	
RCAs/PIR of HCAI incidents: Monitoring of associated action plans linked to CBU Governance Frameworks and demonstration of learning	Per case	LNs	D	D	D	D	D	✓	✓	✓	✓	✓	✓	✓
Review of action plans for HCAI reduction C. difficile and Staphylococcus aureus bacteraemia cases	3 / annum	LNs					✓			✓			✓	
Submission of C. difficile RCA findings to the CCG panel for review to assess for lapses in care	Quarterly	LNs / ADIPC	D	D	D	D	D	✓	✓	✓	✓	✓	✓	✓
Review of revised C. difficile Objective for 2020/21	Annual	ADIPC	To be confirmed											
IPCT team building session	Sep 2020	ADIPC							✓					
Review of progress against this work plan and the IC strategy	Bimonthly	ADIPC					✓			✓				✓
Provision of commentary for Trust Quality Account	Monthly	ADIPC			✓			✓				✓		
Code of Practice for prevention of HCAIs – compliance assessment IPC BAF and Action Plan	Bimonthly	ADIPC		✓		✓		✓		✓		✓		✓
Code of Practice for prevention of HCAIs – compliance assessment	Biannual	ADIPC						✓						✓
Review of HCAI reduction action plans GNBSI	3 / annum	ADIPC				✓			✓			✓		
Revise investigation toolkit for GNBSI	July 2020	ADIPC				✓								
Revise toolkit for investigation of MSSA bloodstream infections	July 2020	ADIPC				✓								
Revise toolkit for investigation of Clostridium difficile cases	July 2020	ADIPC				✓								
Revise National Toolkit for Hospital Onset Covid-19 cases (8-14 days and 15+ days)	June 2020	ADIPC			✓									
Other Committee attendance/Group provision														
Antimicrobial Stewardship Group Meetings	Quarterly	AMSG Lead CMM				D			✓			✓		
Bed meetings	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CCG CDT review panel meetings	Quarterly	ADIPC				D	D	✓	✓	✓	✓	✓	✓	✓
CDT MDT	Weekly	IPCNs				✓	✓	✓	✓	✓	✓	✓	✓	✓
Decontamination Group	Quarterly	ICD / ADIPC				D			✓			✓		
Event planning group	Monthly	ADIPC				D	✓	✓	✓	✓	✓	✓	✓	✓

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

	Target date	Lead	A	M	J	J	A	S	O	N	D	J	F	M
HCAI reporting to ICSC dashboards	Bimonthly	ADIPC				✓	✓	✓	✓	✓	✓	✓	✓	✓
Pseudomonas surveillance in Augmented care area (ICU and NNU)	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VRE surveillance	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complete Quarterly Mandatory Laboratory returns and submit to PHE	Quarterly	Deputy DIPC	✓			✓			✓			✓		
Antibiotic ward rounds daily on ICU	Daily	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Antibiotic ward rounds	Weekly	CMMs	To be confirmed											
Environmental Cleanliness monitoring														
Environmental cleanliness monitoring	Monthly	Facilities Manager	D	D	D	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participate in PLACE assessments	TBC	IPCNs/ LNs	To be confirmed											
Matron and IPC Walkabouts/ Covid Roadshows	Monthly	Matrons /IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Estates PAM assessment	Annual	ADE												
Legionella Assessments and compass flushing reports	TBC	ADE												
Monitor progress with carpet removal and dishwasher installation	Bimonthly	Deputy DIPC												
Audit														
Audit Programme (IPC led) against standard precautions with reporting to ICSC	Annual	IPCNs						✓	✓	✓	✓	✓	✓	✓
Hand hygiene audits	Weekly	LNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MRSA pre-operative screening audit	Quarterly	LN DD						✓			✓			
MRSA screening compliance audits	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Support areas requiring improvements identified on the Quality Metrics programme	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Policy /Guideline Leaflet reviews														
CJD Instrument Handling	Aug 2020	IPCNs												
CJD Nursing Management	Aug 2020	IPCNs												
Tuberculosis	Aug 2020	IPCNs												
Scabies	Aug 2020	IPCNs												
MRSA	Sept 2020	IPCNs												
Measles	Sept 2020	IPCNs												
Surveillance and data collection (local)	Sept 2020	IPCNs												
Glycopeptide resistant enterococci MDRO	Oct 2020	IPCNs												
Admission/transfer and discharge of infectious patients and risk assessment	Oct 2020	IPCNs												
Uniform and Workwear	Oct 2020	IPCNs												
Awareness raising events														
Placement of hand hygiene sanitiser dispensers as per Covid Environmental Safety plan	Jun 2020	IPCNS			✓									
GNBSI and ANTT	Oct 2020	IPCNS							✓					
Uniform and workwear promotion	TBC	All												
October IC week – Topic Boards	Oct 2020	IPCNs							✓					

	Target date	Lead	A	M	J	J	A	S	O	N	D	J	F	M
Trust wide Safety Brief – IPC promotion	Oct 2019	ADIPC							✓					
November World Antibiotic Awareness Week	Nov 2019	IPCNs								✓				
Seasonal flu campaign with WHWB	Dec 2019	WHWB							✓	✓	✓	✓		
Education														
Provide Mandatory training for IPC supporting areas with low compliance figures	Monthly	IPCNS						✓	✓	✓	✓	✓	✓	✓
Participate in CLiPs training	Monthly	IPCNS						✓	✓	✓	✓	✓	✓	✓
Participate in Preceptorship training	Monthly	IPCNS						✓	✓	✓	✓	✓	✓	✓
Mandatory training sessions as per timetable	Mar 2020	IPCNs						✓	✓	✓	✓	✓	✓	✓

D = deferred

✓= Planned

✓= Completed

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/124**			
SUBJECT:	**Workforce Race Equality Standard**			
DATE OF MEETING:	25 November 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.			X
	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)***	#1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust WRES data against the indicators was presented to Strategic People Committee in September 2020. The Committee noted some particular areas of concern relating to formal disciplinary processes, bullying and discrimination. The Committee requested that a more detailed review was undertaken to understand the issues. The findings of that review were presented to Strategic People Committee on 18 November 2020. The Committee were assured that appropriate actions are in place to address any specific concerns and approved the WRES action plan. This paper includes the WRES action plan, which is submitted to Trust Board for noting.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note	Decision
RECOMMENDATION:	Trust Board are asked to note the key findings from the WRES data and the action plan in place.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/20/11/90 + 91		
	Date of meeting	18 November 2020		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Workforce Race Equality Standard	AGENDA REF:	BM/20/11/124

1. BACKGROUND/CONTEXT

The Workforce Race Equality Standard (WRES) is an important requirement for the Trust. The purpose of the standard is to ensure that members of the workforce who are from Black, Asian and Minority Ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The Trust is expected to show progress against a number of indicators of workforce equality, including a specific indicator to ensure that the organisation is representative across all levels.

The Trust WRES data against the indicators was presented to Strategic People Committee in September 2020. The Committee noted some particular areas of concern relating to formal disciplinary processes, bullying and discrimination. The Committee requested that a more detailed review was undertaken to understand the issues. The findings of that review were presented to Strategic People Committee on 18 November 2020. The Committee were assured that appropriate actions are in place to address any specific concerns and approved the WRES action plan.

This paper includes the WRES action plan, which is submitted to Trust Board for noting.

2. KEY ELEMENTS

Key findings from the WRES data are:

- BAME members of staff are under represented at senior levels in the organisation.
- White staff are more likely to be appointed from shortlisting, although there has been an improved for BAME staff since 2019.
- BAME members of staff are more likely to enter a formal disciplinary process that white staff and this indicator has declined since 2019. The Deputy Director of HR and OD has reviewed the case documentation for all cases relating to BAME staff and has assessed that in all cases the formal process was instigated appropriately, there was a fair and proportionate outcome and that the approaches taken demonstrate that the process was executed fairly.
- White staff are more likely to access non-mandatory training and CPD, although there has been an improved for BAME staff since 2019.
- A number of WRES indicators are taken directly from the Staff Opinion Survey results. Data relating to bullying, harassment and abuse from either patients, managers or staff, as well as discrimination from managers, indicate that there are opportunities to improve the experience of BAME staff. These were included in the deep dive presented to Strategic People Committee and the outcomes are included in the WRES action plan.
- Board membership is not currently representative of the ethinic make up of the workforce.

The WRES action plan is included at appendix 1.

3. MONITORING/REPORTING ROUTES

Delivery of the WRES action plan is monitored via Equality, Diversity and Inclusion Committee, which reports to Strategic People Committee.

4. RECOMMENDATIONS

Trust Board are asked to note the key findings from the WRES data and the action plan in place.

Workforce Race Equality Standard Action Plan

Metric Number	Standard	2019 Data	2020 Data	Narrative	2020/21 Actions	Timescales
1	Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2019			The 2020 data, drawn from the organisation's Electronic Staff Record illustrates that in comparison with 2019, there are slight improvements for non-clinical BAME staff above B6 and clinical staff in Bands 6-8a, however BAME members of staff are still under-represented at senior levels.	Introduce targeted marketing of employment opportunities to increase diversity.	Q4 January 2021
					Scope options relating to positive action and present to Strategic People Committee to approve for implementation.	Q4 March 2021
2	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.	1.48	0.83	The data demonstrates that white staff are still more likely than BAME to be appointed from shortlisting, although this likelihood has decreased in comparison with the 2019 data which illustrates a slight improvement.	Develop and launch Equality in Employment policy to cover practical guidance in relation to employing individuals with a range of protected characteristics.	Development in Q3 and launch in Q4 March 2021
					Continue development and delivery of EDI managers training to include case studies from own workforce.	Ongoing
					Include equality, diversity and inclusion responsibilities in all line manager Job Description templates.	Q4 March 2021
					Include equality, diversity and inclusion objective in all staff PDRs	Q4 March 2021
					Refresh recruiting managers training to increase inclusivity of	Q1 2021/2022

					selection processes and increase diversity	
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process.	1.05	3.84	The 2020 data highlights that there has been an increase in the relative likelihood of BAME staff entering the formal disciplinary process in comparison with 2019, which equates to an increase of 5 individuals from 2019. It Is important to note that the numbers overall have decreased from 40 in 2019 to 31 in 2020.	Development and launch of Civility, Kindness and Respect campaign across organisation.	Q4
					Review of Improving People Practices and Fair Processes for all report to inform operational actions	Q3 December 2020
					Senior HR review of cases in the data set. Outcomes and actions to be reported to SPC	Complete
					Senior HR review of cases relating to BAME staff	Q4
4	Relative likelihood of staff accessing non-mandatory training and CPD.	0.99	0.80	The data illustrates that there has been a slight improvement in comparison with 2019 for staff accessing non-mandatory training and CPD.	Develop inclusive talent management programme / framework.	Q4 by 31st March 2021
					Promotion and implementation of BAME specific learning and development opportunities internally and externally.	In place and on-going.
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White: 21.2% BAME: 29.9%	White: 21.6% BAME: 25%	The data demonstrates that there has been an improvement in comparison with 2019. However, it is recognised that there is still a higher percentage of BAME staff experiencing harassment, bullying or abuse from the public in the last 12 months compared with white staff.	Work with the BAME Staff Network, Freedom to Speak Up Team and HR Team to enhance reporting of incidents	Ongoing
					Deep dive of existing data from staff survey, incidents, Freedom To Speak Up and grievances to understand patterns	Complete

					Targeted work via HR Team and OD Team in specific areas highlighted via the analysis	Q4
					Analysis of Staff Survey results from 2020 (available in January 2021) to ascertain any hotspot areas or staff groups.	Q4 January 2021
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White: 18.3% BAME: 22.4%	White: 19% BAME: 26%	The data demonstrates that there has been deterioration in comparison with 2019 in that more BAME staff are reporting experiencing harassment, bullying or abuse from staff in the last 12 months.	Development of EDI calendar to encourage a culture of inclusion.	Q3 October 2020
					Organisational participation in local community culture events such as Warrington Mela (dependent upon COVID-19 restrictions).	Q2 2021
					Investigate, and implement membership of Race Charter at Work.	Q1 2021/22
					Organisational sign-up to Social Partnership Forum's "Call to Action" in relation to bullying and harassment and embed into trust-wide civility, kindness and respect campaign.	Q1 2021/22
					Review the opportunities to collect equality monitoring data as part of Freedom to Speak up	Q3
					Undertake further review of Freedom to Speak up, incidents and HR cases	Q4
					Discuss equality, diversity and	Q3

					inclusion as part of the regular health and wellbeing conversations.	December 2020
7	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	White: 90.7% BAME: 76.1%	White: 91.4% BAME: 82.3%	The data shows that there has been a marked improvement in the percentage of BAME members of staff believing that the trust provides equal opportunities for career progression or promotion.	Promotion and implementation of BAME specific learning and development opportunities internally and externally.	In place and on-going
					Development and implementation of reverse mentoring programme.	Q1 2021/22
					Introduce targeted marketing of employment opportunities to increase diversity.	Q4 January 2021
8	In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues	White: 4.5% BAME: 12.3%	White: 4.50% BAME: 10.70%	The data demonstrates that there has been an improvement compared with the previous year however it is recognised that significantly more BAME members of staff report personally experiencing discrimination at work form a manager, team leader or other colleagues.	Increase BAME representation as Freedom To Speak Up Champions.	Q4 31st March 2021
					Development of EDI Champion role.	Development Q4 / Launch Q1 2020/21
					Development, in partnership with the BAME Staff Network of line manager guidance for dealing with specific concerns from BAME members of staff.	Q4 February 2021
9	Percentage difference between the organisation's Board voting membership and its overall workforce. Note: Only voting members of the Board should be included	White: +3.7% BAME: -9.70%	White: +11.0% BAME: -9.9%	The data demonstrates that in comparison with 2019 there has been a slight deterioration in relation to BAME voting membership and the overall workforce. This is due to a change in the overall workforce, rather than any changes to Board composition.	Participation in the NHS Leadership Academy Shadow Board leadership programme.	Q4 March 2021
					Participation in bespoke EDI training for board members.	Ongoing

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/124**			
SUBJECT:	**Workforce Disability Equality Standard**			
DATE OF MEETING:	25 November 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
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust WDES data against the indicators was presented to Strategic People Committee in September 2020. The Committee noted some particular areas of concern relating to formal bullying, career progression and presenteeism. The Committee requested that a more detailed review was undertaken to understand the issues. The findings of that review were presented to Strategic People Committee on 18 November 2020. The Committee were assured that appropriate actions are in place to address any specific concerns and approved the WDES action plan. This paper includes the WDES action plan, which is submitted to Trust Board for noting.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note	Decision
RECOMMENDATION:	Trust Board are asked to note the key findings from the WDES data and the action plan in place.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/20/11/91		
	Date of meeting	18 November 2020		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Workforce Disability Equality Standard	AGENDA REF:	BM/20/11/124

1. BACKGROUND/CONTEXT

The Workforce Disability Equality Standard (WDES) is an important requirement for the Trust. The purpose of the standard is to ensure that members of the workforce who have a disability have equal access to career opportunities and receive fair treatment in the workplace.

The WDES is a set of ten specific measures (metrics) that will enable NHS organisation's to compare the experiences of disabled and non-disabled members of staff. The Trust is expected to show progress against a number of indicators of workforce equality, including a specific indicator to ensure that the organisation is representative across all levels.

The Trust WDES data against the indicators was presented to Strategic People Committee in September 2020. The Committee noted some particular areas of concern relating to formal bullying, career progression and presenteeism. The Committee requested that a more detailed review was undertaken to understand the issues. The Committee requested that a more detailed review was undertaken to understand the issues. The findings of that review were presented to Strategic People Committee on 18 November 2020. The Committee were assured that appropriate actions are in place to address any specific concerns and approved the WDES action plan.

This paper includes the WDES action plan, which is submitted to Trust Board for noting.

2. KEY ELEMENTS

Key findings from the WDES data are:

- There are are low numbers of staff declaring a disability.
- Disabled staff are under represented at senior levels in the organisation.
- Non-disabled staff are more likely to be appointed from shortlisting, although there has been an improved for Disabled staff since 2019.
- There have been no members of disabled staff entering the formal capability process in the period.
- A number of WDES indicators are taken directly from the Staff Opinion Survey results. Data relating to bullying, harassment or abuse from patients or staff indicate that there are opportunities to improve the experience of disabled staff. These were included in the deep dive presented to Strategic People Committee and the outcomes are included in the WDES action plan.
- There has been a decline in the number of disabled staff who feel the organisation provides equal opportunities for career progression. This was included in the deep dive presented to Strategic People Committee and the outcomes are included in the WDES action plan.
- Disabled staff are more likely to report that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. This was included in the deep dive presented to Strategic People Committee and the outcomes are included in the WDES action plan.

- There has been an improvement in the percentage of disabled staff who are satisfied with the extent to which their organisation values their work, although there is still a disparity with non-disabled staff.
- Disabled staff are more likely to report that the Trust has made adequate adjustments to enable them to carry out their work.
- The staff engagement score for disabled staff has improved, although remains slightly below the score for non-disabled staff.

The WDES action plan is included at appendix 1.

3. MONITORING/REPORTING ROUTES

Delivery of the WDES action plan is monitored via Equality, Diversity and Inclusion Committee, which reports to Strategic People Committee.

4. RECOMMENDATIONS

Trust Board are asked to note the key findings from the WDES data and the action plan in place.

Workforce Disability Equality Standard Action Plan

Metric Number	Standard	2019 Data	2020 Data	Narrative	2020/21 Actions	Timescales
1	Percentage of staff in each of the AfC bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce			The data taken from the organisation's Electronic Staff Record demonstrate that there is an over-representation of disabled members of staff in lower bands and an under-representation across senior levels in comparison with the 2018 WDES data. It is important to note that there are low numbers of staff declaring a disability so a focus will be made on improving self-declaration for 2020-21.	Refresh and re-promotion of self-declaration ESR campaign from Chief People Officer	Q3 December 2020 and then ongoing
					Introduce targeted marketing of employment opportunities to increase diversity	Q4 January 2021
					Scope options relating to positive action and present to Strategic People Committee	Q4 March 2021
					Achieve Disability Confident Level 3	Q4 March 2021
Metric Number	**Standard**	**2019 Data**	**2020 Data**	**Narrative**	**2020/21 Actions**	**Timescales**
2	Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts	1.49	0.83	The data from 2020 demonstrates that there has been a slight improvement in relation to the likelihood of disabled staff being appointed from shortlisting	Develop and launch Equality in Employment policy to cover practical guidance in relation to employing individuals with a range of protected characteristics	Development in Q3 and launch in Q4 March 2021
					Continue development and delivery of EDI managers training to include case studies from own workforce	Ongoing

	Continued… Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts				Include equality, diversity and inclusion responsibilities in all line manager Job Description templates.	Q4 March 2021
					Include equality, diversity and inclusion objective in all staff PDRs	Q4 March 2021
					Refresh recruiting managers training to increase inclusivity of selection processes and increase diversity	Q1 2021/2022
Metric Number	**Standard**	**2019 Data**	**2020 Data**	**Narrative**	**2020/21 Actions**	**Timescales**
3	Relative likelihood of non-disabled staff compared to disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0	0	There has been no change since the 2019 WDES and no members of staff with a disability have been identified as entering the formal capability process.	Development and launch of Civility, Kindness and Respect campaign across organisation	Q4
					Review of Improving People Practices and Fair Processes for all Report to ensure actions and recommendations highlighted in report are implemented within organisation.	Q3 December 2020
Metric Number	**Standard**	**2019 data**	**2020 data**	**Narrative**	**2020/21 Actions**	**Timescales**
4	Percentage of disabled staff compared with non-disabled staff experiencing harassment, bullying or abuse from:	<u>i. Patients / service users:</u> Disabled staff: 24.80% Non-disabled	<u>i. Patients / service users:</u> Disabled staff: 25.70% Non-disabled	The staff survey data from 2019 in comparison with 2018 demonstrates that disabled members of staff have experienced an increase in harassment, bullying	Work with the Disabled Staff Network, Freedom to Speak Up Team and HR Team to enhance reporting of incidents	Q3 and Q4

	Patients / service users, there relatives or other members of the public Manager Other colleagues	staff: 20.09% ii. Managers: Disabled staff: 16.00% Non-disabled staff: 7.90% iii. Other colleagues: Disabled staff: 20.00% Non-disabled staff: 12.60%	staff: 20.90% ii. Managers: Disabled staff: 13.10% Non-disabled staff: 8.40% iii. Other colleagues: Disabled staff: 21.10% Non-disabled staff: 13.20%	or abuse from patients, service users or other colleagues. However, there is a 3% decrease in relation to managers which is a positive development	Deep dive of existing data from staff survey, incidents, Freedom To Speak Up and HR information to understand patterns	Complete
					Targeted work via HR Team and OD Team in specific areas highlighted via the analysis	Q4
					Analysis of Staff Survey results from 2020 (available in January 2021) to ascertain any hotspot areas or staff groups	Q4
	b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Disabled: 44% Non-disabled: 50.6%	Disabled: 48% Non-disabled: 51.5%	In comparison with the previous year's data, there has been a positive increase in disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Development and launch of Civility, Kindness and Respect campaign across organisation	Q4
					Review the opportunities to collect equality monitoring data as part of Freedom to Speak up	Q3
					Undertake further review of Freedom to Speak up, incidents and HR cases	Q4
Metric Number	**Standard**	**2019 data**	**2020 data**	**Narrative**	**2020/21 Actions**	**Timescales**
5	Percentage of disabled staff compared to non-	Disabled: 89.1%	Disabled: 85.8%	The Staff survey data from 2019 in comparison with 2018	Work with Disabled Staff Network to develop content to	Q4

	disabled staff believing the Trust provides equal opportunities for career progression or promotion	Non-disabled: 89.7%	Non-disabled: 91.5%	demonstrates a deterioration in the percentage who feel that the Trust provides equal opportunities for progression or promotion	promote learning and development opportunities	
					Promotion and implementation of specific learning and development support to disabled members of staff	Q4
					Introduce targeted marketing of employment opportunities to increase diversity	Q4 January 2021
Metric Number	**Standard**	**2019 Data**	**2020 Data**	**Narrative**	**2020/21 Actions**	**Timescales**
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled: 29% Non-disabled:21.2%	Disabled:27.9% Non-disabled:19.3%	The Staff survey data from 2019 in comparison with 2018 demonstrates that there has been a slight reduction, therefore an improvement in disabled members of staff feeling pressure to come to work despite not feeling well	Work with Disabled Staff Network and the mental wellbeing hub to develop guidance for line managers in relation to mental health to support members of staff	Q4 March 2021
					Work with Disabled Staff Network to develop guidance for line managers in relation to the management of physical disabilities to support members of staff	Q4 March 2021
					Discuss equality, diversity and inclusion as part of the health and wellbeing conversations for the organisation	Q3 December 2021

					Enage the Disabled Staff Network in the review of the current Attendance Management Policy	Q4
Metric Number	**Standard**	**2019 data**	**2020 data**	**Narrative**	**2020/21 Actions**	**Timescales**
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled: 34.9% Non-disabled: 47.9%	Disabled:39.2% Non-disabled: 54.6%	The Staff survey results from 2019 demonstrate an improvement in disabled members of staff feeling that the organisation values their work	Work with Disabled Staff Network to promote celebration of disability through EDI calendar and activities	Development in Q3 and launch in Q4
Metric Number	**Standard**	**2019 Data**	**2020 Data**	**Narrative**	**2020/21 Actions**	**Timescales**
8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Disabled: 71.3% Non-disabled: 72.1%	Disabled:75% Non-disabled:73.3%	The staff survey results from 2019 demonstrate an improvement from 2018 with adequate adjustments being made.	Promotion of Access to Work scheme for members of staff and line managers including guidance.	Q3 December 2020
					Develop and launch Equality in Employment policy to cover practical guidance in relation to employing individuals with a range of protected characteristics.	Development in Q3 and launch in Q4 March 2021
Metric Number	**Standard**	**2019 data**	**2020 data**	**Narrative**	**2020/21 Actions**	**Timescales**
9	9a) The staff engagement score for disabled staff	Disabled: 6.5 Non-disabled:	Disabled: 6.7 Non-disabled:	The staff survey engagement score for 2019, demonstrates an	Continue to develop the Disabled Staff Network by	Q4 March 2021

	compared to non-disabled staff, and the overall engagement score for the organisation.	7	7.2	improvement from the 2018 staff survey results.	increasing membership and visibility within the organisation.	
	9b) Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard?	N/A		The organisation has committed to the development of a Disabled Staff Network which had its inaugural meeting on the 30th September.	Promotion of disability awareness events as part of the wider EDI calendar	Q3 November 2020
					Achievement of Disability Confident Level 3 for the organisation	Q4 March 2021
					Continue to develop, support and increase membership of the Disability Staff Network.	Q3 December 2020
Metric Number	**Standard**	**2019 data**	**2020 data**	**Narrative**	**2020/21 Actions**	**Timescales**
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: By voting membership of the board	Voting membership of the board: Disabled staff: -2% Non-disabled staff: -5%	Voting membership of the board: Disabled Staff: -2% Non-disabled staff: +42%	In terms of the representation of the board in relation to the wider workforce, that the voting membership of the board has remained the same, however there has been deterioration in relation to the executive membership of the board.	Participation in the NHS Leadership Academy Shadow Board leadership programme	Q4 March 2021
					Participation in bespoke EDI training for board members, including Cultural Competence Training.	Ongoing

	By executive membership of the board	Executive membership of the board: Disabled staff: +7% Non-disabled staff: +27%	Executive membership of the board: Disabled staff: -2% Non-disabled staff: -25%			

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/125+126**			
SUBJECT:	**Quality Assurance Committee and Strategic People Committee – amended Terms of Reference 2020-21**			
DATE OF MEETING:	25 November 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 Quality Assurance Committee (QAC), as a Board Assurance Committee, has assumed responsibility for oversight of the Equality, Diversity and Inclusion Sub Committee for Patient and Service User perspective. The Strategic People Committee (SPC) will have oversight from a People/Staff perspective. To reflect the amendment to the reporting arrangements proposed changes to the Terms of Reference include: <u>Amendment to Section 6 Reporting</u> • Add – Equality, Diversity & Inclusion Sub Committee. Updates have also been made to role titles as appropriate Proposed amendments to the ToR are detailed in the Revision Tracker.			
PURPOSE: ***(please select as appropriate)***	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review to and approve the amended Terms of Reference for SPC and QAC.			
PREVIOUSLY CONSIDERED BY:	Quality Assurance Committee Date: 3.11.2020 Agenda Ref: QAC/20/11/212 Approved	Strategic People Committee Date: 18.11.2020 Agenda Ref: SPC/20/11/87 Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

TERMS OF REFERENCE

QUALITY ASSURANCE COMMITTEE

1. PURPOSE

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

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly

3. QUORUM

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

4. MEMBERSHIP

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

Core Members

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

Attendees

- Obstetrics/Obstetrics Safety Champion Lead + Governance Lead

Observers

- **Public Governor**

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

5. AUTHORITY

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

6. REPORTING

The Committee will have the following reporting responsibilities:

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

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

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

7. DUTIES & RESPONSIBILITIES

The Committee will undertake the following duties:

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

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

8. ATTENDANCE

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

9. ADMINISTRATIVE ARRANGEMENTS

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

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

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

Papers are to be submitted in the following format:

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

10. REVIEW / EFFECTIVENESS

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

TERMS OF REFERENCE REVISION TRACKER

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

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

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

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

TERMS OF REFERENCE
STRATEGIC PEOPLE COMMITTEE

1. PURPOSE

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

The Strategic People Committee will seek assurance on the:

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

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

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

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

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly.

3. MEMBERSHIP

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

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- ~~Director of HR + OD~~ Chief People Officer
- ~~Deputy Director HR & OD~~ Deputy Chief People Officer
- Chief Operating Officer

- Executive Medical Director
- Chief Nurse & Deputy Chief Executive
- Director of Strategy
- ~~Director of Finance + Commercial Development~~ Chief Finance Officer & Deputy Chief Executive
- ~~Director of Community Engagement + Fundraising~~ Director of Communications & Engagement

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

- ~~Head of Education Development & Wellbeing~~ – replace with Head of Staff Engagement & Wellbeing
- ~~Head of Medical Staffing and Education – Needs to be removed as this post no longer exists~~
- Head of HR ~~Business Partners~~
- Head of Workforce Systems and Intelligence

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

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

4. QUORUM

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

5. AUTHORITY

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

6. REPORTING

Governance

The Strategic People Committee will have the following reporting responsibilities:

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

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

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

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

Duties – advisory:

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

Duties – monitoring:

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

Duties of members:

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

Sub-Committees (Groups):

- Operational People Sub Committee
- Equality Diversity & Inclusion Sub Committee

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

8. ATTENDANCE

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

9. ADMINISTRATIVE ARRANGEMENTS

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

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

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

Papers are to be submitted in the following format:

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

10. REVIEW / EFFECTIVENESS

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

TERMS OF REFERENCE REVISION TRACKER

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

REVISIONS

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

	assurance committee 2. **Membership** – Written approval by quorate membership rather than full membership 3. **Duties & Responsibilities** – Section on Decision Making. Clarity on SPC role to assure actions taken to recruit and retain our workforce Section on Monitoring. Scope of Employee Relations Case Report clarified and to be included in workplan 4. **Subcommittees** – to include Triangulation Group		Approved Trust Board (September 2018)
20 March 2019	**Section 3 – Membership**	Updated attendee titles	
20 March 2019	**Section 7 – Duties + Responsibilities**	Triangulation Group removed	
18 March 2020	**Section 3 – Membership**	Updated attendee titles	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 10 – Administrative Arrangements**	Updated submission of papers timeframe	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 3 - Membership**	Removal of reference to Head of HR Strategic Projects	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 4 - Quorum**	To amend in line with other assurance committees	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 8 - Attendance**	To insert the term 'nominated' before deputy	V6 SPC 18.03.2020 Trust Board 25.03.2020
22 July 2020	**Section 3 – Membership**	Updated Executive Director titles, Deputy HRD&OD and attendee titles	V6.1 SPC 22 July 2020
18 November 2020	**Section 6 – Reporting**	**Add** Equality Diversity & Inclusion Sub Committee	V6.1 SPC 18.11.2020 Trust Board xx.xx.xxxx

TERMS OF REFERENCE OBSOLETE

Date	Reason	Approved by:
	Version 5 replaced with Version 6	SPC 18.03.2020 and Trust Board 25.03.2020

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/127**		
SUBJECT:	**Finance & Sustainability Committee Revised Terms of Reference**		
DATE OF MEETING:	25 November 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 Finance & Sustainability Committee (FSC), as a Board Assurance Committee, has assumed responsibility for oversight of Digital Services. To reflect the amendment to the reporting arrangements proposed changes to the Terms of Reference were supported at the FSC on 23 September 2020 and include: <u>Amendment to Section 4- Duties and Responsibilities</u> • Add - Receive a monthly Digital Services report and maintain oversight of digital investments in line with the Digital Strategy. <u>Amendment to section 6- Core Attendees</u>: • Add – Chief Information Officer <u>Amendment to section 9 – Reporting Groups</u> • Add – Digital Board Other amendments include updates of role titles to reflect recent changes. Proposed amendments to the ToR are detailed in the Revision Tracker.		
PURPOSE: ***(please select as appropriate)***	Information	Approval **√**	To note	Decision
RECOMMENDATION:	To approve			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	FSC/20/09/131		
	Date of meeting	23 September 2020		
	Summary of Outcome	Supported		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

FINANCE & SUSTAINABILITY COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

The Finance and Sustainability Committee ("the Committee") is accountable to the Board of Directors (the Board) and will operate under the broad aims of reviewing financial and operational planning, performance and strategic & business development.

2. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain external assurance; legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.

The Chair of the Committee will report to the Board annually on its work and performance in the preceding year. The Trust's Standing Orders of Reservation and Delegation and Standing Financial Instructions apply to the operation of the Committee.

4. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following two areas:

Finance and performance

- To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the Monitor Provider Licence (under the auspices of NHS Improvement).
- Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- To monitor the effectiveness of the Trust's financial performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Trust's performance against its annual financial plan and budgets.
- Review the service line reports for the Trust and seek assurance that service improvements are being implemented.
- To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- To provide overview and scrutiny to the development of the medium and long term financial models (MTFM and LTFM).
- To ensure the MTFM and LTFM is designed, developed, delivered, managed and monitored appropriately.

- To ensure that appropriate clinical advice and involvement in the MTFM and LTFM is provided.
- To review and monitor the in-year delivery of annual efficiency savings programmes.
- To review the performance indicators relevant to the remit of the Committee.
- Consider any relevant risks within the Board Assurance Framework and corporate level Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Key Issues Report.
- To monitor compliance with NHSI requirements relating to pay policies
- To review and monitor the Trust's overall pay bill
- To monitor all elements of the Board Assurance Framework that relate to the work of this Committee

Strategy, planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £500k or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.
- Receive a monthly Digital Services report and maintain oversight of digital investments in line with the Digital Strategy.

5. MEMBERSHIP

The Committee shall be composed of not less than two (2) independent Non-Executive Directors, at least one of whom shall have recent and relevant financial experience.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

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

6. CORE ATTENDEES

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

- Chief Finance Officer & Deputy CEO
- Chief Nurse & Deputy CEO
- Chief Operating Officer
- Medical Director

- Chief People Officer
- Deputy Director of Finance & Commercial Development
- Chief Information Officer
- Director of Strategy (when required)
- Trust Secretary

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

7. QUORUM

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

8. FREQUENCY OF MEETINGS

Meetings shall be held on a monthly basis.

9. REPORTING GROUPS

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting;
- separate reports to support the working of the Committee or addressing areas of concern these Reporting Groups may have;
- an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

- Capital Planning Group
- Finance and Resources Group
-
- Digital Board

10. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

11. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed at least annually by the Committee.

Date: September 2020

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Finance and Sustainability Committee
Version:	**V**7
Implementation Date:	September
Review Date:	March 2021
Approved by:	Finance + Sustainability Committee
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
22 March 2017	**3 – Reporting arrangements**	- There is no requirement to circulate Committee minutes unless specifically requested to the Trust Board, rather the Chair's key issues report will highlight points of note in the public forum.	
22nd March 2017	**4. Duties and Responsibilities**	- To recognise NHS Improvement as an umbrella organisation with oversight of Monitor-imposed regulation or enforcement	
22 March 2017	**6 - Attendance**	- Change of Core Membership to Core Attendees to distinguish between membership (non-executive – required for quoracy) and those invited to attend – not included in quoracy. - Changes to core attendees to include, Chief Nurse, Medical Director, Director of HR&OD, Deputy Director of Finance	
22 March 2017	**9. Reporting Groups**	Two groups removed: - The Business Planning sub Committee (strategic). - Strategic & Annual Planning Steering Group. One Group added: - Pay Spend and Review Committee minutes to reporting groups.	
22 March 2017	**10 Administrative Arrangements**	- Due to change in administrative support to the Committee - Agreement with the Chair and Director of Finance to amend the timescale for circulating papers	
18th October 2017	**4. Duties and responsibilities** **6. Core attendees** **9. Reporting Groups**	- Delete items relating to Estates and IM&T - Delete Director of IM&T Remove IM&T Steering Cttee, Lorenzo Project Group, IM Governance and Records	

22nd November 2017	**Section 4 Duties and Responsibilities** **Section 9 Reporting Groups**	- To monitor compliance with NHSI requirements relating to pay policies - To review and monitor the Trust's overall pay bill - To monitor all elements of the Board Assurance Framework that relate to the work of this Committee To include: reports on premium pay spend	
21st March 2018	**Core Attendees**	Addition of Medical Director	Trust Board 29.5.2019
19th September 2018	**Core Attendees**	Remove Director of Transformation	Trust Board 29.5.2019
20 March 2019	**Section 6: Core Attendees**	Remove Medical Director Add Head of Corporate Affairs	Trust Board 29.5.2019
20 March 2019	**Section 9: Reporting**	Add Financial Resources Group Remove Out Patient Turnaround Remove ICIC	Trust Board 29.5.2019
18 March 2020	**Section 6: Core Attendees**	ADD Medical Director Amend Title of Head of Corporate Affairs to read Trust Secretary Amend title of Deputy director of Finance Strategy to read Deputy Director of Finance & Commercial Development ADD Director of Strategy (when required)	FSC 18.03.2020 Trust Board 25.03.2020
18 March 2019	**Section 9: Reporting**	Remove Urgent & Emergency Care Improvement Committee	FSC 18.03.2020 Trust Board 25.03.2020
23rd September 2020	**Section 4 Duties and Responsibilities**	Addition of reports from Digital Services	FSC 23.09.2020
23rd September 2020	**Section 6: Core Attendees**	Amend the titles of three Directors Add Chief Information Officer	FSC 23.09.2020
23rd September 2020	**Section 9: Reporting**	Add Digital Board	FSC 23.09.2020

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
20 March 2020	**V5 to be replaced by V6**	FSC 18.03.2020
23 September 2020	**V6 to be replaced by V7**	FSC 23.09.2020

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/129**
SUBJECT:	**Medical Appraisal and GMC Revalidation Annual Report: November 2020**
DATE OF MEETING:	25th November 2020
AUTHOR(S):	Andrea Stazicker, Revalidation Lead
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	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)*	All
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides assurances to the Board that the system for medical appraisal and the processes for monitoring the completion of annual appraisals to support GMC revalidation for the medical workforce are robust. Doctors who practise medicine in the UK must be registered, and hold a licence to practise Both registration and licensing are delivered by the GMC. Every licensed doctor who practises medicine must revalidate. Revalidation is an evaluation of a doctor's fitness to practise. It supports professional development, drives improvements in clinical governance and gives patients confidence that the doctor is up to date. GMC revalidation is based on annual whole practice appraisals; information from systems of clinical governance and a five yearly revalidation recommendation. All doctors have a legal obligation to revalidate and failure to comply with the requirements may result in withdrawal of their licence to practise Most licensed doctors are supported with their appraisal and revalidation through connection to a 'designated body'. Within that organisation, a 'responsible officer' oversees the process of revalidation and makes a recommendation to the GMC about whether a doctor should be revalidated. The designated body is the organisation in which the doctor undertakes most or all of their practice and their responsible officer is a senior doctor within that organisation. The relationship between a doctor, their designated body and responsible officer is known as their 'connection details'. The Trust maintains the list of doctors for whom it is the designated body. The responsible officer is Dr Alex Crowe. The responsible officer must: 1. make sure doctors have access to appraisal systems and processes for collecting and holding information

	2. make a recommendation to the GMC every fiveyears, indicating whether the doctor is up to date, fit to practise and should be revalidated. The GMC sets clear guidance on the requirements for annual appraisal and the supporting information that a doctor must present. Doctors at WHHFT collate their supporting information using CRMS - a web based system enabling the secure storage of documentation. Since 2012 WHHFT has had processes and systems in place to enable, track and monitor appraisal completion rates. **Key Results** ▪ In 2019/2020 96% of appraisals were completed ▪ Within WHHFT 234 doctors require a annual appraisal ▪ There are 71 trained appraisers Monitoring and recording of appraisal completion across the Trust was maintained during the first wave of the COVID pandemic. Doctors in the front line were allowed to have an approved missed appraisal.			
PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision n/a
RECOMMENDATION:	For the Committee to note and approve the year-on-year results that have been achieved for completion of annual medical appraisals.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC 20 11 89		
	Date of meeting	18 November 2020		
	Summary of Outcome	Noted and approved.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Medical Appraisal and GMC Revalidation Annual Report: November 2020	AGENDA REF:	BM/20/11/129

1. BACKGROUND/CONTEXT

Doctors who practise medicine in the UK must be registered, and hold a licence to practise which is granted by the General Medical Council. Every licensed doctor who practises medicine must revalidate. Revalidation is an evaluation of a doctor's fitness to practise. It supports professional development, drives improvements in clinical governance and gives patients confidence that the doctor is up to date. GMC revalidation is based on annual whole practice appraisals; information from systems of clinical governance and a five yearly revalidation recommendation. All doctors have a legal obligation to revalidate and failure to comply with the requirements may result in withdrawal of their licence to practise.

Most licensed doctors are supported with their appraisal and revalidation through a connection to a 'designated body'. Within that organisation, a 'responsible officer' oversees the process of revalidation and makes recommendations to the GMC about whether a doctor should be revalidated. The designated body is the organisation in which the doctor undertakes most or all of their practice and their responsible officer is a senior doctor within that organisation. The relationship between a doctor, their designated body and responsible officer is known as their 'connection details.' The Trust maintains the list of doctors for whom it is the designated body. The responsible officer is Dr Alex Crowe.

The responsible officer must:

1. Ensure that doctors have access to appraisal systems and processes for collecting and holding information.
2. Make a recommendation the GMC every five years on whether the doctor should be revalidated.

WHH has a statutory duty to support the responsible officer in discharging their duties and oversees compliance by:

- monitoring the frequency and quality of medical appraisals within the organisation
- checking there are effective systems in place for monitoring the conduct and performance of doctors
- confirming that there is periodic feedback from patients and colleagues so that their views can inform the appraisal and revalidation process
- completing appropriate pre-employment background checks (including pre-engagement for locums) to ensure that doctors have the necessary qualifications and experience

The GMC sets clear guidance on the requirements for annual appraisal and the supporting information that doctors must present. There are six types of supporting information that doctors must collect reflect on and discuss at their annual appraisal. These are:

- Continuing professional development
- Quality improvement activity
- Significant events
- Feedback from patients
- Feedback from colleagues
- Compliments and complaints.

By providing all six types of supporting information over the five year revalidation cycle and reflecting and discussing at their annual appraisal, doctors will demonstrate their practice against all 12 attributes outlined in the GMC guidance, Good medical practice framework for appraisal and revalidation. This allows completion of the appraisal and the responsible officer can make a recommendation about revalidation.

Doctors at WHHFT collate their supporting information using CRMS - a web based system enabling the secure storage of documentation. Since 2012 WHHFT has had processes and systems in place to enable, track and monitor appraisal completion rates.

2. KEY ELEMENTS

2.1 Appraisal and Revalidation Performance Data

WHH have a comprehensive process which facilitates submission of reports to NHS Revalidation North. This includes:

- Tracking of end of month appraisal completion rates for both the financial and calendar year
- Delivery of in month specialty compliance rates
- Delivery of end of month medical appraisal exception reports to clinical directors for all specialties. This includes the stages of notification and reasons why an appraisal has not achieved final sign-off
- Notification correspondence

Figures 1 and 2 show the medical appraisal completion rates for the calendar and financial year**.** The completed percentage reflects medical appraisals completed by scheduled monthly cohort, not the total medical workforce to be appraised. NHS England postponed appraisal during the first wave of the COVID 19 pandemic. However the Trust continued to support doctors who were able to have an appraisal. The responsible officer granted approved-missed appraisals to doctors who were clinically on the front line of the pandemic. Table 1 summarises the annual appraisal completion rates between 2012 and 2020.

Figure 1: Medical appraisal completion for calendar year January to December 2020 as at 31st October 2020

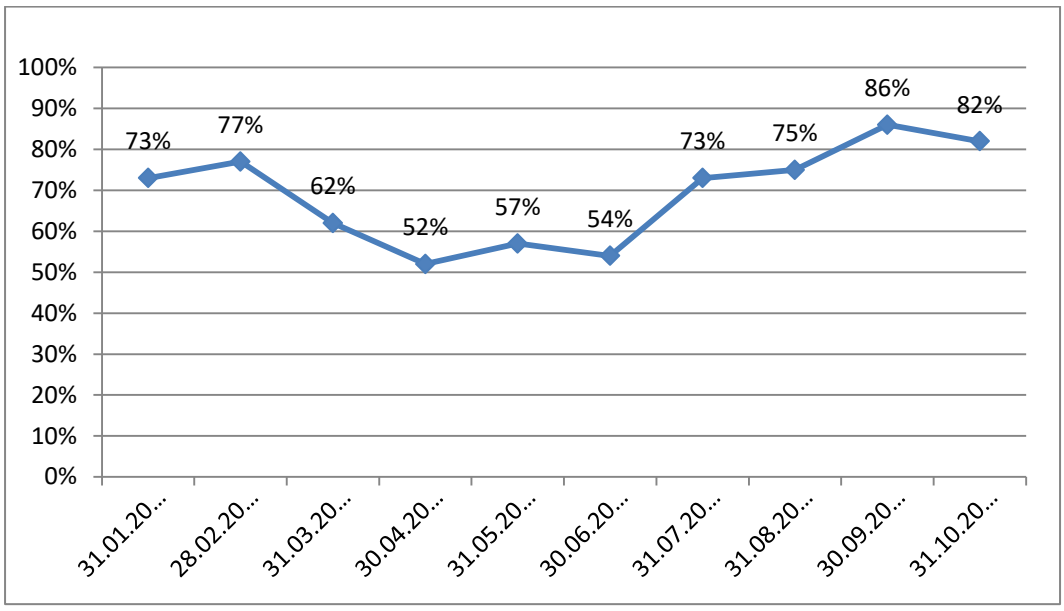


Figure 2: Medical appraisal completion rate for financial year April 2020 to March 2021 as at 31st October 2020(actual vs projected)

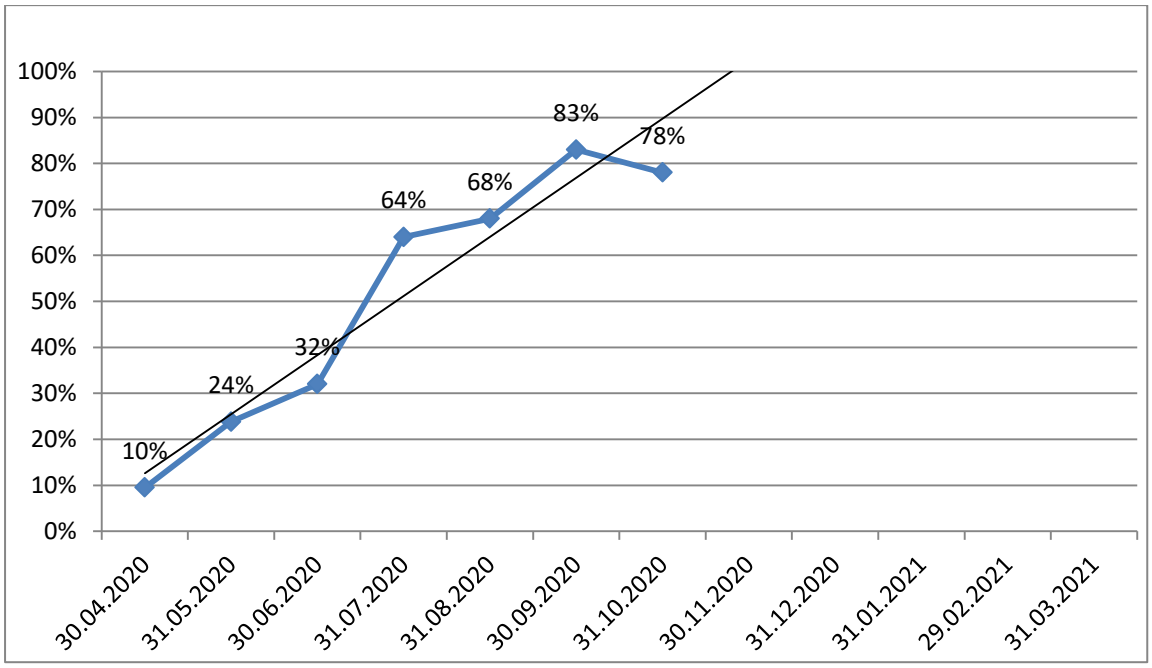


Table 1. Annual appraisal completion rates between 2012 and 2020		
Year	**Dates**	**% completed appraisals**
1	April 2013 to March 2014	99.4%
2	May 2012 to March 2013	93%
3	April 2014 to March 2015	96%
4	April 2015 to March 2016	94%
5	April 2016 to March 2017	94%
6	April 2017 to March 2018	90%
7	April 2018 to March 2019	93%
8	April 2019 to March 2020	96%

The timelines for completion, tracking and and notification for medical appraisals are outlined below:

1. The appraisal meeting must take place during the birth month of the appraisee. (month one)

2. Appraisal outputs including the summary, personal development plan and feedback evaluation must be completed by the end of the month following the birth month. (month two)

3. If completion has not happened by the 1st of the next month (month three) – **Letter 1** of the 'non-engagement' process is sent to the appraisee. There is a two week deadline for completion of the appraisal and final-sign off.

4. If completion has not happened by the date required then **Letter 2** of the 'non-engagement' process is sent with a further two week deadline.

5. Failure to complete by the third deadline will result in **Letter 3** of the 'non-engagement' process being issued with a final two week deadline. The letter states that failure to comply by this final deadline will result in the GMC being contacted and the doctor will be reported for non-engagement in the appraisal process via Form Rev6.

Figures 3 and 4 show the % of appraisals completed within the month of birth during 2020 and the number completed at month end.

Figure 3. Appraisal completion (%) within month of birth in 2020 as at 31st October 2020

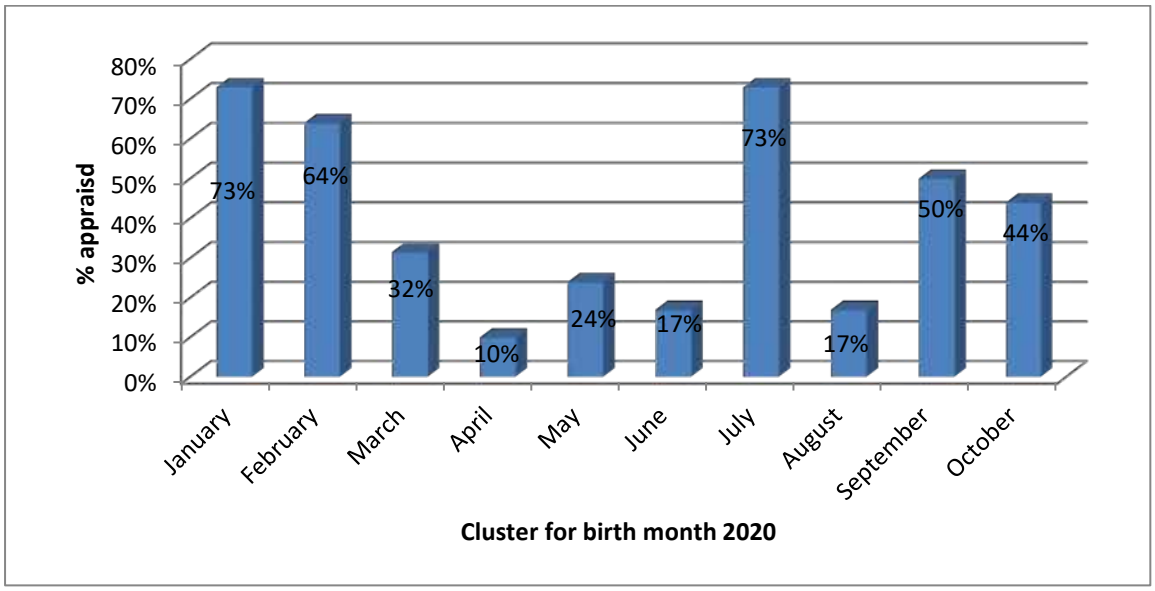
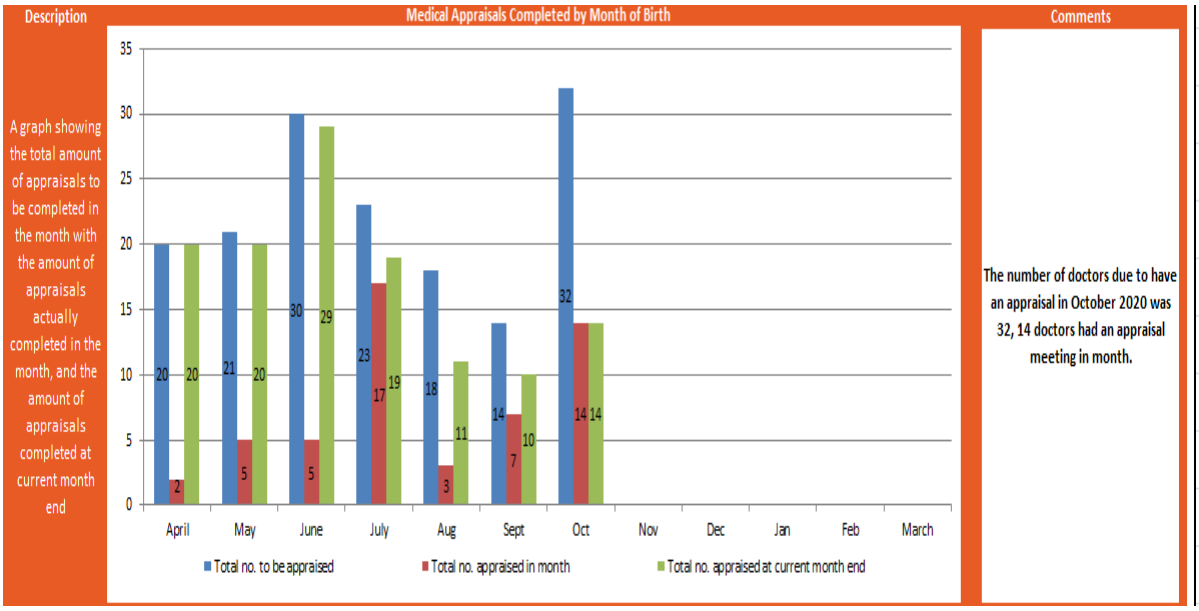


Figure 4. Appraisal completion in 2020 within month of birth compared with current date as at 31st October 2020



2.2 Appraisers

There are 71 medical appraisers within the Trust. A training workshop for new appraisers was held in October 2020 and nine internal delegates attended. Appraiser Forums planned for April and October 2020 and the new Forum for all appraisees planned for November 2020 have been postponed due to the COVID 19 pandemic.

Figure 5 shows the distribution of appraisees by specialty and Figure 6 shows the average number of appraisees per appraiser.

Figure 5. Number of doctors to be appraised by specialty (Total =237)

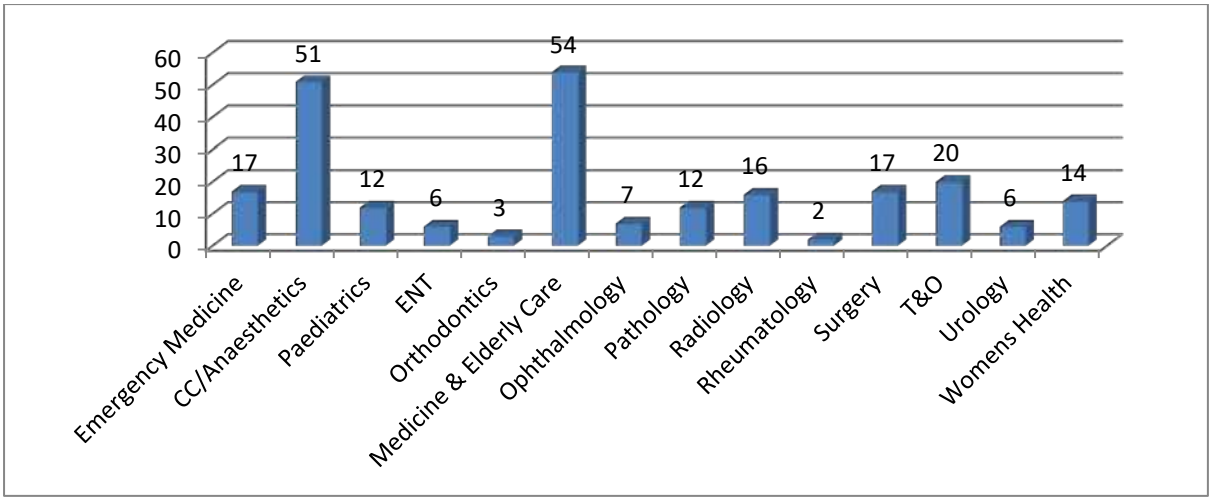
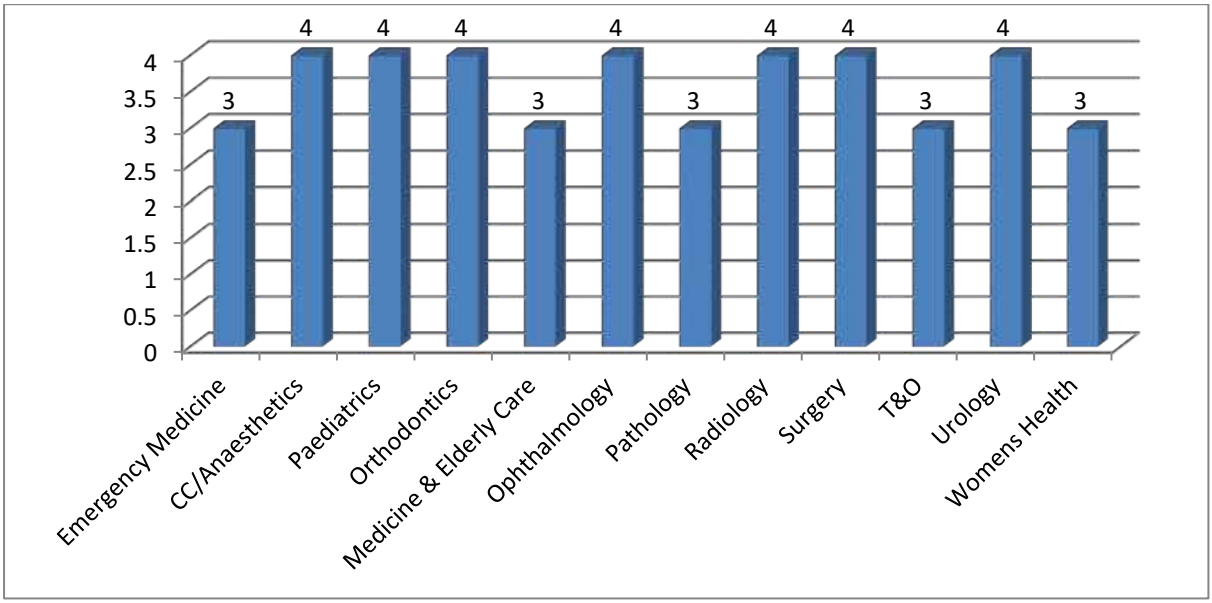


Figure 6. Average number of appraisees allocated to an appraiser October 2020



2.3 Revalidations

The table below shows the number of submissions made over the last 6 year period. The Trust has a robust approach to the tracking and monitoring of revalidation deadlines which is demonstrated by every submission in the last 6 years being made either ahead of time or on the date it was due.

Figure 7. Revalidation Tracker Over Last 6 Years

Financial Year	Deferrals	Reported for Non-Engagement	Revalidate	Total Submissions
2014 - 15	6	0	66	72
2015 - 16	12	0	69	81
2016 - 17	3	0	14	17
2017 - 18	5	1	14	20
2018 - 19	4	0	45	49
2019 - 20	7	0	68	75
Totals	37	1	276	314

A Revalidation Panel took place in January 2020, dealing with revalidations due up to April 2020. Following this the GMC deferred Revalidation Dates by one year for those due between March 17th 2020 and March 31st 2021. Therefore no Revalidation Panels were required.

A further instruction was issued by the GMC on 11th June, stating that revalidations could be recommended for all doctors with a deferred date. In Warrington this involved 53 doctors, and all were contacted by email to express a preference for either revalidation as soon as possible or waiting until the due date in 2021. 26 doctors wished to proceed soon, and evidence is being collated currently with a view to holding a Revalidation Panel in October or November 2020, to deal with this group. The other 27 will be dealt with in panels later this year and up to the end of 2021, depending on their supporting information being ready.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

No action required

4. IMPACT ON QPS?

The Medical Workforce is an invaluable asset to the Organisation and as such, all doctors with a licence to practise utilise their Medical Appraisals as a demonstration of evidence to the GMC that they remain safe to deliver patient care. The submission of this Annual Report to NHS England provides assurance that the Medical Workforce is fully engaged in the Medical Appraisal process which directly supports GMC Revalidation.

5. MEASUREMENTS/EVALUATIONS

As revalidation has now been in place since 2012, designated bodies and responsible officers must be able to provide assurance to patients, the public, the service and the profession that the appropriate systems and processes are in place to ensure that every licensed medical practitioner is safe to practise. The Framework of Quality Assurance provides support in demonstrating the required assurance. The framework includes processes such as the annual organisational audit (AOA) using a standardised template.

Each designated body must provide the following data in the AOA return:

- The number of doctors with whom the designated body has a prescribed connection
- The number of doctors due to hold an appraisal meeting in the reporting period
- The number of those doctors above who held an appraisal meeting in the reporting period
- The number of those doctors above who did not hold an appraisal meeting in the reporting period
- The number of doctors above for whom the responsible office accepts the postponement is reasonable
- The number of doctors above for whom the responsible officer does not accept the postponement is reasonable

The appraisal activity quarterly reports are sent to the NHS Regional Revalidation Team. NHS England has not requested data this year due to the postponement of medical appraisal during the COVID 19 pandemic. However the WHH Appraisal and Revalidation Group have continued to monitor and record appraisal completion for internal records (see Figure 7).

Figure 7

Framework of Quality Assurance for Responsible Officers and Revalidation, Annex B - Quarterly Information Template (Q2)

Please complete this quarterly information template for the period 1 July 2020 to 30 September 2020 and return to

	Indicator	Q1 (1 Apr to 30 Jun)	Q2 (1 July to 30 Sep)	Q3 (1 Oct to 31 Dec)	Q4 (1 Jan to 31 Mar)
1	**Name of designated body** (or NHS England Area Team or Region) Note: Please ensure your organisation's name is written exactly as it is recorded on GMC Connect	Warrington & Halton Teaching Hospitals NHS Foundation Trust			
2	Number of doctors with whom the designated body has a **prescribed connection**	265	269		
3	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	71	55		
3.1	Number of those within #3 above who **had an appraisal meeting** in the reporting period	20	36		
3.2	Number of those within #3 above who **did not have an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	51	19		
	Data entry checker				
3.2.1	Number of doctors[1] in 3.2 above for whom **the RO accepts the postponement is reasonable**	51	19		
3.2.2	Number of doctors[1] in 3.2 above for whom **the RO does not accept the postponement is reasonable**	0	0		
	Data entry checker				
4	**Any Comments** you wish to raise (e.g. new RO, new appraisal lead etc.):				

6. TRAJECTORIES/OBJECTIVES AGREED

CRMS Medical Appraisal portfolios:

- Review of appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is appropriate and available - by the Deputy RO/Medical Appraisal Lead prior to sign-off. For example, if information that is required to be seen is not held in the portfolio, this will be returned with instructions the Appraisee/Appraiser as required.
- Review of appraisal folders to provide assurance that the appraisal outputs: personal development plan, summary and sign offs are complete and to an appropriate standard - by the Deputy RO/Medical Appraisal Lead prior to sign-off.
- Review of appraisal outputs to provide assurances that any key items identified pre-appraisal as needing discussion during the appraisal is included in the appraisal outputs - by the Deputy RO/Medical Appraisal Lead prior to sign-off.

For the individual Medical Appraiser:

- An annual record of the appraiser's reflection on his or her appropriate continuing professional development.
- An annual record of the appraiser's participation in appraisal calibration events such as reflection on appraisal network meetings.
    - WHH Medical Appraisal Forum Attendance Registers are used to demonstrate engagement of the Appraisers.
    - 360° Patient and Colleague Feedback Reports are provided from the web-based system **360© Clinical** and these Reports are uploaded onto the Medical Appraisal portfolio. These Reports offer a "national confidence interval" in the assessment of a Doctor.

7. MONITORING/REPORTING ROUTES

- The appraisal activity quarterly reports are sent electronically to the NHS Regional Revalidation Team:
- NHS England Template: Statement of Compliance. Annual submission (September)
- NHS England Annual Board Report. Annual submission (September)
- NHS England Annual Organisation Audit. Annual submission (July)

8. TIMELINES

Below are the WHH timelines for completion tracking and and notification periods for medical appraisals (timelines during non-pandemic circumstances):

1. The Appraisal Meeting must take place during the birth month of the Appraisee – but can be between 9 and 15 months of the birth month.

2. The Appraisal Meeting, PDP, Summary and Feedback Evaluation are required to be completed by the end of the following month of the birth month.

3. If completion has not happened by the 1st of the next month (month 3) – **Letter 1** of the "non-engagement" Letters will be sent to the Appraisee.

4. If completion has then not happened by the middle of the third month, **Letter 2** of the "non-engagement" Letters will be sent to the Appraisee

5. If completion has not then happened by the end of the third month, **Letter 3** of the non-engagement Letters will be sent to the Appraisee, informing them that the doctor will be reported to the GMC for non-engagement

9. ASSURANCE COMMITTEE

N/A

10. RECOMMENDATIONS

The medical appraisal and GMC revalidation annual report 2020 for noting, support and approval.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/130**	
SUBJECT:	**Learning from Deaths Q2 -2020/21**	
DATE OF MEETING:		
AUTHOR(S):	Layla Alani, Deputy Director 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)***	None	
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 2, 2020/21; • 210 deaths occurred within the Trust • 50 Structured Judgement Reviews (SJRs) were completed • 5 of the 50 SJRs were presented to the Mortality Review Group (MRG) that quarter • 36 of the 210 deaths from Q2 have triggered for an SJR review and will be allocated to a reviewer. We are not an outlier for HSMR or SHMI. However, the Mortality Review Group analyses data in relation to Mortality and it is indicated that we have an excess number of deaths in the Cardiac Dysrhythmia diagnosis group. MRG have noted that a Focus Review is to be undertaken to obtain any learning. The MRG aim to conduct this focus review in Quarter 3 with findings being available in Quarter 4. A Focused Review into 30 COVID-19 deaths began in Q2. The findings of which will be available in Q3. There was 1 serious incident relating to a death during Q2. An update on the Medical Examiner and Medical Examiner Officer roles can be seen in Section 3.6 of this report.	

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:				
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/20/11/219		
	Date of meeting	3rd November 2020		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Deaths Report Quarter 2, 2020-21	AGENDA REF:	BM/20/11/130

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

3.1 Total number of deaths and investigation levels

During 1st July 2020 to 30th September 2020, 210 patients passed away in within the Trust.

By 30th September 2020, 50 SJRs had been completed.

There was 1 serious incident relating to a death during Q2. (Details of the SJRs and RCAs are contained within **Appendix 1** of this report).

3.2 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 2020/21 Quarter 2, 50 Structured Judgement Reviews were completed by members of the MRG.

Table 1 below details their overall care rating:

Jul / Aug / Sept 20	Overall Assessment Care Rating Following SJR					Total
	1: Very Poor	2: Poor	3: Adequate	4: Good	5:Excellent	
	0	**3**	**9**	**33**	**5**	**50**

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.

The three cases rated as '2 Poor' were discsussed at MRG the findings of which can be found with details below:

Case 1 (M7452): The MRG concluded that there should have been prompt communication regarding the patient's healthcare plan with next of kin. However following review of the care rating the panel disagreed with the overall score of '2 Poor' for the patient's care. The review was subsequently revised to '3 Adequate'. Lessons learnt were distributed to the appropriate clinical services clinical governance meetings.

Case 2 (M7535): The Trust Mortality Lead discussed the case with Consultant Respiratory Lead for the Trust.There was need for prompt review of the deteriorating patient and documentation of NEWS. It is also important to ensure that the patient is on the appropriate ward to support clinical diagnosis. MRG reviewed the care of the patient which was otherwise adequate. Lessons learnt were distributed to the appropriate clinical services clinical governance meetings.

Case 3 (M7539):. There was appropriate decision making for CPR with appropriate discussion with patient and family. There was also review of patient by palliative care consultant. However there was no senior review of the patient or Consultant review of DNACPR. MRG reviewed the care of the patient which was otherwise adequate. Lessons learnt were distributed to the appropriate clinical services clinical governance meetings.

The SI noted in Appendix 1 refers to one death in Q2 which woud have been subjected to an MRG review but was escalated directly to an SI.

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.

Below are the current Focus Reviews that are underway at present:

- **COVID-19 Deaths Focused Review**

The MRG have also prepared terms of reference for a Focused Review into Covid-19 deaths. This review commenced in Q2 with the aim to complete the review by October 2020 and present to this committee in November 2020.

- **Cardiac Dysrhythmia Focus Review**

Cardiac Dysrhythmias have been noted to be a statistically significant outlier for the Trust. HED SHMI reports that the Trust has recorded 20 observed deaths compared with the 7.8 expected deaths for this diagnostic group. The data for this review is currently being revised by the coding team before a focus review is started to ensure that any coding errors are identified. The MRG intend to begin the focus review in Q3 and aim to have findings available by Q4.

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 Q2 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 *Case of the Month*) from deaths for Q2 can be seen in **Appendix 2.**

3.6 Medical Examiner

The Medical Examiner (ME) and Medical Examiner Officer (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. These roles were recruited to in Quarter 2.

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 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 the death certification process.

Medical examiner offices will be staffed by a team of medical examiners, supported by a medical examiner officer who will lead 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.
At WHH we envisage a phased implementation with full rollout by February 2021. Eventually all deaths *not* referred to HM Coroner will be scrutinised.

4. TRAJECTORIES/OBJECTIVES AGREED

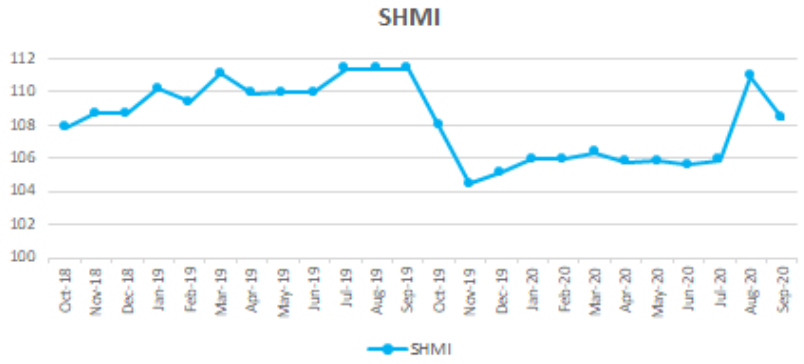
SHMI / HSMR Summary

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 October 2018 and demonstrates the current position as 109.58 compared to our peer group. The Trust is not showing as 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 October 2018 and demonstrates our current position at 108.44. The Trust is not showing as an outlier for HSMR.

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

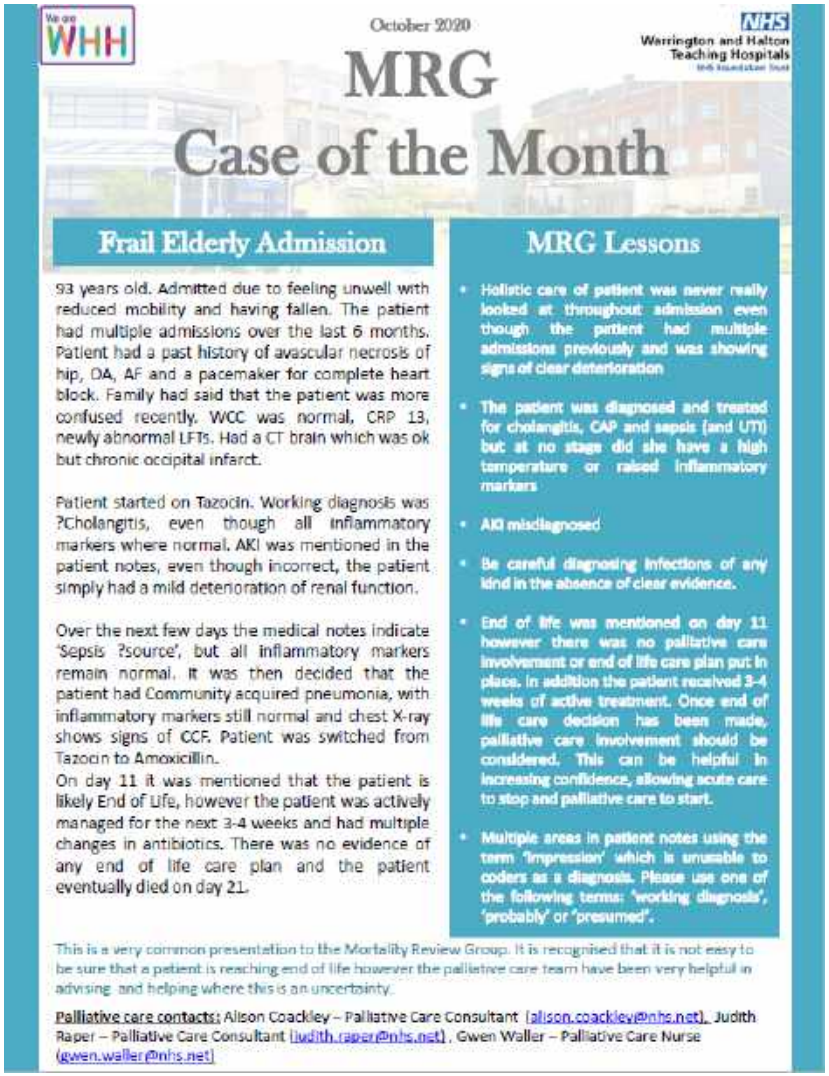
APPENDIX 1: UPDATE ON CASES

STEIS Reference	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 (Inquest ID: 2188)	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 (Inquest ID:	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	Subject to inquest – no date set as yet

STEIS Reference	Description	Deemed as having problems in care
3470)	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.	
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 (Inquest ID: 2967)	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 (Inquest ID: 2920)	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 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.	Subject to inquest – no date set as yet
2020/4597 (Inquest ID: 3697)	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 Q1 that required a serious incident review.		
2020/21 – Q2 – There was 1 case during Q2 that required a serious incident review.		
2020/15724	The patient arrived (17.8.20 at 23:27) in the Emergency Department, blood gas taken at 01:32 showing lactate of 13.72. Patient seen by ITU team and surgeons and required an urgent CT scan as ischaemic bowel was queried. Patient was noted as looking extremely unwell. Patient vomited further and became less responsive and went into	SI Investigation in progress

STEIS Reference	Description	Deemed as having problems in care
	cardiac arrest at 02:32 and sadly passed away.	

APPENDIX 2: LEARNING FROM DEATHS



We are WHH

October 2020

NHS Warrington and Halton Teaching Hospitals

MRG Case of the Month

Frail Elderly Admission

93 years old. Admitted due to feeling unwell with reduced mobility and having fallen. The patient had multiple admissions over the last 6 months. Patient had a past history of avascular necrosis of hip, DA, AF and a pacemaker for complete heart block. Family had said that the patient was more confused recently. WCC was normal, CRP 13, newly abnormal LFTs. Had a CT brain which was ok but chronic occipital infarct.

Patient started on Tazocin. Working diagnosis was ?Cholangitis, even though all inflammatory markers where normal. AKI was mentioned in the patient notes, even though incorrect, the patient simply had a mild deterioration of renal function.

Over the next few days the medical notes indicate 'Sepsis ?source', but all inflammatory markers remain normal. It was then decided that the patient had Community acquired pneumonia, with inflammatory markers still normal and chest X-ray shows signs of CCF. Patient was switched from Tazocin to Amoxicillin.

On day 11 it was mentioned that the patient is likely End of Life, however the patient was actively managed for the next 3-4 weeks and had multiple changes in antibiotics. There was no evidence of any end of life care plan and the patient eventually died on day 21.

MRG Lessons

- Holistic care of patient was never really looked at throughout admission even though the patient had multiple admissions previously and was showing signs of clear deterioration
- The patient was diagnosed and treated for cholangitis, CAP and sepsis (and UTI) but at no stage did she have a high temperature or raised inflammatory markers
- AKI misdiagnosed
- Be careful diagnosing infections of any kind in the absence of clear evidence.
- End of life was mentioned on day 11 however there was no palliative care involvement or end of life care plan put in place. In addition the patient received 3-4 weeks of active treatment. Once end of life care decision has been made, palliative care involvement should be considered. This can be helpful in increasing confidence, allowing acute care to stop and palliative care to start.
- Multiple areas in patient notes using the term 'Impression' which is unusable to coders as a diagnosis. Please use one of the following terms: 'working diagnosis', 'probably' or 'presumed'.

This is a very common presentation to the Mortality Review Group. It is recognised that it is not easy to be sure that a patient is reaching end of life however the palliative care team have been very helpful in advising and helping where this is an uncertainty.

Palliative care contacts: Alison Coackley – Palliative Care Consultant (alison.coackley@nhs.net), Judith Raper – Palliative Care Consultant (judith.raper@nhs.net), Gwen Waller – Palliative Care Nurse (gwen.waller@nhs.net)

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/131**
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined Report for Q1&2 - April – September 2020**
DATE OF MEETING:	25 November 2020
AUTHOR(S):	Mark Tighe, Guardian of Safe Working
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first 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)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #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):*	The report covers Q1 and Q2 of the current financial year 2020-2021. This is because Q1 was a turbulent time for the Trust, which was reflected in very low numbers of Exception Reports submitted by the medical trainee; the 8 ERs were the lowest seen since the ER system on Allocate was introduced. Q2 reporting has returned to more normal levels, with 47 during this period mainly from FY1 doctors and half from general surgery, as the workload picked up in this specialty post phase 1 lockdown. There are a large number of ERs still open (n=56) and there is a constant emphasis in the need to have reports signed off by the Educational Supervisors. The Trust has become more rigid in not permitting compensatory payment or TOIL after 2 weeks, if there has been no attempt to contact the supervisor following a report. Whilst the Trust encourages exception reporting (to highlight persistent issues in training or workload of our juniors), it is important that trainees realise that they must be signed off if compensation is to be awarded.

	Two 'Immediate Safety Concerns' were raised by the urology trainees which were addressed quickly. One work schedule review is planned for Ophthalmology ST3+ trainees. No fines were submitted by the Guardian in Q1 or Q2. To conclude, the trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in line with safe working hours in our organisation. Persistent issues are dealt with in a timely manner.			
PURPOSE: ***(please select as appropriate)***	**Information**	**Approval**		
RECOMMENDATION:	Please note the findings of the report and consider the assurances made accordingly. The Committee are requested to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients. Any concerns that the Committee have should be reported back to the Guardian of Safe Working for his attention, consideration and actions accordingly.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/20/11/97		
	Date of meeting	18.11.20		
	Summary of Outcome	Noted and approved.		
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Guardian of Safe Working for Junior Doctors - Combined Report for Q1&2 – April – September 2020	AGENDA REF:	BM/20/11/131

1. BACKGROUND/CONTEXT

Junior Doctors Contract 2016

The Terms & Conditions of the 2016 Junior Doctor Contract are well-established at WHH. Whilst rotas are fully compliant, work schedule reviews can be undertaken if there appear to be persistent problems with individual rotas. Most medical trainees will engage with their Consultants, Educational Supervisors (ES) and the Guardian of Safe Working (GSW) if any new issues develop. The Junior Doctors Forum (JDF) is held bi-monthly and attended by Dr Alex Crowe – Executive Medical Director (EMD), Dr Alison Coackley, Director of Medical Education (DME), Mr Mark Tighe, the Guardian of Safe Working Hours for the Trust and Medical Education representatives.

The GoSW attends the Regional Guardian Forum, and confirms that the Trust is working in alignment with other surrounding Trusts.

As part of the 2016 Contract for Junior Doctors, the Trusts GoSW is required to submit data to the Lead Employer and the data is present quarterly to the St Helens and Knowsley Hospitals Trust Board; this report relates to the number of trainees hosted by WHH on the 2016 contract.

Junior Doctors on the 2002 Contract

It is important to remember that the vast majority of the Junior Doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contract. However, some will retain the 2002 pay protection until the end of their Training Contract. The Trust remains cognisant of a recent Case Law (Hallett vs Derby) which affects Trust's using Allocate for monitoring exercises; a further update will be provided in due course.

2. KEY ELEMENTS

For the purpose of this update, and because of the highly unusual work patterns within a pandemic situation, it was decided to amalgamate Q1 and Q2 into a single report

Quarter	Reporting Period	Deadline for Data Provided by the Host
Q1 Report	1st April 2020	30th June 2020

Reporting Time Period:	1st April - 30th June 2020
Trust Name:	Warrington & Halton Teaching Hospitals NHS Foundation Trust
Guardian of Safe Working Hours Name:	Mr Mark Tighe
GOSW Email Address:	mark.tighe@nhs.net
No. of doctors/dentists in training (total)	192
No. of doctors/dentists in training on the 2016 contract TCS (total)	192
No. of lead employer trainees on the 2016 contract at your Trust	120
Amount of time available in job plan for Guardian to do the role	1.5 PA's
Admin support provided to the Guardian (if any)	Under review
Amount of job-planned time for educational supervisors	0.25 PA's per trainee

Exception Reports (ER) over past quarter	
Reference period of report	01/04/20 - 30/06/20
Total number of exception reports received	8
Number relating to immediate patient safety issues	0
Number relating to hours of working	7
Number relating to pattern of work	0
Number relating to educational opportunities	1
Number relating to service support available to the doctor	0

***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	12
Total number of overtime payments	5
Total number of work schedule reviews	0
Total number of reports resulting in no action	9
Total number of organisation changes	0
Compensation	0
Unresolved	35
Total number of resolutions	**26**
Total resolved exceptions	**26**

***Note**:*
** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*
** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*
** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

Reasons for ER over last quarter by specialty & grade						
ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate	General surgery	FY2	4	0	0	0
Total			**4**	**0**	**0**	**0**
No. relating to hours/pattern	Acute Medicine	Foundation house officer 1	2	2	1	3
	Acute Medicine	FY1 *	0	2	0	2
	Cardiology	Foundation house officer 1	1	0	1	0
	Gastroenterology	Foundation house officer 1	8	0	4	4
	Gastroenterology	ST3	0	0	0	1
	Gastroenterology	ST6	0	0	0	1
	General surgery	Foundation house officer 1	19	0	8	11
	General surgery	FY1 *	5	0	0	5
	General surgery	FY2	4	0	0	0
	Geriatric medicine	Foundation house officer 1	2	0	1	0
	Paediatrics	Foundation house officer 1	0	2	2	0
	Paediatrics	ST1 *	0	0	0	1
	Respiratory Medicine	Foundation house officer 1	6	0	6	2
	Respiratory Medicine	ST3	2	1	3	0
	Trauma & Orthopaedic Surgery	Foundation house officer 1	1	0	0	1
	Traumatic & orthopaedic surgery	FY1 (2016)	0	0	0	1
	Urology	Foundation house officer 1	1	0	0	1
Total			**51**	**7**	**26**	**33**
No. relating to educational	Acute Medicine	Foundation house officer 1	0	1	0	1
	General surgery	Foundation house officer 1	1	0	0	1
Total			**1**	**1**	**0**	**2**
No. relating to	Obstetrics and gynaecology	ST3 *	1	0	0	0
Total			**1**	**0**	**0**	**0**

In the 1st Quarter (Q1) of this financial year, there were just 8 Exception Reports (ERs) recorded. This is the lowest number recorded in any quarterly period. This obviously related to the ongoing national crisis, and was to the great credit of our trainees, that they worked tirelessly and without complaint during this exceptional time. Undoubtedly, access to training was greatly reduced, especially in surgical specialties, but they were prepared to accept this, and work where they were required.

Quarter	Reporting Period	Deadline for Data Provided by the Host
Q2 Report	**1st July 2020**	**30th September 2020**

Quarterly Report on Safe Working Hours Data	
Reporting Time Period:	1st July – 30th September 2020
Trust Name:	Warrington & Halton Teaching Hospitals NHS Foundation Trust
Guardian of Safe Working Hours Name:	Mr Mark Tighe
GOSW Email Address:	mark.tighe@nhs.net
No. of doctors/dentists in training (total)	192
No. of doctors/dentists in training on the 2016 contract TCS (total)	192
No. of lead employer trainees on the 2016 contract at your Trust	120
Amount of time available in job plan for Guardian to do the role	1.5 PA's
Admin support provided to the Guardian (if any)	Under review
Amount of job-planned time for educational supervisors	0.25 PA's per trainee
Exception Reports (ER) over past quarter	

Reference period of report	01/07/20 - 01/10/20
Total number of exception reports received	47
Number relating to immediate patient safety issues	2
Number relating to hours of working	36
Number relating to pattern of work	5
Number relating to educational opportunities	5
Number relating to service support available to the doctor	1

***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	6
Total number of overtime payments	14
Total number of work schedule reviews	0
Total number of reports resulting in no action	0
Total number of organisation changes	0
Compensation	0
Unresolved	56
Total number of resolutions	**20**
Total resolved exceptions	**20**

***Note**:*
** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*
** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*
** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

Reasons for ER over last quarter by specialty & grade						
ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate	Cardiology	Foundation house officer 1	0	2	2	0
Total			**0**	**2**	**2**	**0**
No. relating to hours/pattern	Acute Medicine	Foundation house officer 1	3	5	5	3
	Acute Medicine	FY1	0	1	0	1
	Acute Medicine	FY1 *	2	0	0	2
	Anaesthetics	CT1	0	1	0	1
	Cardiology	Foundation house officer 1	0	2	2	0
	Cardiology	FY1	0	3	3	0
	Gastroenterology	Foundation house officer 1	4	0	0	4
	Gastroenterology	FY2	0	1	0	1
	Gastroenterology	ST3	1	0	0	0
	Gastroenterology	ST6	1	0	0	0
	General surgery	Foundation house officer 1	11	0	0	11
	General surgery	FY1	0	9	0	9
	General surgery	FY1 *	5	0	0	5
	Geriatric medicine	FY1	0	5	1	1
	Ophthalmology	ST3	0	4	0	4
	Paediatrics	ST1 *	1	0	0	0
	Psychiatry	FY1	0	2	0	2
	Respiratory Medicine	Foundation house officer 1	2	0	2	0
	Respiratory Medicine	FY1	0	2	2	0
	Trauma & Orthopaedic Surgery	Foundation house officer 1	1	0	0	1
	Trauma & Orthopaedic Surgery	FY2	0	3	3	0
	Trauma & Orthopaedic Surgery	FY2 *	0	2	0	2
	Traumatic & orthopaedic surgery	FY1 (2016)	1	0	1	0
	Urology	Foundation house officer 1	1	0	0	1
	Urology	FY1	0	1	0	1
Total			**33**	**41**	**19**	**49**
No. relating to educational opportunities	Acute Medicine	Foundation house officer 1	1	0	0	1
	Cardiology	Foundation house officer 1	0	1	1	0
	Gastroenterology	CT1	0	1	0	1
	General surgery	Foundation house officer 1	1	0	0	1
	General surgery	FY1	0	1	0	1
	Trauma & Orthopaedic Surgery	FY2 *	0	1	0	1
	Urology	FY1	0	1	0	1
Total			**2**	**5**	**1**	**6**
No. relating to	Anaesthetics	CT1	0	1	0	1
Total			**0**	**1**	**0**	**1**

In Quarter 2 (Q2) there was an increase in ERs to 47, which reflects a return to normal reporting for a three month period.

The majority of the ERs still relate to Foundation Doctors working past their allocated time, usually on an ad-hoc basis. Interestingly, these have occurred primarily in General Surgery**,** followed by Medicine during the two quarters.

Summary of Q1 & Q2 Exception Reports

The majority of ERs have been submitted by FY1 doctors (80%) reflecting the busy workload of our junior trainees on the wards. More have been received from General Surgery than Medicine, which partly reflects the variable work patterns of the surgical specialties.

Over 80% of ERs relate to excess hours worked. Trainees have commented that they have to stay late to complete ward duties or review and manage sick inpatients, which they feel they cannot hand over to the on-call teams. This is entirely understandable and predictable, although routine duties should not need to be done out of hours generally.

Six ERs were submitted as missed educational opportunities; almost invariably due to a busy ward workload preventing teaching opportunities to trainees.

Two ‘Immediate Safety Concerns’ were noted from urology F1s. The juniors felt unsupported by a couple of the middle grade urologists, and were left managing patients and feeling out of their depth. This is being addressed with regular meetings with the consultant urologists, and further appointments will hopefully help in this regard.

It can be confirmed that all Foundation Programme Doctors employed during Q1&2 were well on track to progress through their current year of training.

Concerns remain that there is a significant delay in the review meetings between the ES and Junior Doctor, once an ER has been submitted. 56 ERs remain outstanding at the end of Q2. The need for sign-off of ERs is continually reinforced to our trainees at the Junior Doctors Forum and at their Trust Induction.

Any difficulties with the sign-off process are escalated to the Medical Education Service and/or the Guardian of Safe Working for action.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Guardian of Safe Working is satisfied that the junior doctors working at WHH on rotation are happy with their compliant rotas, accepting the fact that it is the nature of their job that they will have to stay beyond their hours at times, particularly if they have patients who are unwell or have a higher volume of work. The main issue with Exception Reporting at WHH is the delay in achieving reports sign-off. Some supervisors are slow to respond when in receipt of ERs, but the junior doctors on occasion do not sign off the report once the exception meeting has taken place. Medical Education and the GoSW will look to implement a system of escalation to encourage timely ER sign off.

Issues raised by juniors in receiving time off to complete mandatory training (MT) have been addressed and can be evidenced in the ERs submitted, as well as compliance rates for MT completion. It is a Trust requirement for mandatory training to be undertaken within 4 weeks of commencement of post. If this has not been achieved, junior doctors are contacted to ensure completion within 2 weeks. If they are unable to complete the training in rostered time due to work commitments, they will be eligible for compensatory Time Off in Lieu (TOIL) or payment following submission of an Exception Report.

Whilst there have been no work schedule reviews in Q1 or Q2, there has been a problem however flagged with Ophthalmology ST3+ non-resident on-call rotas. They are not currently paid to attend wards or the Emergency Department (ED) during the out of hour's period for emergencies. For example, they are often resident for over 8 hours on the weekend which is not currently remunerated. A meeting has been arranged with the rota manager and CBU lead to correct this.

No further issues have been raised relating to break times in ED.

4. IMPACT ON QPS?

The Medical Workforce is an invaluable asset to the Organisation. The Guardian of Safe Working Hours has been introduced to protect patients and doctors by making sure doctors are not working unsafe hours. The **guardian** will: act as the champion of safe working hours for doctors in approved training programmes.

5. MEASUREMENTS/EVALUATIONS

Exception Reports submitted annually to Lead Employer 2020

Quarterly Report on Safe Working Hours Data		
Reporting Time Period:		October 2019 - December 2019
Trust Name:		Warrington & Halton Teaching Hospitals NHS Foundation Trust
Guardian of Safe Working Hours Name:		Mr Mark Tighe
GOSW Email Address:		mark.tighe@nhs.net
No.of doctors/dentists in training (total)		195
No.of doctors/dentists in training on the 2016 contract TCS (total)		166
No. of lead employer trainees on the 2016 contract at your Trust		92
Amount of time available in job plan for Guardian to do the role		2 PA's
Admin support provided to the Guardian (if any)		Under Review
Amount of job-planned time for educational supervisors		0.25 PA's per Trainee

	Exception reports								Work Schedule Reviews								Fines by department	
Specialities	No.at CT1/2 Level		No.at ST3+ Level		No. given TOIL or payment			No. that are on-going	No.at CT1/2 Level		No.at ST3+ Level		No. given TOIL or payment			No. that are on-going	No.of fines levied	Values of fines levied
	Raised	Closed	Raised	Closed	TOIL	Payment	Other - Please Specify		Raised	Closed	Raised	Closed	TOIL	Payment	Other- Please Specify			
General Surgery (Inc HPB/OG/CR)																		
Urology																		
Gynaecology & obstretrics			1					1										
Orthopaedics																		
Vascular																		
ENT/ Head & Neck			1					1										
Plastics (Inc. Burns)																		
Neuro																		
Cardiothoracic																		
Maxillofacial																		
Transplant																		
Anaesthetics																		
ITU																		
Paediatrics	1							1										
Aemergency medicine (A&E)																		
General medicine (AMU)																		
Cardiology																		
Respiratory																		
Gastroenterology			1					1										
Nephrology																		
Endocrinology (Inc. Diabetes)																		
Neurology																		
Stroke Medicine																		
Elderly care																		
Ophthalmology																		
Dermatology																		
Oncology																		
Haematology																		
Chemical / Histopathology																		
Microbiology																		
Radiology																		
Other (e.g. Psychiatry)																		

*If you have any additional comments, issues arising or concerns then please fully detail in the section below

We are continuing to communicate with our educational superivsors and trainees to improve our response rates

6. TRAJECTORIES/OBJECTIVES AGREED

The Medical Education Service will continue to run month-end Exception Reports to identify those that have not been signed-off to improve turnaround times in accordance with the NHS Employers timelines as follows:

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every Exception Report submitted, for either payment or TOIL, the Educational Supervisor is required to respond within 7 days.
4. The Trainees are required to indicate their 'acceptance' or 'escalate' to the next stage (i.e. Level 1 Review). It is only following confirmation of acceptance, that the Exception Report can be closed.

The GoSW will be provided with timely data to support undertaking of the role in the coming year, with particular reference to improvement in response times for ERs.

7. MONITORING/REPORTING ROUTES

Copies of the Guardian of Safe Working Hours' Reports, both the Quarterly and Annual Reports should also be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in the Trust's Annual Quality Account and signed off by the Chief Executive; the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

It is also normal practice for the Trust's Executive Committee (Strategic People Committee) to have sight of any reports before they are submitted to the Board.

It is good practice to share a copy of the report with the Junior Doctors Forum of the employing/Host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

8. TIMELINES

SPC – Strategic People Committee
Guardian of Safe Working - Quarterly Reports, Safe Working Hours Jnr Doctors in Training:-

- (Q1 – end of June 2020) – submitted November 2020
- (Q2 – end of Sept 2020) – submitted November 2020
- (Q3 - end of Dec 2019) – to be submitted January 2021
- (Q4 – end of March 2020) – to be submitted May 2020

Trust Annual Board Report
Guardian of Safe Working Annual Report, Safe Working Hours Jnr Doctors in Training:-

- submitted May 2020

9. ASSURANCE COMMITTEE

N/A

10. RECOMMENDATIONS

The report covers Q1 and Q2 of the current financial year 2020-2021. This is because Q1 was a turbulent time for the Trust, which was reflected in very low numbers of Exception Reports submitted by the medical trainee; the 8 ERs were the lowest seen since the ER system on Allocate was introduced.

Q2 reporting has returned to more normal levels, with 47 during this period mainly from FY1 doctors and half from general surgery, as the workload picked up in this specialty post phase 1 lockdown.

There are a large number of ERs still open (n=56) and there is a constant emphasis in the need to have reports signed off by the Educational Supervisors.

The Trust has become more rigid in not permitting compensatory payment or TOIL after 2 weeks, if there has been no attempt to contact the supervisor following a report. Whilst the Trust encourages exception reporting (to highlight persistent issues in training or workload of our juniors), it is important that trainees realise that they must be signed off if compensation is to be awarded.

Two Immediate Safety Concerns were raised which were addressed quickly in the urology specialism.

One work schedule review is planned for Ophthalmology ST3+ trainees.

No fines were submitted by the Guardian in Q1 or Q2.

To conclude, the trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in line with safe working hours in our organisation. Persistent issues are dealt with in a timely manner.

Please note the findings of the report and consider the assurances made accordingly. The GSW can attend subsequent board meetings if any queries or concerns are raised.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/132**
SUBJECT:	**Trust Engagement Dashboard**
DATE OF MEETING:	25th November 2020
AUTHOR(S):	Pat McLaren, Director of Communications & Engagement
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first 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):	#145 (a) Failure to deliver our strategic vision.
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Dashboard is for the period 2020 Q2 Jul-Sept and addresses: - Level of success in managing the Trust's reputation in the media and across digital and social platforms - Our engagement with patients, staff and public via our social media channels - The Trust's website and levels engagement with this key platform - Patient enquiries via our website - Patient/public feedback on the independent platforms - Engagement with the Trust through the Freedom of Information process. **Key items to note in Q2** • **Media** – while Covid-19 continued to dominate the global news agenda, our local and regional media remained keenly interested in our COVID data. For transparency, we now publish this on our website on weekdays making access a simple process for media colleagues. Media sentiment remained largely neutral, ie where media reported on Covid statistics, however the Trust pressed ahead with key strategic projects which drew positive attention. • **Twitter** – Followers continue to climb steadily to 11.9K with engagements reaching 160K • **Facebook** likes again surged to circa 9K - both Facebook and Twitter channels were extensively used to promote Public Health England Covid-19 messaging. • **Website visitors** varied reaching 40K in September, Visitors continued to access via a mobile platform. • **Website enquiries** – we dealt with 886 patient enquiries through our website • **Patient Feedback:** remains lower than normal with just 20 reviews posted in the quarter, predominately positive • **Freedom of Information Requests** (FOI) Supported by the Information Commissioner, the processing of FOIs during the pandemic was paused to ensure front line staff were not

	distracted from providing patient care. The Trust recommenced processing FOIs in July 2020 continues to focus on clearing the backlog to achieve real-time processing FOIs within the standard 20 working day timeline. • **WHH Charity** – for the first time we include WHH Charity data in our dashboard. Both website and social traffic is significantly lower for our charity but a project to host WHH Charity on the trust's website is underway with the aim of integrating and benefiting from the large footfall and engagement seen by the Trust's more accessible and established platforms.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Board is requested to receive and note the Trust's engagement dashboard for Q1.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors		
	Agenda Ref.	COG/20/11/56		
	Date of meeting	12 November 2020		
	Summary of Outcome	Received and noted.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

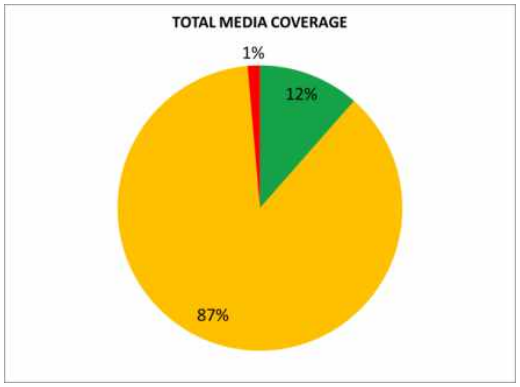
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Engagement Dashboard

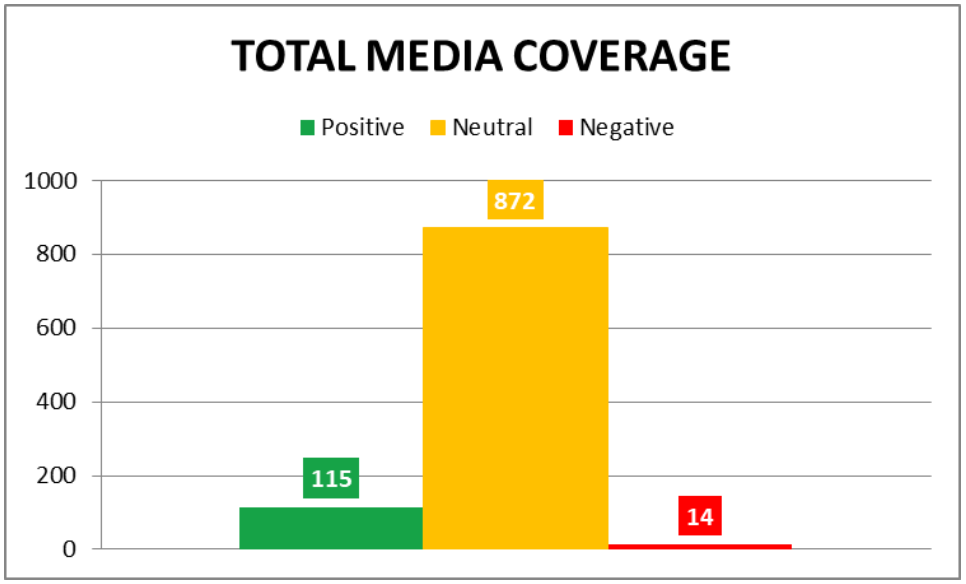
Q2: July 2020 – September 2020

Media Summary: Q2

Media top stories



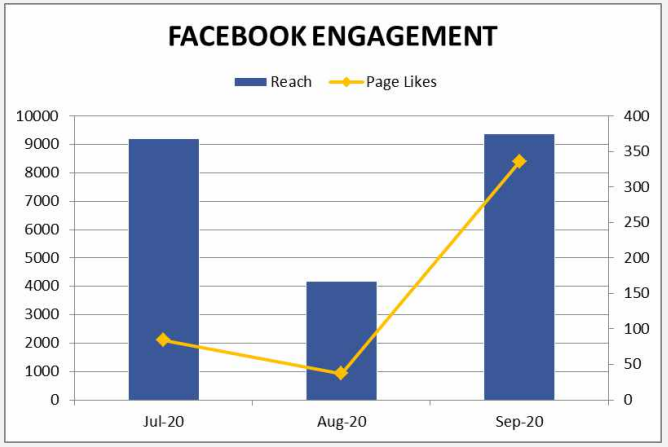
Covid-19 cases and RIPs continued to dominate media reporting in the quarter, each assigned a 'neutral' rating.

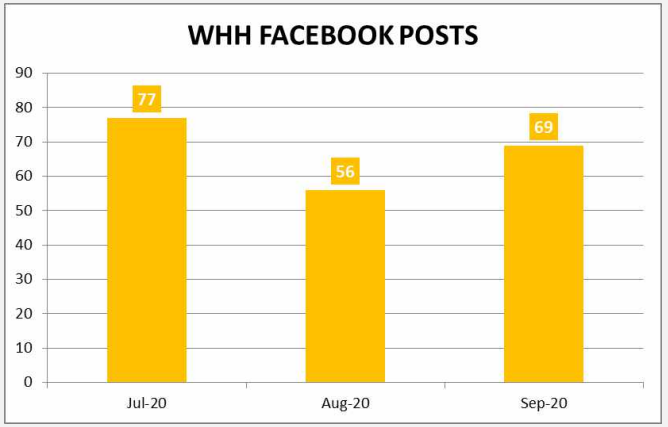


Top positive media	Reach	publication
£300million funding for NHS hospitals	89,545,580	Daily Mail
HOSPITAL chiefs discussed plans for a new hospital with the health minister	6,720,707	Liverpool Echo
Spitfire Flyover NHS Thank You	903,152	Stoke Sentinal
Castleford Tigers' winger praises care at Warrington Hospital A&E	815,145	Yorkshire Post
Appleton man makes £51,000 donation	549,456	Warrington Guardian
How Warrington Hospital coped with coronavirus – and what it plans next	549,456	Warrington Guardian
Warrington Hospital nominated for innovation award thanks to coronavirus ingenuity	466,967	Warrington Guardian
Call NHS 111 to book appt at ED	466,967	Warrington Guardian
Top Negative media	**Reach**	**publication**
DNAR on patient record	50,709,531	Independent
Coronavirus deaths	6,488,418	Liverpool Echo
One in four Staff sickness at Cheshire trusts was because of the virus	582,304	Chester Chronicle
LETTER: 'I went to A&E and nobody was following coronavirus protocols'	466,967	Warrington Guardian

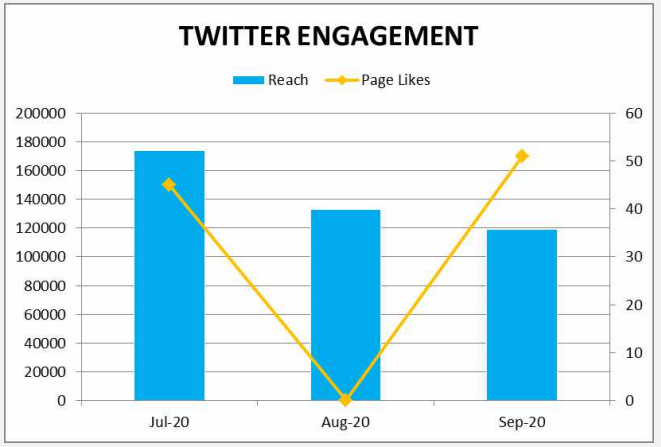
WHH Social Media: Q2

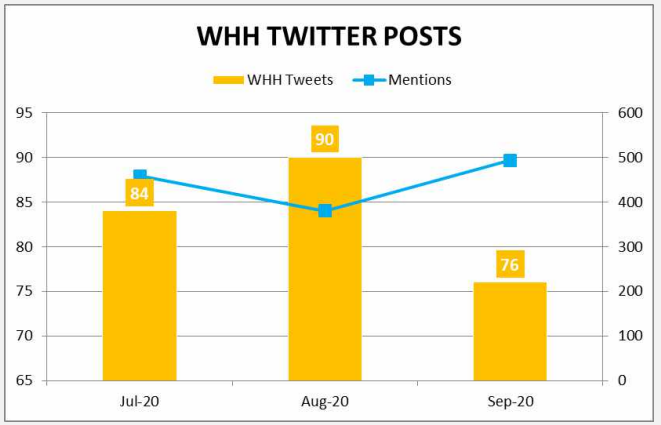
TOTAL FACEBOOK FOLLOWERS
9,698



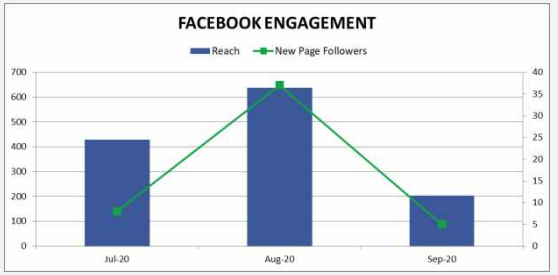


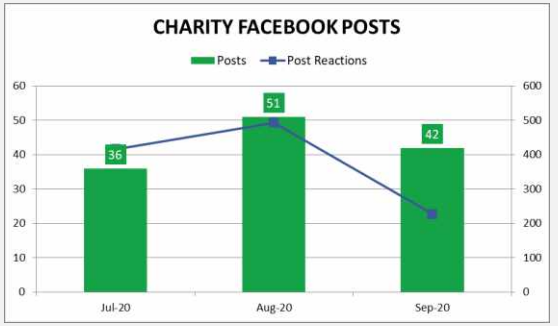
TOTAL TWITTER FOLLOWERS
11,943

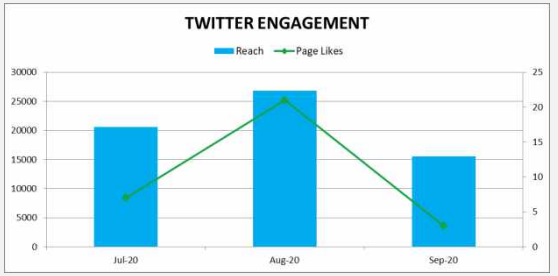


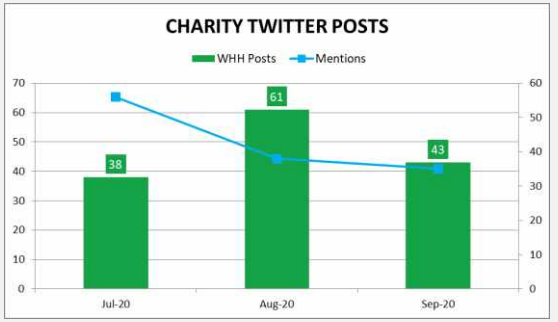


WHH CHARITY SOCIAL MEDIA ANALYTICS

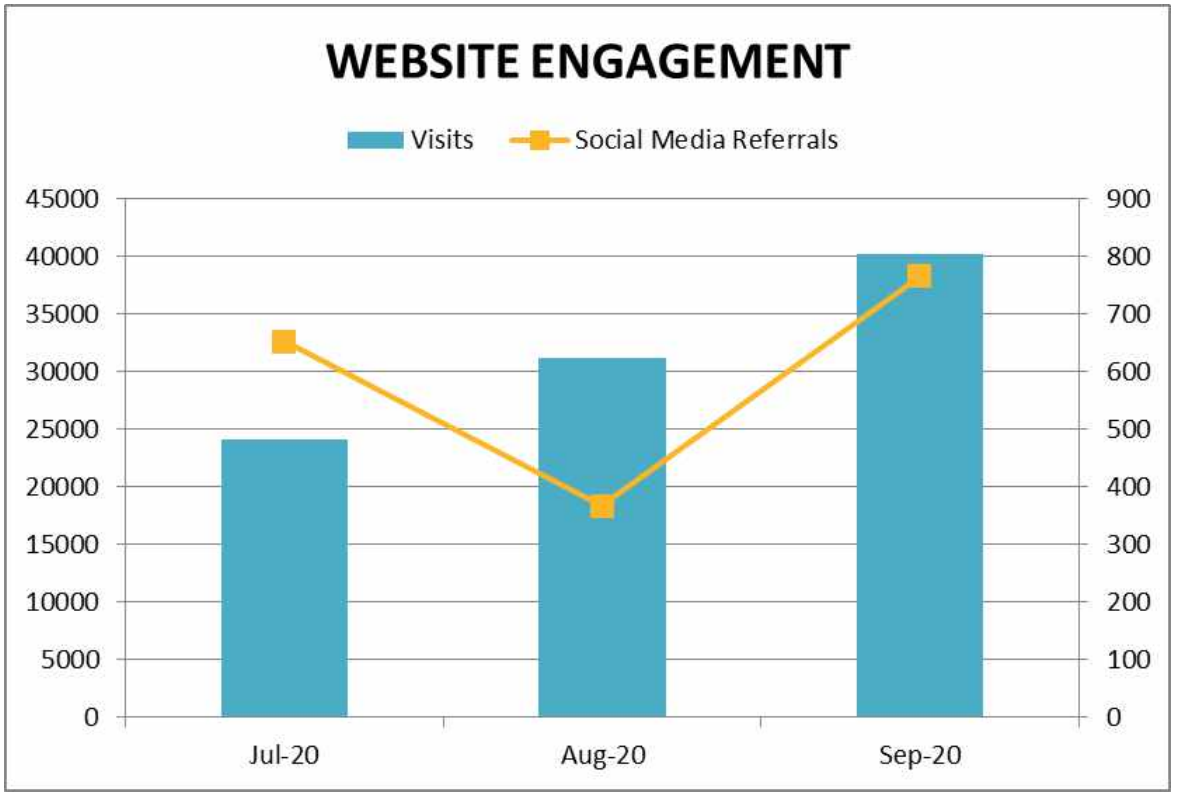


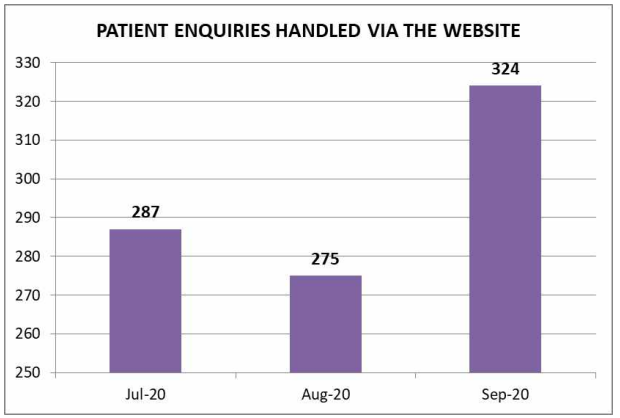


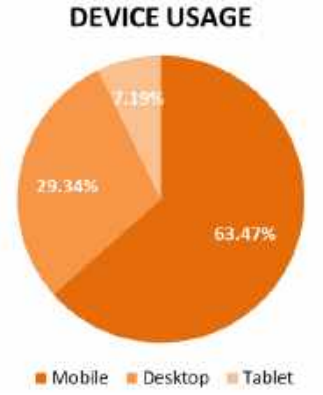




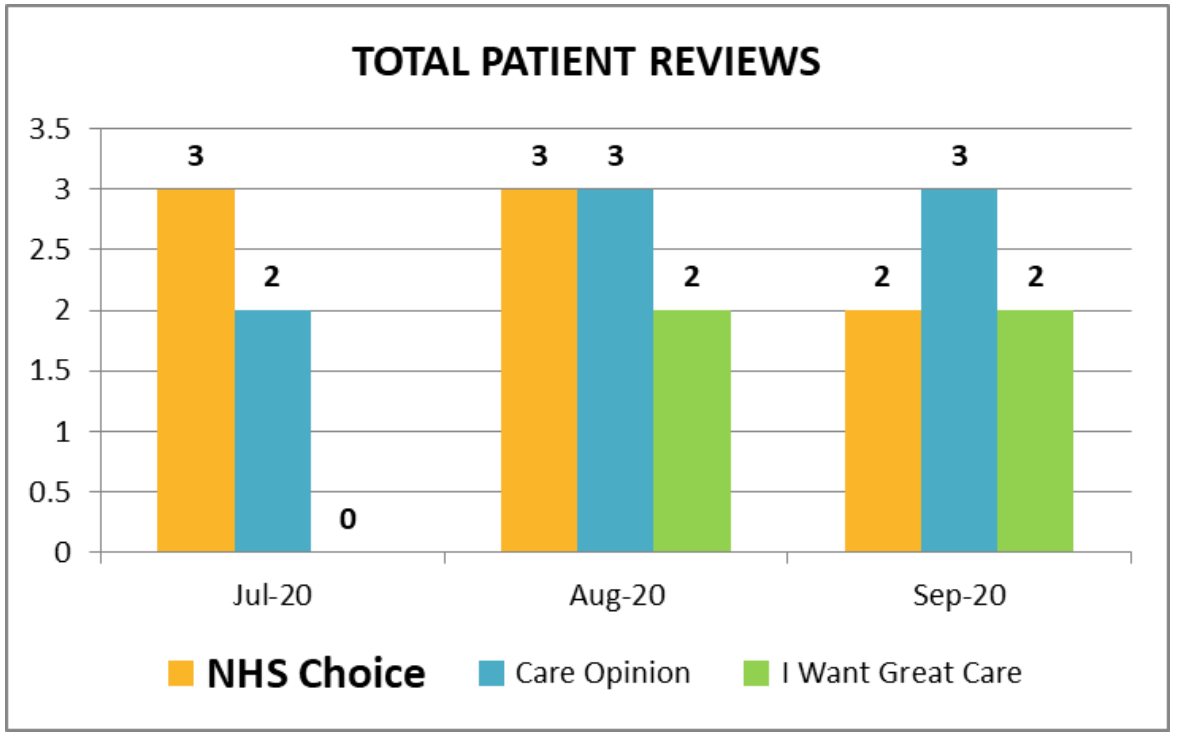
WHH Website: Q2





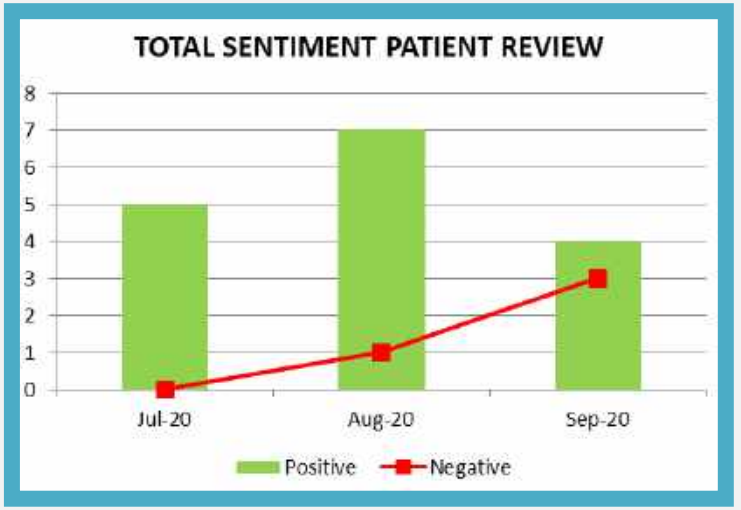


Patient Experience: Q2



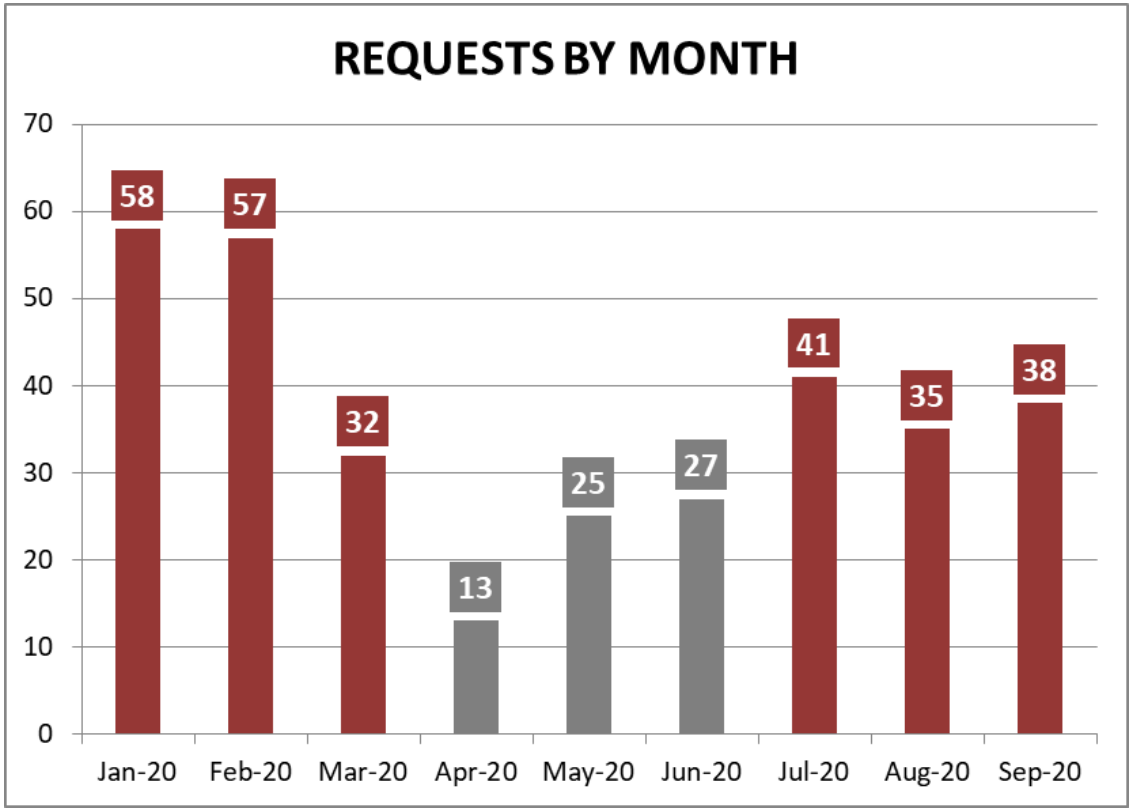
TOTAL ONLINE PATIENT FEEDBACK

20



Freedom of Information update: January – September 2020

The FOI process was paused due the COVID-19 pandemic on 19th March 2020.
FOI processing re-commenced on 14th July 2020.
Numbers in brackets indicate Q1 data



TOTAL REQUESTS to date
326

CURRENTLY IN PROCESS
124 (177)

OVERDUE
93 (87)

FOIs COMPLETED OVER THE 20 WORKING DAY DEADLINE
77(26)

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/20/11/133	
SUBJECT:	**Use of Resource Assessment (UoRA) Update – Q2 2020/21**	
DATE OF MEETING:	25th November 2020	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer and 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.	x 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. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #135 Failure to provide adequate and timely IMT system. #125 Failure to maintain an old estate. #145 (a) Failure to deliver our strategic vision. #145 (b) Failure to fund two new hospitals. #241 Failure to retain medical trainee doctors.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust continues to progress improvement in its Use of Resources both internally and in collaboration with system wide partners, however COVID-19 has impacted progress. The Trust Board agreed at the meeting in July 2020 to streamline the previous Lord Carter/Use of Resources report to focus on Use of Resources. Therefore, this is the first report in the new format.	

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

RECOMMENDATION:	The Board of Directors is asked to: 1. Note the contents of this report.	
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)***	Choose an item.	

REPORT TO THE BOARD OF DIRECTORS

SUBJECT	Use of Resource Assessment (UoRA) Update – Q2 2020/21	AGENDA REF:	BM/20/11/134

1. BACKGROUND/CONTEXT

The Use of Resource Assessment (UoRA) is designed to improve understanding of how effectively and efficiently the Trust uses its resources. The UoRA is based on 5 key lines of enquiry (KLOEs) these are; clinical services, people, clinical support services, corporate services and finance. The UoRA workstream has prepared a narrative for each KLOE and has developed a dashboard. This forms the basis from which to review and improve each KLOE indicator.

UoRA data is from the Model Hospital and has been benchmarked against peer and national median groups. The RAG rating is based on the Trust's position against the national median on the model hospital. The peer median group is based on NHSI's peer finder tool.

2. KEY ELEMENTS

This paper presents the update for Quarter 2. Progress has been impacted by the COVID-19 pandemic. Performance against each UoRA KLOE is set out in **Appendix 1**, the full detail for each KLOE indicator and associated actions can be found in **Appendix 2**.

UoRA National Status

UoRA inspections continue to be suspended nationally in response to COVID-19. The Model Hospital is now being updated with some monthly and quarterly indicators. However annual indicators have not been updated in some time, with data from 2018/19 still being displayed. At this time, there are no timescales when the inspections will resume or the format future inspections will take given the potential impact of additional costs, resources and the reduction in activity that has been required as part of the COVID-19 response.

The Trust re-started the Use of Resources Group in October 2020, however due to operational pressures the meeting in November had to be cancelled.

3. RECOMMENDATIONS

The Board of Directors is asked to:

1. Note the contents of this report.

Andrea McGee
Chief Finance Officer and Deputy Chief Executive
18th November 2020

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21
KLOE 1 - Clinical										
Pre Procedure Elective Bed Days	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21
Pre Procedure Non Elective Bed Days	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21
Emergency Readmission (30 Days)	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21
Did Not Attend (DNA) Rate	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21
KLOE 2 - People										
Staff Retention Rate	March 2018	June 2018	September 2018	December 2018	December 2018	December 2018	December 2018	March 2020	March 2020	June 2020
Sickness Absence Rate	February 2018	May 2018	August 2018	November 2018	November 2018	June 2019	October 2019	March 2020	March 2020	June 2020
Pay Costs per Weighted Activity Unit	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	This indicator has been moved to a "Legacy" area of the model hospital and is no longer being updated.		
Medical Costs per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19
Nurses Cost Per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19
AHP Cost per WAU (community adjusted)	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2019/19
KLOE 3 – Clinical Support Services										
Top 10 Medicines - Percentage Delivery of Savings	March 2018	March 2018	March 2018	March 2018	March 2018	September 2019	November 2019	March 2020	March 2020	August 2020
Pathology - Overall Costs Per Test	Q2 2017/18	Q4 2017/18	Q4 2017/18	Q2 2018/19	Q2 2018/19	Q4 2018/19	Q2 2019/20	Q3 2019/20	Q3 2019/20	Q3 2019/20
KLOE 4 – Corporate Services										
Non Pay Costs per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	This indicator has been moved to a "Legacy" area of the model hospital and is no longer being updated.		
Finance Costs per £100m Turnover	2016/17	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19
Human Resource Costs per £100m Turnover	2016/17	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19
Procurement Process Efficiency and Price Performance Score Clinics	Q4 2016/17	Q4 2016/17	Q4 2017/18	Q3 2018/19	Q3 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q2 2019/20
Estates Costs Per Square Meter	2016/17	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19

KLOE 5 - Finance									
Capital Services Capacity*									
Liquidity (Days)*									
Income & Expenditure Margin*									
Agency Spend - Cap Value*									
Distance from Financial Plan*									

*the model hospital does not benchmark these indicators against the national median and therefore there is no RAG rating available.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

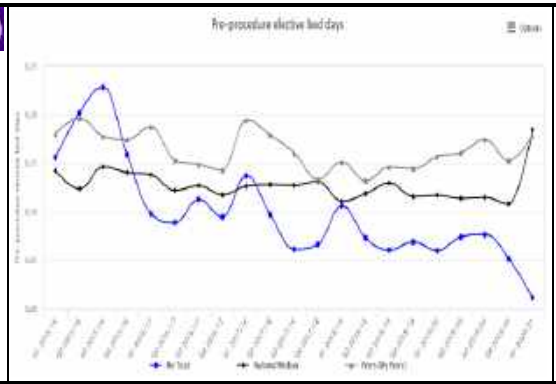
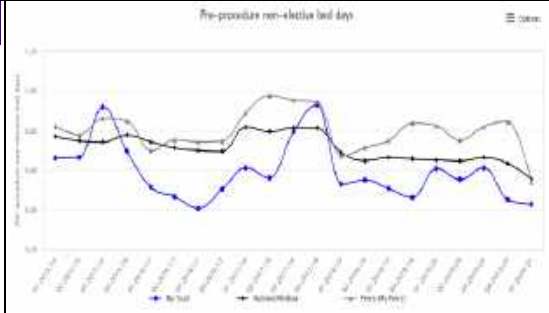
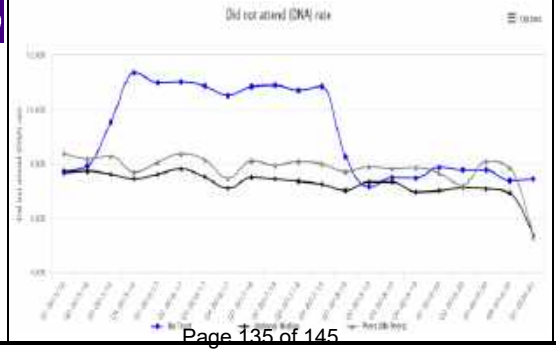
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q2 2020/21

Action/ Recommendation | **Benchmarking/Progress** | **Trend** | **Narrative - Warranted/Unwarranted & Justifiable**

KLOE 1: Clinical/Operational

KLOE Operational Lead: Hilary Stennings

Pre Procedure Elective Bed Days - The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median: 0.18 days** Q1 2020/21 **Peer Median: 0.18 days** **Target: Maintain** **Best Quartile: 0.8 days** **WHH Position:** **0.1 days** **Ranking:** **1/10 Peer Group** **Quartile:** **1 (Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing in the best quartile for this metric and is performing better than the national and peer medians.** The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency. Performance against this metric is further monitored via the Theatre Performance Dashboard. The Theatre dashboard has been enhanced using Power BI dashboards which allows a "Live" view of theatre performance and productivity. Improvements have been made during the pandemic, however this is likely due to the reduction in the elective programme and the Trust would expect to see a slight rise in the days, however the Trust was performing better than the national median prior to the pandemic.
Pre Procedure Non Elective Bed Days - The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median: 0.55 days** Q1 2020/21 **Peer Median: 0.54 days** **Target:** **Best Quartile: 0.44 days** **WHH Position:** **0.43 days** **Ranking:** **02/10 Peer Group** **Quartile:** **1 (Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing in the best quartile for this metric and is performing better than the national and peer medians**. The Trust continually reviews opportunities to improve efficiency around emergency and non elective procedures. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency. Improvements have been made during the pandemic, however this is likely due to the reduction in non elective activity and the Trust would expect to see a rise, however the Trust was performing better than the national median prior to the pandemic.
Did Not Attend Rate - Rate of patients not attending their outpatient appointment	**National Median: 5.37%** Q1 2020/21 **Peer Median: 5.31%** **Target: 5.37%** **Best Quartile: 4.34%** **WHH Position:** **7.43%** **Ranking:** **10/10 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing worse than the national and peer medians.** The Trust reintroduced a text reminder service which has resulted in a significant improvement in the DNA rate. Further improvements have been made to the text message and a communications campaign has been launched (Don't Let Me Down). DNA performance continues to be monitored through the Outpatient Steering Group. During the pandemic, the use of virtual and telephone appointments have been rapidly expanded and it is anticipated the Trust will see an improvement during future reporting periods.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

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Peer Median

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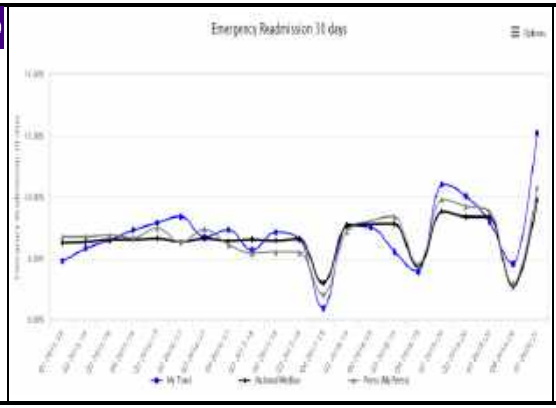
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q2 2020/21

Action/ Recommendation	Benchmarking/Progress		Trend	Narrative - Warranted/Unwarranted & Justifiable
Emergency Readmission Rates (30 Days) - This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median: 9.87%** **Peer Median: 10.30%** **Best Quartile: 8.66%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q1 2020/21** **Target: 9.87%** **12.07%** **9/10 Peer Group** **4 (Worse)**		**The Trust is performing worse than national and peer medians.** Every effort is made when discharging patients to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to review any inappropriate discharges and ensure lessons are learned. The Trust is fully engaged with GIRFT and continues to use the intelligence to make improvements in efficiencies and quality of services.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Trust Position

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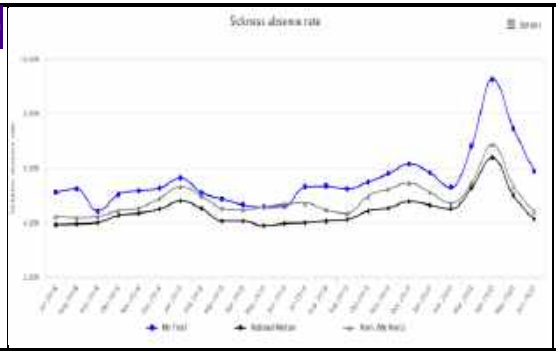
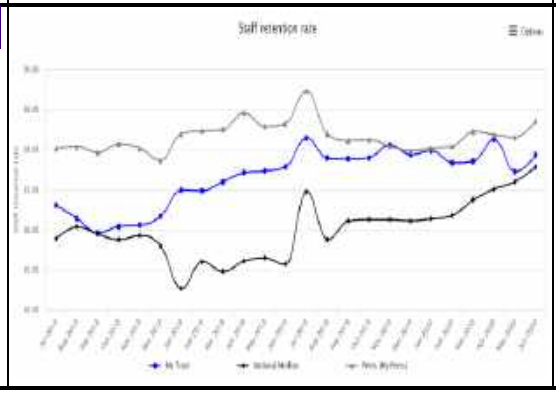
Use of Resources Assessment Dashboard - Q2 2020/21

KLOE 2: People

KLOE Operational Lead: Deborah Smith/Carl Roberts

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Staff Sickness - Percentage of staff FTE sick days.	**National Median: 4.13%** **June 2020** **Peer Median: 4.42%** **Target: 4.2%** **Best Quartile: 3.58%** **WHH Position:** **5.89%** **Ranking:** **9/10 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: Trust Board, TOB, SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national and peer medians.** Significant strategic and operational work has been undertaken to improve the position.
Staff Retention Rate - The percentage of staff that remained stable over 12 months period.	**National Median: 87.6%** **June 2020** **Peer Median: 88.7%** **Target: 89.4%** **Best Quartile: 89.4%** **WHH Position:** **87.90%** **Ranking:** **3/10 Peer Group** **Quartile:** **3 (2nd Best)** **Monitoring: SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing better than the national median.** The Trust's performance demonstrates the success of the programme of work implemented in line with the NHSI nursing retention programme. This improvement is an important factor in reducing vacancies and therefore temporary staffing costs. Improved retention with successful recruitment will directly impact on Agency Costs per WAU and other Costs per WAU. It is anticipated that the Trust's retention rate will drop slightly over the coming months, as a result of the temporary staffing whom joined the Trust as part of the response to the COVID-19 pandemic leaving their post. However, this trend will be in line with the national and peer medians.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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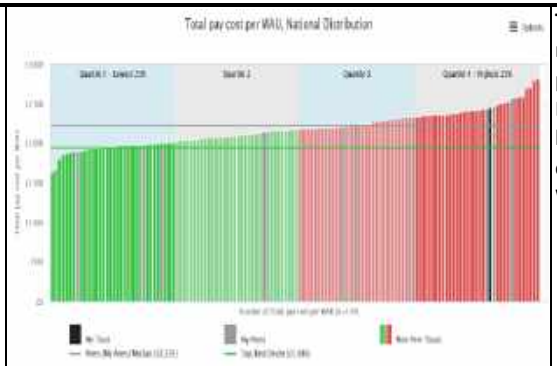
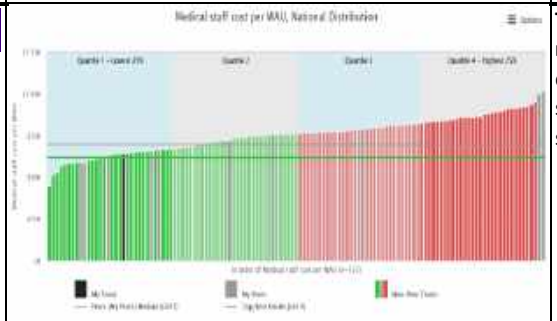
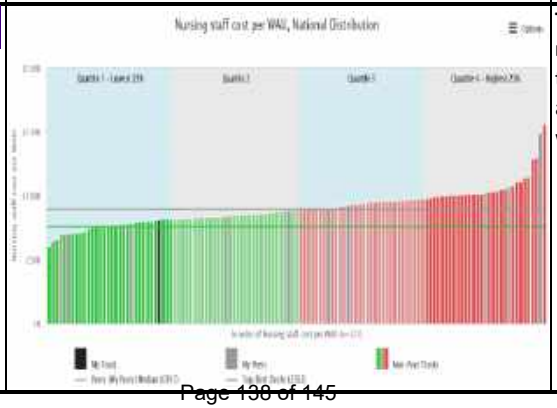
Use of Resources Assessment Dashboard - Q2 2020/21

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Pay Costs per Weighted Activity Unit - This metric shows the amount the trust spends on pay per WAU across all areas of NHS clinical activity. **This Metric is no longer being updated on the model hospital.**	**National Median: £2180** 2017/18 **Peer Median: £2312** **Target: £2312** **Best Quartile: £2014** **WHH Position:** **£2,455** **Ranking:** **9/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: Trust Board, SPC (From March 2019), FSC, TOB** **Source: Trust consolidated annual accounts and reference cost data**		**The Trusts Pay costs per WAU are worse than the national and peer median.** This metric is no longer being updated on the model hospital, however higher pay costs per WAU suggests there are opportunities to review the way we work. By reviewing our current workforce and seeking examples of where other Trusts have transformed their workforce, whilst continuing to deliver outstanding patient care, could lead to cost efficiencies. This will directly impact on Agency Costs per WAU and other Pay Costs per WAU.
Substantive Medical Costs per WAU - This metric shows the amount the trust spend on pay for medical staff per WAU across all areas of NHS clinical activity.	**National Median: £763** 2018/19 **Peer Median: £697** **Target: Maintain** **Best Quartile: £672** **WHH Position:** **£642** **Ranking:** **4/11 Peer Groups** **Quartile:** **1 (Best)** **Monitoring: SPC** **Source: ESR, Trust consolidated annual accounts and reference cost**		**The Trusts medical pay costs per WAU are better than the national and peer median**. However the large number of vacancies within this workforce will have contributed to this. As the Trust seeks to recruit to these vacant posts, we could see costs per WAU increase, however this may lead to the reduction in other areas such as agency costs.
Substantive Nursing Cost Per WAU - Total pay costs for nursing staff, adjusted for the % of Trust expenditure reported in reference costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median: £892** 2018/19 **Peer Median: £897** **Target: Maintain** **Best Quartile: £821** **WHH Position:** **£817** **Ranking:** **4/11 Peer Group** **Quartile:** **1 (Best)** **Monitoring: SPC** **Source: ESR, Trust consolidated annual accounts and reference cost**		**The Trusts Nursing Costs per WAU are better than the national and peer medians.** However again the large number of vacancies will have contributed to this. The Trust seeks to reduce reliance on temporary staffing by offering alternative retention and recruitment solutions with the expansion of the nursing workforce, advanced practice and specialist interest roles.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

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National Median	
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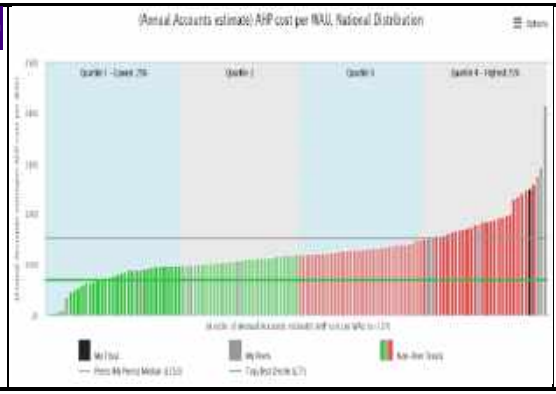
Use of Resources Assessment Dashboard - Q2 2020/21

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Substantive AHP Cost per WAU Total pay costs for Allied Health Professionals, adjusted for the % of trust expenditure reported in Reference Costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median: £121** **2018/19** **Peer Median: £153** **Target: £153** **Best Quartile: £99** **WHH Position:** **£251** **Ranking:** **08/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: SPC** **Source: ESR, Trust consolidated annual accounts and reference cost**		**The Trusts AHP Costs per WAU are worse than the national and peer medians.** Across the therapy element of AHP, pay costs for community/other work has been included in the cost per WAU calculation on Model Hospital. This indicator includes costs for staffing who are outsourced via SLA to other Trusts. This activity is not included in the WAU, if these costs were removed, the revised estimated costs per WAU would be £123 which brings the Trust in line with the national median. • For example, we have Therapists working as 'first point of contact practitioners'. Rather than seeing a GP first, patients with musculoskeletal issues are triaged by a Therapist and either discharged, treated or referred to secondary care. Also Therapy staff within RARS form part of Halton integrated community teams and the activity sits with the borough council.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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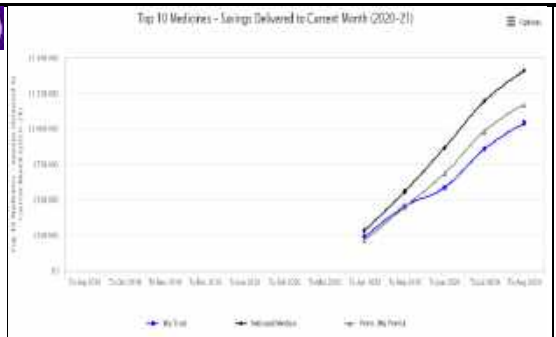
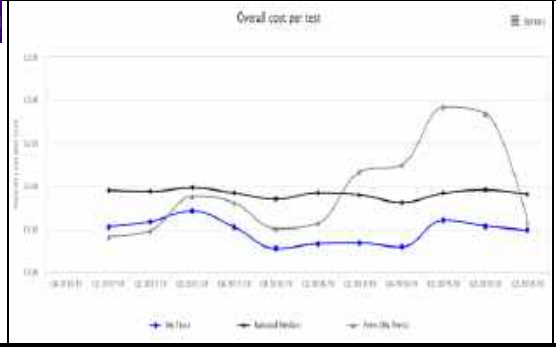
Use of Resources Assessment Dashboard - Q2 2020/21

Action/ Recommendation | **Benchmarking/Progress** | **Trend** | **Narrative - Warranted/Unwarranted & Justifiable**

KLOE 3: Clinical Support

KLOE Operational Lead: Diane Matthew
KLOE Operational Lead: Neil Gaskell
KLOE Operational Lead: Mark Jones

Top 10 Medicines - Percentage Delivery of Savings (Pharmacy)	**Benchmark: £620k** **August 2020** **Peer Median: £1.17m** **Target: Benchmark** **Best Quartile: N/A** **WHH Position:** **£1.04m** **Ranking:** **3/10 Peer Group** **Quartile:** **N/A** **Monitoring: Medicines Governance Committee** **Source: Rx-Info Define© (processed by Model Hospital)**		**The Trust is performing better than the national benchmark.** As of August 2020, the Trust has achieved £1.04m savings which is positive. The Trust continues to work with CCGs to identify opportunities for medication savings. The Trust is participating in a QIPP project to identify areas where prescribing is sub-optimal and where joint working could produce improvements/savings.
Pathology - Cost Per Test - The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median: £1.90** **Q3 2019/20** **Peer Median: £1.59** **Target: Maintain** **Best Quartile: £1.52** **WHH Position:** **£1.49** **Ranking:** **2/4 Peer Group** **Quartile:** **1 (Best)** **Monitoring: Pathology Business Meeting** **Source: NHSI Q Pathology Data Collection 19/20**		**The Trust is performing better than the national and peer medians.** Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities. It is anticipated that the cost per test will rise as a result of the COVID-19, as the number of tests performed has reduced. This will be in line with the National and Peer medians. Data collections have now resumed and the Trust has submitted up to date data including the annual position for 2019/20 and Q1 2020/21.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

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Use of Resources Assessment Dashboard - Q2 2020/21

Action/ Recommendation

KLOE 4: Corporate Services

Benchmarking/Progress

Trend

Finance
Procurement
HR & OD
Estates & Facilities
IM&T

Narrative - Warranted/Unwarranted & Justifiable

KLOE Operational Lead: Jane Hurst
KLOE Operational Lead: Alison Parker
KLOE Operational Lead: Deborah Smith/Carl Roberts
KLOE Operational Lead: Ian Wright
KLOE Operational Lead: Matthew Gardner

Non Pay Costs per WAU - This metric show the amount the trust spends on non-pay per WAU across all areas of NHS clinical activity. **This Metric is no longer being updated on the model hospital.**	**National Median: £1307** 2017/18 Peer Median: £1200 Target: Maintain **Best Quartile: £1172** **WHH Position:** £1,027 **Ranking:** 3/11 Peer Group **Quartile:** 1 (Best) **Monitoring: FSC** **Source: HSCIC - NHS Digital iView Stability Index**	UoR	**The Trusts non pay costs per WAU are better than the national and peer medians.** The Trust continues to review opportunities to reduce non-pay costs whilst maintaining quality. This indicator is no longer being updated on the model hospital.
Finance Costs per £100m Income - Total finance cost divided by trust turnover multiplied by a £100m	**National Median: £653k** 2018/19 Peer Median: £673k Target: Benchmark **Best Quartile: £541k** **WHH Position:** £838k **Ranking:** 10/11 Peer Group **Quartile:** 4 (Worse) **Monitoring: FSC** **Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template**	UoR	**The Trusts Finance costs per £100m income are worse than the national and peer medians based on national benchmarking data.** This indicator has not been updated since 2018/19, no national benchmarking has taken place for 2019/20. There has been an overall reduction in Finance costs per £100m income in 2018/19 from £852k to £839k which includes the restructure of some teams and the removal of posts. The Trust is currently above the national median based on costs per £100m income; however the absolute cost of the finance function is below the national median. There remains an issue with the way the SBS costs are treated and this has affected the position, if these costs were removed, it would bring the Trust to below the national median.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

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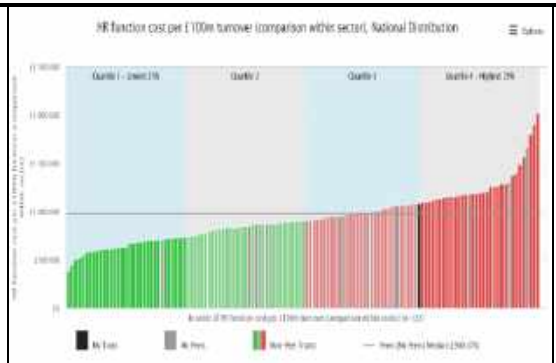
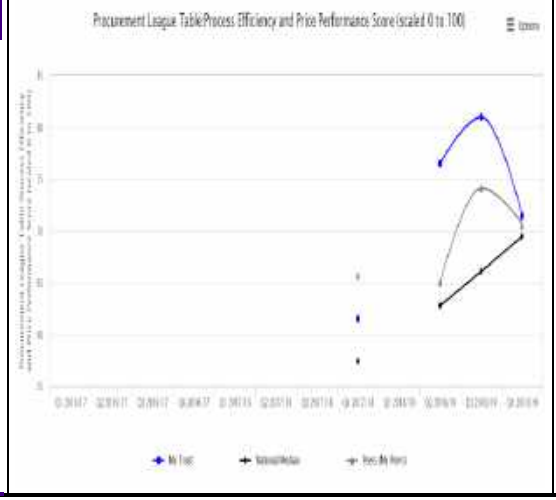
Use of Resources Assessment Dashboard - Q2 2020/21

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Human Resource Costs per £100m Income - HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median: £911k** 2018/19 **Peer Median: £980k** **Target: Benchmark** **Best Quartile: £745k** **WHH Position:** **£1.09m** **Ranking:** **8/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: SPC** **Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template**		**The Trusts HR costs per £100m income is worse than the national median based on the national benchmarking data.** This indicator has not been updated since 2018/19, no national benchmarking has taken place for 2019/20. The Trust has seen a reduction in HR costs per £100m income in 2018/19 from £1.2m to £1.1m which brings the Trust to just above the national median. Payroll costs have reduced in 2018/19 from £114k to £97k and this is below the national median with core payroll in the national best quartile. HR costs per FTE are lower than the national and peer medians, which is a fairer comparison than turnover and with the exception of Medical Staffing & Education each sub-function is also below the national median based on this.
Procurement Process Efficiency and Price Performance Score - This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.	**National Median: 56** **Q2 2019/20** **Peer Median: 44.7** **Target: 72** **Best Quartile: 72** **WHH Position:** **61** **Ranking:** **4/11 Peer Group** **Quartile:** **3 (2nd Best)** **Source: Purchase Price Index and Benchmark (PPIB) tool**		**The Trust is better the national median for Procurement Process Score.** Contributing to the League Table position is the use of EDI (Electronic Transfer of Orders and Invoices). The Trust has never used an external supplier to manage it's catalogues which is contributing factor in the use of EDI; the Trust manages its own catalogues resulting in the performance against the use of EDI being lower. The Trust is however, moving to Edge for Health (this has been suspended due to COVID-19) which will improve the EDI metric and therefore contribute to the Procurement League Table ranked position.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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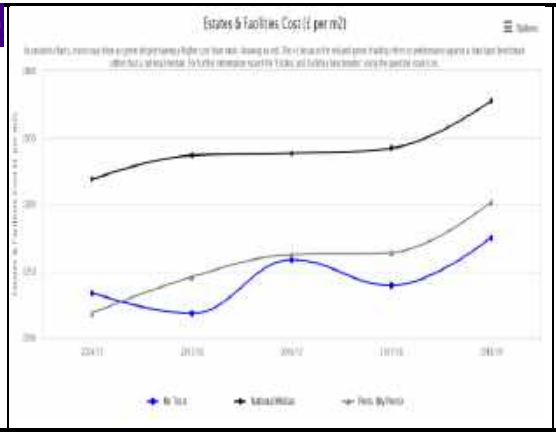
Use of Resources Assessment Dashboard - Q2 2020/21

Action/ Recommendation	Benchmarking/Progress		Trend	Narrative - Warranted/Unwarranted & Justifiable
Estates & Facilities Costs (£ per m2) - The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.	**National Median: £377** **Peer Median: £302** **Best Quartile: £322** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: Estates and Facilities Operational Group** **Source: ERIC 2018-19 Total Estates and Facilities Running Costs**	**2018/19** **Target: Maintain** **£275** **3/11 Peer Group** **1 (Best)**		**The Trust Estates and Facilities costs are better than the national and peer medians.** The Trust has invested year on year to reduce backlog maintenance, however without a significant increase in investment, the amount of backlog to bring the estate up to appropriate standards will always rise. This in turn has and will continue to have an adverse effect on overall estates and facilities costs. The Trust has had the opportunity in 2020/21 to significantly invest in backlog maintenance and should see the benefits of this in 2021/22.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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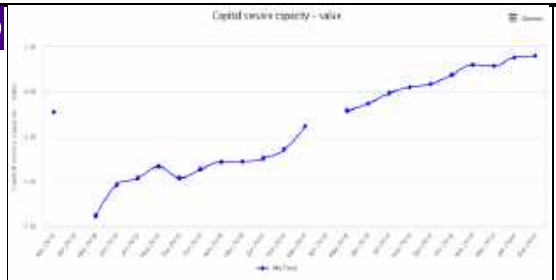
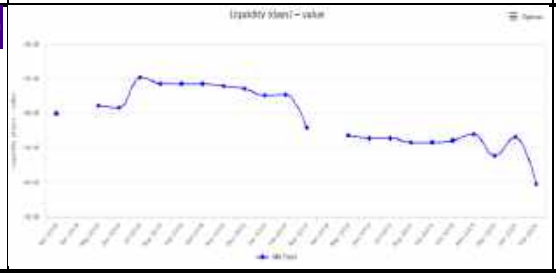
Use of Resources Assessment Dashboard - Q2 2020/21

KLOE 5: Finance

KLOE Operational Lead: Jane Hurst

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Capital Services Capacity - The degree to which the provider's generated income covers its financial obligations	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 1.99 (February 2019) WHH Current Position: 2.95 (October 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**	UoR 	Use of Resource (Finance) reporting has been suspended since March. Therefore the information on the model hospital is out of date. The Finance position has significantly changed since April 2020 due to the COVID-19 pandemic under the new financial regime. For months 1-6 the Trust has shown a break even position, the Trust received top up income to address COVID-19 costs, this ended in September 2020. The Trust continues to respond to developments and awaits next steps.
Income & Expenditure Margin - The income and expenditure surplus or deficit, divided by total revenue.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -0.85% (February 2019) WHH Current Position: -0.62% (October 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**	UoR 	For months 1-6, the Trust has shown a break even position. The Phase 3 plan assumes a £10.3m deficit on the basis that R=1. An initial estimate of wave 2 costs is an additional £5m to the end of March 2021. The current forecast at M7 if a second wave continues is a £15m deficit which has been included in our M7 return.
Liquidity (Days) - Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -66.53 (February 2019) WHH Current Position: -25.60 (October 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**	UoR 	The Trust's cash position has been c£20m, this was due to all Trusts receiving an extra income payment in M1 to support cashflow. As a result, the Trust has been able to pay suppliers promptly resulting in an improvement in compliance against the better practice payment code (BPPC) which was 87% (Cumulative) in September 2020.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

Trust Position

National Median

Peer Median

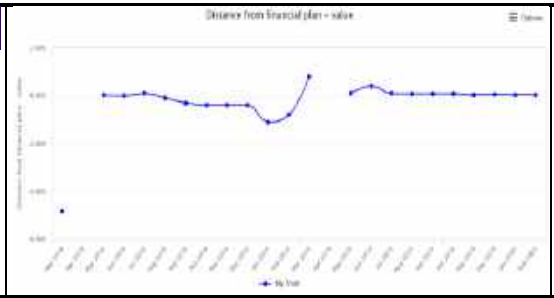
Key

Green on the Model Hospital (Better than the National Median)

Red on the Model Hospital (Worse than the National Median)

Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q2 2020/21

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Distance from Financial Plan - Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 0.04% (February 2019) WHH Current Position: -0.21% (October 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		In October 2020, the Trust submitted a revised plan (Phase 3). The revised plan assumed the COVID-19 R rate would continue to equal 1 or below and did not take into account a potential second wave.
Agency Spend - Cap Value - The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 13.00% (February 2019) WHH Current Position: **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		There is no agency cap for 2020/21, however the Trust continues to closely monitor agency spending for both business as usual and COVID-19 requirements.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/11/134**	
SUBJECT:	**Amendment to the Constitution – change to Non-Executive Directors Terms of Office**	
DATE OF MEETING:	25th November 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's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* The Paper sets out a proposal to allow, by way of amendment of the Trust's Constitution, additional terms of office for Non-Executive Directors of up to three years, following their initial term. Non-Executive Directors may serve for a maximum of 9 years. The proposal was supported at the Governor Nomination 7 Remuneration Committee (GNARC) held on 28th October 2020 and unanimously approved by the Council of Governors on 12th November 2020	

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

RECOMMENDATION:	The Board is asked to consider the requested amendment to the constitution and to approve. These amendments which will be entered to create v3.9	
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	COG/20/1/61
	Date of meeting	12th November 2020
	Summary of Outcome	Approved

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Amendment to the Constitution – change to Non-Executive Directors Terms of Office**	**AGENDA REF:**	**BM/20/11/134**

1. BACKGROUND/CONTEXT

The Trust's Constitution states:

45. Amendment of the constitution

45.1. The Trust may make amendments to its constitution if:
45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and
45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.

Following an amendment made to the Constitution in March 2019, in relation to the *appointment of initial Chair, Deputy Chair and initial other Non-Executive Directors* the Trust's Constitution (Section 25.5) currently states:

Any term beyond six years (eg, two three-year terms) for a Non-Executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-Executive Directors may, in exceptional circumstances for business/continuity reasons, serve longer than six years (eg, two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-evaluation and re-appointment and is subject to ratification by the Council of Governors in line with terms detailed in section 5.4 of the Council of Governors Nominations and Remuneration Committee. Serving more than six years could be relevant to the determination of a non-executive's independence. Non-executive Directors may hold office for a maximum of 9 years.

2. KEY ELEMENTS

Following discussions at the Governor Working Parties in September and October 2020 and the Governors Nomination and Remuneration Committee on 28th October 2020, and in order to provide both greater flexibility and stability, it is proposed that the Trust's Constitution is amended as follows:

Non-Executives are appointed for an initial period of up to three years. Appointments may be renewed at the end of the period of office, subject to the recommendations of the Council of Governors Nomination and Remuneration Committee and approval of the Council of Governors, for a further period up to three years. Non-Executives may serve up to a maximum of 9 years

3. RECOMMENDATIONS

The Board is asked to consider the requested amendment to the constitution and to approve. These amendments which will be entered to create v3.9