WHH Trust Board Meeting Part 1 (Meeting Held in Public)

Wednesday 28 September 2022
10.00am-12.30pm
Halton Education Centre, Halton, Runcorn

SUPPLEMENTARY PAPERS

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 28th September 2022, 10.00am – 12.30pm
Halton Education Centre/Via MS Teams

SUPPLEMENTARY PAPERS

TO NOTE FOR ASSURANCE						
BM/22/09/123 PAGE 4		Learning from Experience Report Q1	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 2nd August 2022 Agenda Ref: QAC/22/08/210 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/09/124 PAGE 31		Infection Prevention & Control Q1 Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 6th September 2022 Agenda Ref: QAC/22/08/214 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/09/125 PAGE 57		Infection Prevention and Control - Board Assurance Framework	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 6th September 2022 Agenda Ref: QAC/22/09/236 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/09/126 PAGE 109		Safeguarding Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 6th September 2022 Agenda Ref: QAC/22/09/235 Outcome: Approved	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/09/127 PAGE 132		Learning from Deaths Review Q1 Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 2nd August 2022 Agenda Ref: QAC/22/08/212 Outcome: Noted for Assurance	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/22/09/128 PAGE 143		Guardian of Safe Working Q1 Report,	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 21st September 2022 Agenda Ref: SPC/22/09/103 Outcome: Noted for Assurance	***Paper***	Paul Fitzsimmons, Executive Medical Director
BM/22/09/129 PAGE 151		Freedom To Speak Up Bi-Annual Report	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 21st September 2022 Agenda Ref: SPC/22/09/94 Outcome: Noted for Assurance	***Paper***	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO
BM/22/09/130 PAGE 164		EPRR Assurance Letter/Statement of Compliance	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 21st September 2022 Agenda Ref: SPC/22/09/XXX Outcome: Noted for Assurance	***Paper***	Dan Moore, Chief Operating Officer
BM/22/09/131 PAGE 173		Digital Strategy Group Report	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 21st September 2022 Agenda Ref: FSC/22/09/152 Outcome: Noted for assurance	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/22/09/132 PAGE 186		Health & Safety Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 2nd August 2022 Agenda Ref: QAC/22/08/202 Outcome: Approved	***Paper***	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO
BM/22/09/133 PAGE 201		Violence Reduction Strategy	***To note for assurance***	Committee: Quality Assurance Committee	***Paper***	Dan Moore

				Date of Meeting: 2nd August 2022 Agenda Ref: QAC/22/08/203 Outcome: Approved		Chief Operating Officer
BM/22/09/134 **PAGE 223**		Trust Organisational Chart	***To note for assurance***	Committee: Executive Management Team Date of Meeting: 8th September 2022 Agenda Ref: ETM/22/658	***Paper***	Simon Constable Chief Executive
BM/22/09/135 **PAGE 235**		Bi-Annual Safe Staffing Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 2nd August 2022 Agenda Ref: QAC/22/08/207 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/09/123**	
SUBJECT:	**Learning from Experience Report Q1 2022**	
DATE OF MEETING:	28th September 2022	
AUTHOR(S):	Layla Alani, Director of Governance & Quality, Interim Deputy Chief Nurse	
	Alison Talbot, Associate Director of Governance	
	Maresa Kelsall, Patient Safety Manager	
	Josephine Hancox, Head of Complaints, PALS & Legal Services	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) because of the ongoing COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#1134** If we see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain. **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety **#1579** If the North West Ambulance Service is unable to provide the expected response times for critical transfers due to demand then the	

	Trust may not be able to transfer patients with time critical urgent care needs to specialist units which may result in patient harm			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The information within the Learning from Experience report is extracted from the Datix system and other Clinical Governance reports for Incidents, Complaints, Claims, Health & Safety and Clinical Audit related to Quarter 1, 2022/23.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to noted the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/08/210		
	Date of meeting	02.08.22		
	Summary of Outcome	The Quality Assurance Committee noted the contents of the report.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Experience Q1 2022	AGENDA REF:	BM/22/09/122

1. BACKGROUND/CONTEXT

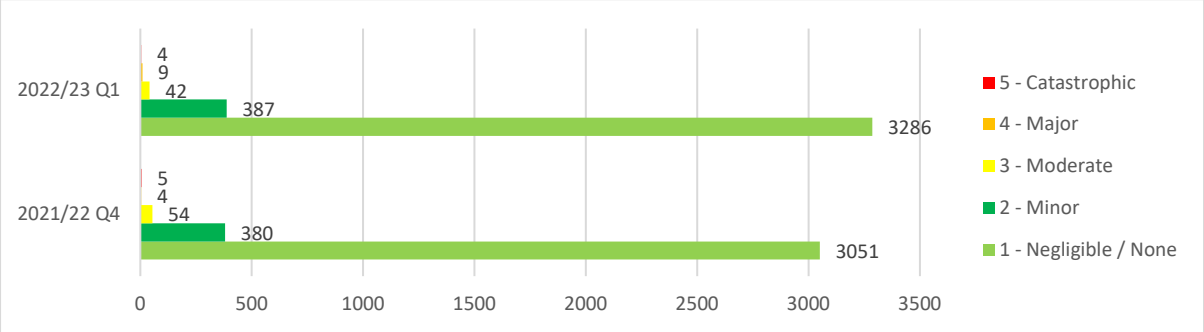
This report relates to the period 1st April 2022 to 30th June 2022 (2022/23 Q1). It contains a quantitative and qualitative data analysis (using information obtained from the Datix risk management system) of incidents, complaints, claims, health & safety and clinical audit. The report includes a summary of themes, trends and key findings identified in Quarter 1 with specific recommendations to support learning across the organisation.

2. KEY ELEMENTS

a. Learning from Incidents

Reporting Position

There was a 7% increase in incident reporting across the Trust in 2022/23, Q1 (3494 in 2021/22 Q4 vs 3728 in 2022/23 Q1). The number of no harm incidents reported increased by 8% in Q1, increase in incident reporting likely linked to increased attendances / operational pressures. Incident reporting is within normal variation.



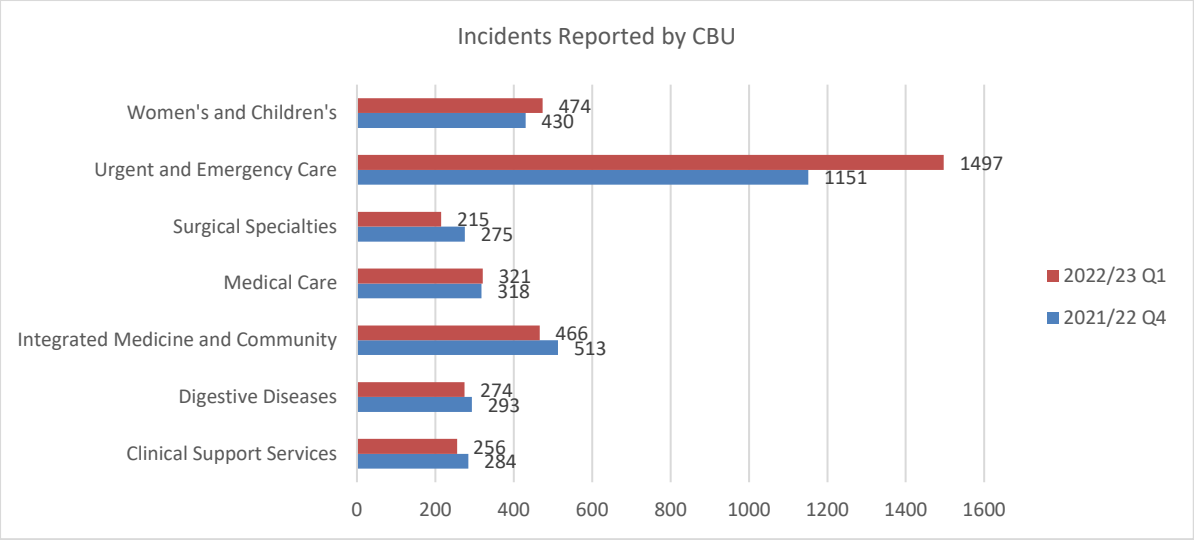
The above graph shows that 4 incidents were deemed as catastrophic in Q1. 9 were deemed as major. 42 were deemed as moderate and the rest minor or negligible. Compared to Q4, 5 incidents were deemed catastrophic, 4 were deemed as major and 54 were deemed moderate. However, it is important to note that incidents should not be defined only by their grade and should be investigated on the learning that is identified as per the Serious Incident framework 2015. Themes across incidents in Q1 relate to delays in treatment and falls. Work is underway to understand the effects of deconditioning as a result of an increased length of stay and patients identified as no right to reside as a result of external health and social care provision. Delays to treatment have also shown to have been significantly impacted by increased attendances, acuity of patients and staffing challenges.

Incidents reported per CBU

There was an increase in the number of incidents reported from the previous Quarter, demonstrating a positive reporting culture. A total of 3503 incidents were reported across the 6

CBUs and Clinical Support Services in Quarter 1, this has increased from 3264 when compared to Quarter 4.

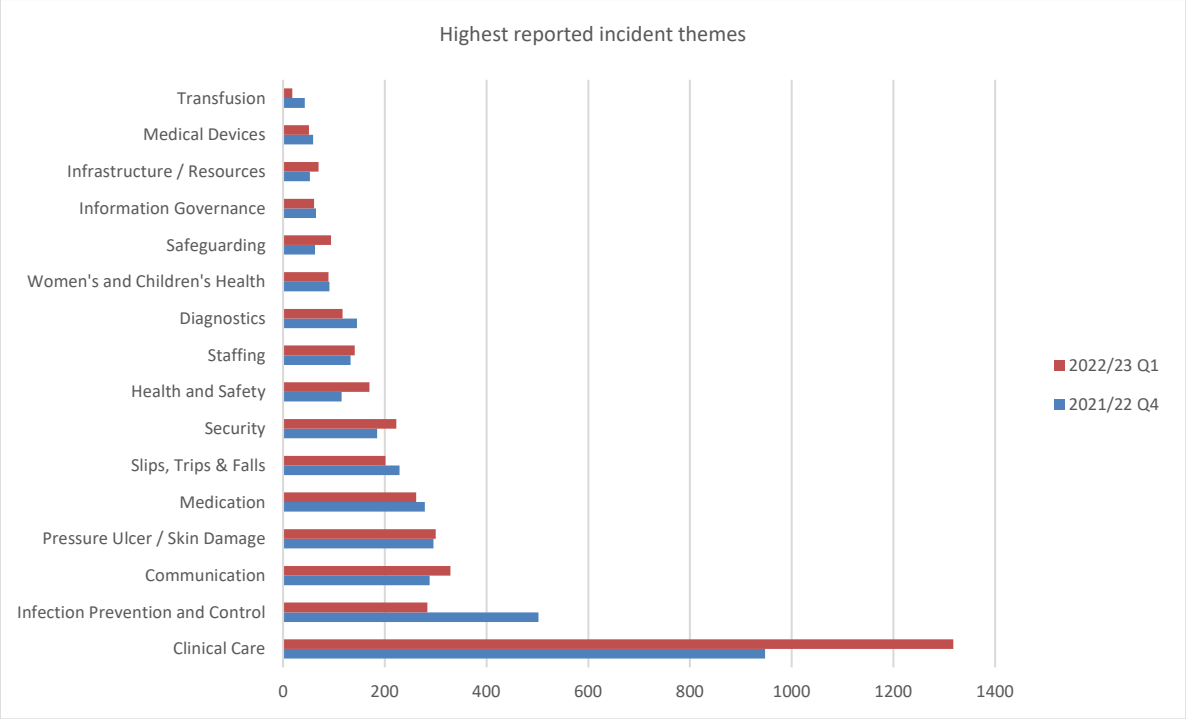
In Quarter 1, Urgent and Emergency care reported the highest number of incidents (1497), this was also the case in Quarter 4 (1151), themes include delay to assessment and time to treatment reflecting the challenges of increased activity being experienced nationally. Of those reported in Quarter 1, 99% of these were minor or negligible harm. This demonstrates that the Urgent and Emergency Care CBU is promoting a culture of positive incident reporting. There has been a slight decrease in surgical specialities, Integrated Medicine and community, Digestive Diseases and clinical support services. Although this is a decrease it is still within statistical control. In order to continue emphasis on incident reporting, the report to improve campaign continues. The governance managers also offer a daily prompt to all CBUs when reviewing incidents. In addition, bespoke Datix training will be offered by the senior administrator for Datix over the next Quarter. A weekly drop in governance session has been established to support any additional training needs. A rolling agenda item has been added to the CBU Governance agenda to highlight the reduction in reporting to those areas noted.



Types of Incidents being reported

The number of incidents reported relating to clinical care, communication and Health and Safety increased in Q1, 1817 compared to 1351 in Q4. Incidents reported related to infection prevention and control whilst diagnostics and slips, trips & falls decreased in Q1, 602 compared to 876 in Q4. Health and Safety incidents relate to injury to staff and manual handling. A deep dive has been requested and will be reported through the Health and Safety Sub Committee.

As per the below graph, incidents relating to clinical care continue to be the most commonly reported at 1318 and 98% of these incidents were minor or negligible harm. When compared to Q4 this is a reporting increase of 370 with no real variance to incident grading (98% Vs 97%), thus evidencing a positive reporting culture. The increase in incident reporting is a likely consequence of increased demands on operational capacity and capability.



Incident Themes

In Quarter 1, there has been an increase in the number of clinical care incidents reported (39%) with no increase in harm noted many of these relate to 12 hour breach standard. The governance team have been feeding back to CBU's through governance meetings aspects of clinical care which include 12 hour breaches (709), delay in treatment (81) and delay in assessment (66).

There has been a decrease in the number of infection prevention and control incidents reported. This is indicative of the on-going work of the Infection Prevention & Control Team in fostering a culture of continued vigilance across the organisation and incident reporting. In order to support this on-going piece of work, the Quality Improvement Team have developed a Gram-Negative Bloodstream Infections (GNBSI) collaborative. The aim of this collaborative is to reduce healthcare associated GNBSI by 5% by March 2022 and will focus on hot spot areas as noted within the Datix system. A change package outlining evidence-based interventions will be developed in Quarter 2 2022/2023 (revised due to operational pressures), for all wards to implement, it is ongoing at present. Work is also in progress to update and develop relevant trust wide policies and training.

Serious and Concise Incidents closed within Quarter 1

There were 18 Serious Incidents closed within Quarter 1. The highest reporting areas for SI's are (associated learning is noted in the learning section of this report):

Area	Number	Findings
Birth Suite	2	1. Maternal Death 2. Maternity Divert
Ward B18	2	1. Missed diagnosis 2. Fall with fracture
ED Majors	2	1. Delay to be seen, deterioration 2. Delay to be seen

There were 28 concise incidents closed within Quarter 1.

Learning from Incidents and Assurance

The Associate Director of Governance and the Patient Safety Manager continue to attend the CCG meetings in order to present Serious Incidents alongside the Investigating Officer. This enables feedback and assurance in real time through broad discussion with health partners. The Serious Incident Review Group is chaired by the Chief Nurse of the CCG, who has commented that the meeting is proving successful in providing appropriate assurance to the CCG. In addition, the Director of Governance and Quality presents at the Clinical Quality Focus Group any themes and trends and offers assurance to the CCG with learning actions identified. A Root Cause Analysis checklist (RCA) has been added to the RCA template which strengthens the review and ensures all processes have been followed. Plans will be put in place in accordance with future ICB structures.

RCA checklist

This checklist provides a tool in their assessment of systems investigation into RCAs			
Phase of investigation	Element	Answer (yes/no)	If no, was there a robust rationale and that prevents this affecting the quality of the investigation?
Set up/ preparation	Is the Lead Investigator appropriately trained?	Y	
	Did the core investigation team consist of more than one person?	Y	
	Were national, standard NHS investigation guidance and ~~process used~~?	Y	
Gathering and mapping	Was the appropriate evidence used (where it was available) ~~i.e.~~ patients notes/records, written account?	Y	
	Were interviews conducted?	Y	
	Is there evidence that those with an interest were involved (*making use of briefings, de-briefings, draft reports etc.*)?	Y	
	Is there evidence that those affected (*including patients/staff/ victims/ perpetrators and their families*) were involved and supported appropriately?	Y	
	Is a timeline of events produced?	Y	
	Are good practice guidance and protocols referenced to determine what should have happened?	Y	
	Are care and service delivery problems identified? *(This includes what happened that ~~shouldn't~~ have, and what didn't happen that should have. There should be a mix of care (human error) and service (organisational) delivery problems)*	Y	
	Is it clear that the individuals have not been unfairly blamed? (*Disciplinary action is only appropriate for acts of wilful harm or wilful neglect*)	Y	
Analysing information	Is there evidence that the contributory factors for each problem have been explored?	Y	
	Is there evidence that the most fundamental issues/ or root causes have been considered?	Y	
Generating solutions	Have strong (effective) and targeted recommendations and solutions (targeted towards root causes) been developed? Are actions assigned appropriately? Are the appropriate members ~~i.e.~~ those with budgetary responsibility involved in action plan development? Has an options appraisal been undertaken before final recommendation made?	Y	
Throughout	Is there evidence that those affected have been appropriately involved and supported?	Y	
Next steps	Is there a clear plan to support implementation of change and improvement and method for monitoring?	Y	
Overall assessment and feedback			

Following Root Cause Analysis (RCA) investigations of these incidents, the following themes were identified, and actions implemented. In order to measure the success of the learning, complaints, PALS, incidents and risk are monitored on a weekly basis to ensure a downward trend of the specific learning points noted below or timely escalation where required. Learning will be further strengthened in 22/23 by the introduction of a Trust wide Learning Framework and the national implementation of the Patient Safety Incident Response Framework.

Inadequate communication

There were three RCAs that cited communication as a fundamental component in achieving improved outcomes and a better patient experience. This related to communication between teams across Radiology and Cardiology. Within the cardiology report an outcome was to discuss a method of escalation for delayed transfers in-between hospitals. This will ensure review of the pathway to make contact with Liverpool Heart and Chest Hospital after 48hours. This will enable the team to determine if a delay is likely and if so to investigate other possible facilities to transfer and/or to perform these diagnostic tests.

On one of the reports a change in process had already been put in place on 1st April 2021 due to bringing vascular imaging service reporting back 'in house' in April 2021. Audits have been completed to ensure no further patients had been missed and these was clear communication between teams. A wider review of the service is underway to identify further opportunities for improvement.

On the third report there was a lack of communication between radiology staff and the patient which resulted in a Never Event. A patient was injected with lidocaine to the wrong arm prior to a scan being performed. An action from this incident was to amend LocSSIP documentation to include a section to confirm procedure and indicate laterality at the 'time out' stage. This acts as a safety net to mitigate risk.

Inadequate Documentation

7 of the RCAs completed in Quarter 1 found that documentation errors or omissions were root causes or direct contributory factors in the incidents. In order to address the documentation omissions identified in the Integrated Medicine and Community RCA, whereby comfort rounds and body maps were incomplete, a pressure ulcer collaborative was commenced within the CBU, and the area are working closely with the Quality Improvement team utilising traffic light systems and 'heal heroes'. This theme was noted as a trend across other RCAs within K25 and Integrated Medicine and Community CBU. This is monitored centrally via the governance department with care and comfort audits being completed with oversight provided as part of by the pressure ulcer collaborative and Deputy Chief Nurse.

There were two Women's & Children's RCAs relating to maternity unit closures. One of the issues identified that there was no clear communication and action log to action escalation in a timely manner when in amber status. There was no formal proforma to capture dependency, staffing ratio and skill mix. In order to ensure consistency and timeliness of communication a Maternity Escalation Flow Chart to support staff decision making has been developed and is now in use.

Pressure Damage K25 and A4: The contributory factors within both of these RCA's was that care, comfort and repositioning charts were not completed accurately or timely. Tissue Viability are working closely with the ward areas to provide additional support focusing on specific training needs.

Ward B19 - Heel Heroes!

Heel check - Time and date

Morning check: _____
Afternoon check: _____
Night check: _____

Examination – (Circle answers)

Morning:

Footwear removed? Yes/No/NA

Pain? Yes/No

Label condition of heels on diagram (E.g. dry, intact, blanching, non-blanching, darkened area, broken, scab)

Afternoon:

Footwear removed? Yes/No/NA

Pain? Yes/No

Label condition of heels on diagram:

(E.g. dry, intact, blanching, non-blanching, darkened area, broken, scab)

Night:

Footwear removed? Yes/No/NA

Pain? Yes/No

Label condition of heels on diagram (E.g. dry, intact, blanching, non-blanching, darkened area, broken, scab)

Risk – Is the patient at risk of heel breakdown? Yes/No

Do they have any of the following:

Dementia, reduced consciousness, reduced mobility, increased dependence, frailty, vascular disease, sensory impairment, malnutrition/dehydration, Other:

_____

Offered assistance?

Morning: Yes/No/NA
Afternoon: Yes/No/NA
Night: Yes/No/NA

Elevation – Have you elevated the heels?

Morning: Yes/No/NA
Afternoon: Yes/No/NA
Night: Yes/No/NA

Safety Measures – Are any of the following in place?

Repose boots, pillows, heel pads, dressings, airflow mattress, soft foam mattress, creams applied, other:

_____

Morning: sign: Designation:

Afternoon: sign: Designation:

Night: sign: Designation:

Chairman: Steve McGuirk CBE DL QFSM **Chief Executive:** Simon Constable FRCP

Communication

9 out of the 18 RCAs identified challenges with communication between teams. The first RCA was a patient who had been sent in by the General Practitioner awaiting surgical review. A decision was made that as the patient was clinically well and had stable physiological observations, it was unlikely that there would be any interventions required that night. As a result it was agreed that the patient could be discharged home with a plan to return to the surgical clinic. The patient went home but did not have his bloods reviewed which later indicated that he was septic. There was a lack of communication between teams in regards to who the patient was under and who should review bloods taken on attendance. Urgent blood test results should be reviewed before patients are discharged from the ED. When it is clinically appropriate to discharge a patient without all blood results being available, it is the responsibility of the clinician requesting investigations to review the results and act on them accordingly or to formally hand over this task and document this in the clinical record.

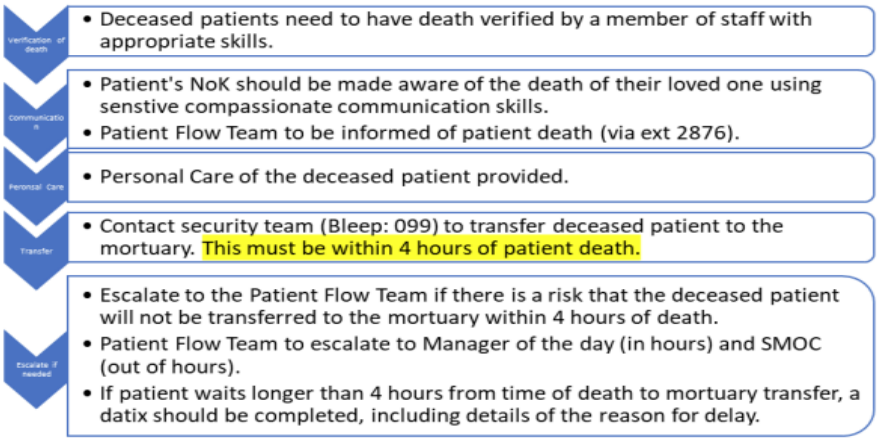
Another report which relates to communication was a patient who was repatriated back from Whiston hospital to Ward B14 . There was miscommunication around the time that the patient would be transferred back, and this was completed out of hours. The patient missed critical medications. As a result of this a pathway and policy will be development for those be repatriated back from other hospitals to ensure a timely medical review is undertaken.

Falls resulting in harm:

There were 5 falls resulting in harm closed in Quarter 1 these occurred on A8, C21, A1, CAU and B18. Within all the reports there was a delay in completing/repeating risk assessments to identify patients as a falls risk. As a result of this the Quality Improvement team are meeting regularly with the Associate Chief Nurses to transfer responsibilities of the change package and to enhance learning with methods of measurement and monitoring in place. As a result of capacity, capability, length of stay and patients that have no right to reside evidence within investigations indicates that falls have increased with deconditioning a significant contributory factor.

Safety Alerts

WHH uses the daily Safety Brief to share learning on a wider scale, these are shared Trust wide via communications, and noted as pop-ups on computer screens and shared at daily staffing huddles. The below table provides examples of Safety Alerts issued by the Trust via the daily safety brief following incidents that occurred or were investigated in Quarter 1:

Subject	Detail	Date issued
Care of the Deceased Patient	It has been identified that in some instances there are long waits for the transfer of deceased patients from time of death to the mortuary. **Action:** The below process was circulated Trust wide with emphasis on the importance of the deceased being moved within 4 hours of the death occurring.  **Assurance:** We will know that this communication has had the desired impact by monitoring the number of incidents relating to this and transfer log times from the ward to the mortuary.	27/05/22
Patient administered medication twice	A patient has been administered a flupentixol decanoate depot injection by a Nurse from the Mental Health Recovery Team on a ward. The flupenthixol decanoate depot injection was also prescribed and administered on the ward by the ward staff, so the patient was administered her flupenthixol decanoate depot injection twice. **Action:** A new process was agreed for staff to follow when a patient on this medication is admitted with input from the Mental Heath Recovery Team, in order for staff to check whether or not the patient has already had the medication in the community. **Assurance**: We will know that this communication has had the desired impact by monitoring the number of incidents reported relating to this issue.	21/06/22
Patient developed a pressure ulcer after being discharged in a cast.	A patient was discharged home with a plaster cast in place. A pressure ulcer developed, and the patient had not been given information on signs to look out for or who to contact should the patient have any concerns. **Action:** A communication was circulated to remind staff of the information to be given to patients in casts prior to discharge. An information leaflet was also circulated to be given to patients in plaster casts to advise them of what to look out for an who to contact if they have any concerns.	06/06/22

	Assurance: We will know that this communication has had the desired impact by monitoring the number of incidents and complaints reported relating to this issue. This will include a review of interface incidents. Interface incidents are also monitored as part of the Trust Interface Meeting with the CCG.	

Never Events from this Quarter

There were 0 Never Events opened in Quarter 1. The list of incidents that can be considered as "Never Events" is included as Appendix 1.

Duty of Candour

The Trust maintains its position of 100% compliance with Duty of Candour.

b. Learning from Complaints and PALS

Complaints

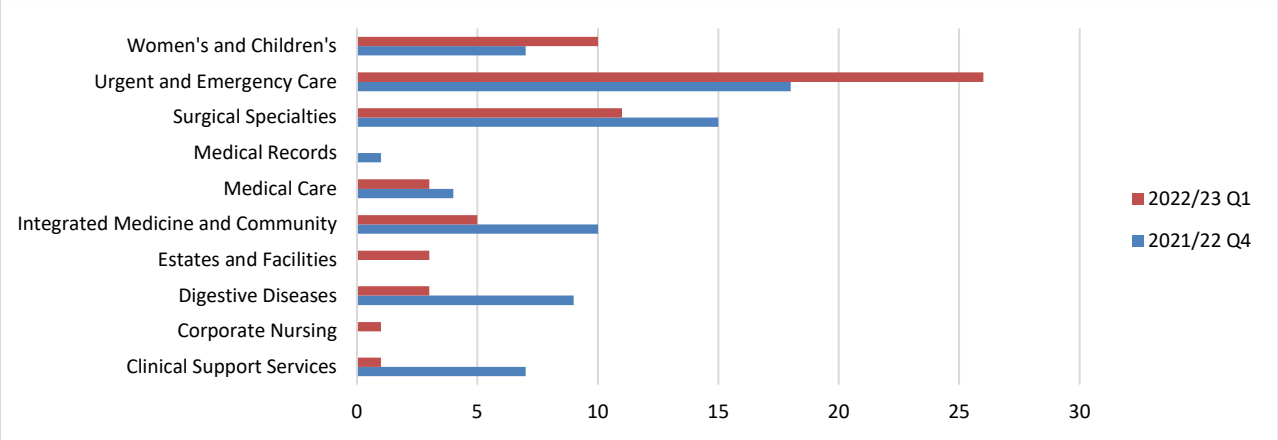
Complaints received

As per the below graph, there was an 11% decrease in complaints opened Trust-wide in Q1 (71 in Q4 versus 63 in Q1). Urgent and Emergency Care (18 in Q4 vs. 26 in Q1) and Women's and Children's (7 in Q4 vs 10 in Q1) reported an increase in the complaints received.

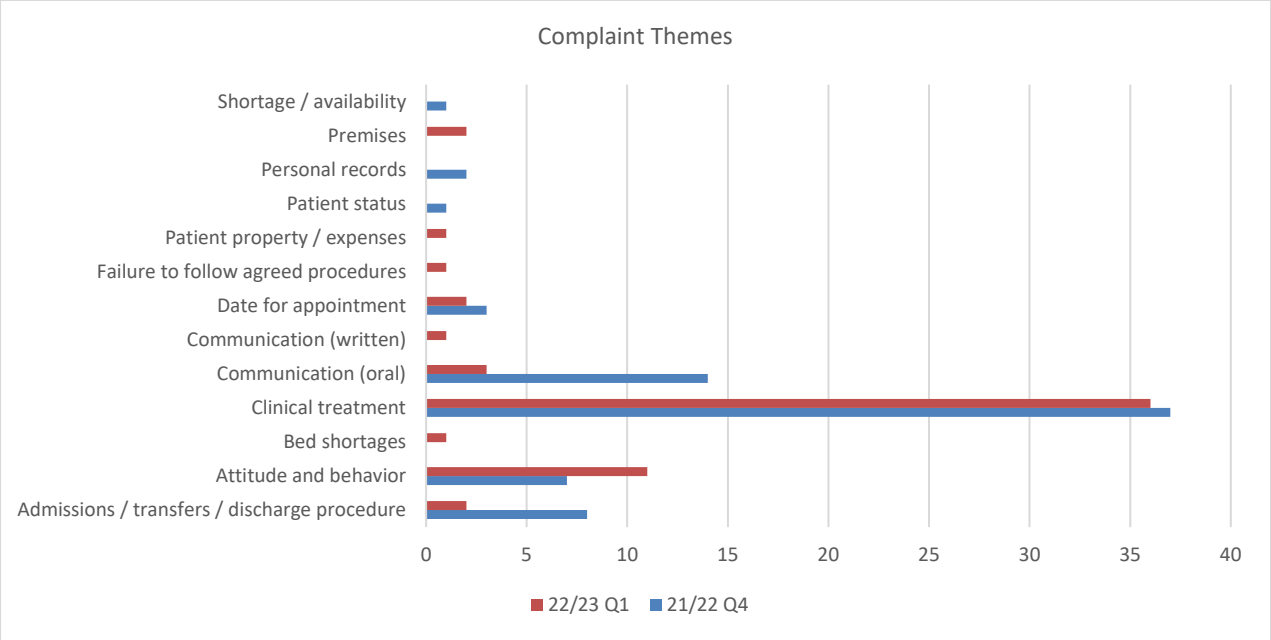
The majority of complaints received relating to Urgent and Emergency Care within Q1 related to delays in being seen (5) and suspected misdiagnosis (9). The Head of Complaints is undertaking a deep dive review supported by the Associate Director of Governance and Patient Safety Manager of complaints received relating to misdiagnosis in the Emergency Department for the last 6 months, to identify any themes and potential areas for service improvement. The findings of this review will be shared with the Senior Management Team for the CBU and reported through the next LFE. It is important to note that a Rapid Incident Review (RIR) is undertaken for each complaint graded as high .The RIRs undertaken for the Urgent and Emergency Care complaints have shown no harm has been caused as a result. The deep dive review will focus on learning from the delays, rather than potential harm as these have all had a rapid review attended by senior clinical and nursing teams.

Of the 10 complaints received for Women's and Children's in Q1, 4 related to suspected delayed diagnosis (each for different conditions), one of these has been closed as a complaint and is being progressed as a Concise investigation. Of the remaining 5, 2 have been closed and will be progressing as Serious Incident investigations following RIRs. The other 4 relate to issues in communication or cancellation of procedures.

The remaining CBU's saw a decrease in the number of complaints received as noted in the graph below.



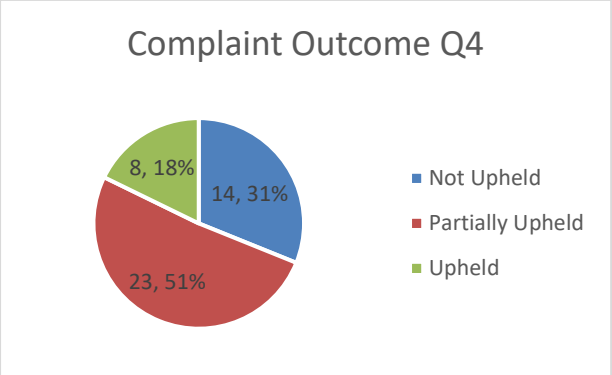
The themes of complaints received in Q4 vs Q1 are outlined within the below chart. Clinical Treatment remains the most common theme of complaints received. This category of complaints includes alleged delayed or misdiagnosis and delayed treatment. The number of complaints relating to this theme have increased slightly from 37 in Q4 to 36 in Q1. This is triangulated with the themes noted within incidents.

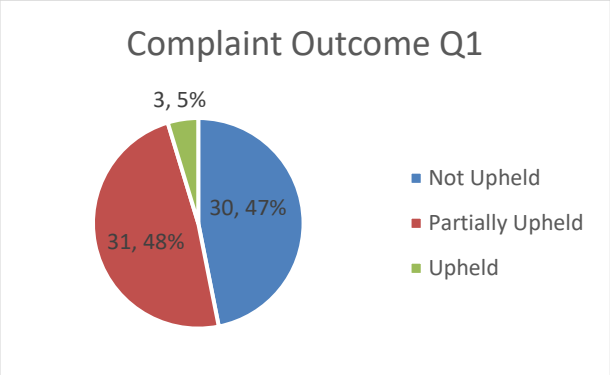


Complaints closed

There was an increase in the number of complaints closed in the Trust in Q1 (45 in Q4 versus 64 in Q1). More complaints are closed month on month than are opened. The below pie charts demonstrate the outcomes for complaints closed in Q4 vs Q1. In Q1 a greater percentage of complaints were not upheld (31% in Q4 vs. 47% in Q1), indicating that the care and treatment provided was appropriate.

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





Responsiveness
All specialties have responded to complaints within timeframe in Q1. The Trust had a target to respond to 90% of complaint on time and in Q1 the Trust continued to achieve 100%. The Trust continues to have 0 breached complaints and there are no complaints over 6 months old.

Complainants continue to be offered the opportunity to attend a meeting with the appropriate team to facilitate meaningful discussion as an initial measure – this approach facilitates wider learning and understanding. It is also noted that fewer complainants return with further questions or expressions of dissatisfaction after resolution meetings when compared with complaints responded to in writing. The actions from these meetings are managed in the same way as a written response; these are recorded on Datix and monitored. Meetings are still classified as a complaint and therefore these are monitored in the same way as written responses.

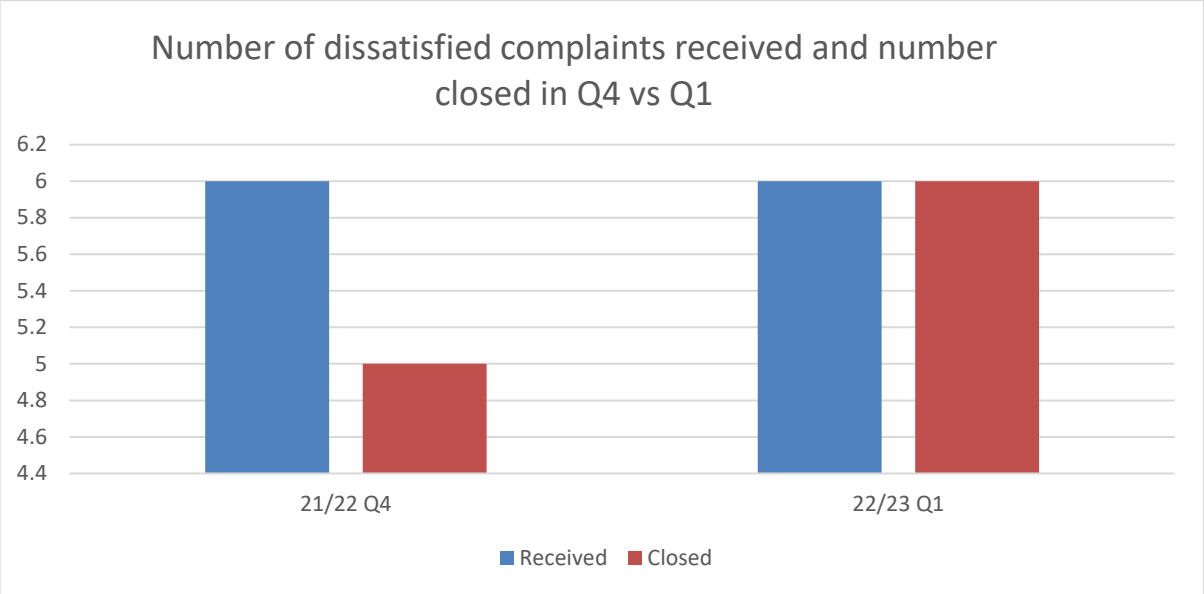
Actions resulting from Complaint investigations
The following table provides examples of complaints responded to in Q1, and the actions we took in order to address the concerns raised and improve our processes. For further assurance, a complaints position with learning is provided quarterly to the Quality Assurance Committee. The Chairman also holds a monthly complaint meeting where a CBU or speciality will present a complaint, the lessons learnt, and actions implemented.

You Said….	We Did….
A patient's relative raised concerns in regard to staff on the ward not being aware of whether or not a procedure had gone well after the patient returned to the ward.	The handover process on the ward has been changed for when a patient is brought back to the ward following a procedure. The new process is that a nurse to nurse discussion takes place and is recorded in the patient's notes, outlining whether the procedure took place, whether there were any complications and any other points to be noted.
A Doctor was late to clinic due to having to attend a remote MDT meeting off site which overran.	A room has now been allocated for Doctors to attend remote meetings in. This will mean that when a Doctor is due to attend clinic after an MDT meeting, they will be able to do so without having to commute in. This will also reduce the risk of clinic starting late if the MDT meeting overruns.

A patient raised concerns about the communication between staff on different units. The patient felt that staff on the maternity ward were not always fully aware of the plan in place for babies being cared for on the neonatal unit.	A new process was implemented whereby midwives from the maternity ward now attend the neonatal daily patient reviews, in order to ensure staff on both wards are aware of the plans of care for mothers and babies and in order to update mothers on any changes to the plan of care for babies on the neonatal unit.

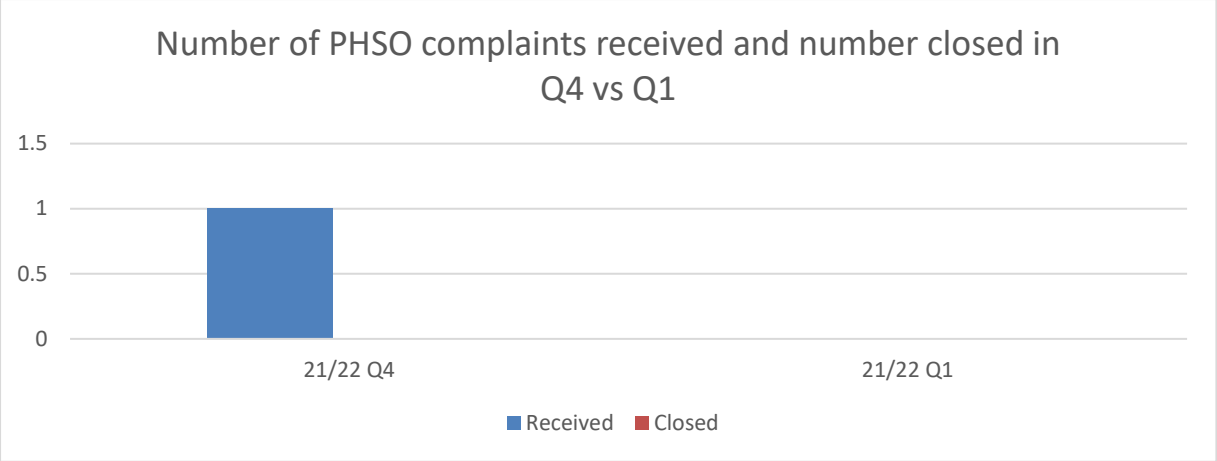
Dissatisfied Complaints

The below graph demonstrates the numbers of dissatisfied complaints received and closed in this Quarter vs. the previous Quarter. The Complaints Team is continuing to work with the CBUs to improve the quality and detail of the complaint responses to reduce the number of dissatisfied complaints. The same number of dissatisfied complaints were opened in Q1 as in Q4 (6). The roll out of a formal complaints training package begun in Q1 and will continue into Q2. The aim of these training sessions is to give staff in the CBUs information around how formal complaints and PALS can be responded to, to give the best outcome for our patients and their families. This also facilitates learning in real time. This training is expected to improve the quality of responses which will help to reduce the number of dissatisfied complaints received.



PHSO Complaints

There were no PHSO complaints received within Q1. PHSO complaints continued to be dealt with in a timely manner. There have been no PHSO complaints closed within Q1 as the investigations being undertaken by the PHSO have not yet concluded.



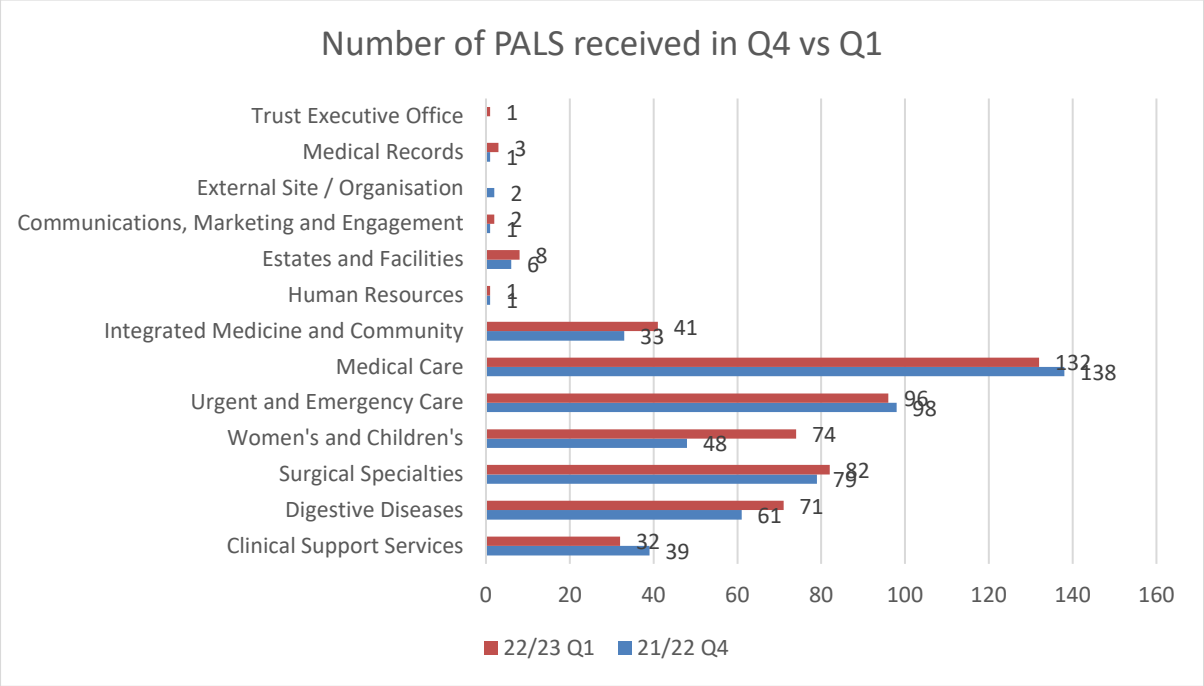
PALS

PALS received

There were 543 new PALS received in Q1, a 6.8% increase from the 507 received in Q4. The below chart demonstrates the breakdown of PALS received for each service. In Q1, a new PALS Standard Operating Procedure (SOP) was introduced, which provides the PALS Team with clearer direction on the handling of PALS cases. In Q1, the average response time for PALS cases was 2.4 days, which is under the Trust's target response time of 3 working days.

PALS closed

In Q1 there were 541 PALS cases closed, an increase of 2.6% from 527 closed in Q4. The below chart demonstrates the breakdown for PALS closed for each service.



PALS relating to the Women's and Children's CBU saw the largest increase in cases closed in Q1, with 72 cases closed, compared with 50 closed in Q4. The increase is due to an increase in PALS received within the quarter and also due to the CBU working to ensure that all PALS cases are closed within

the Trust's 3 working-day turnaround period. The number of complaints closed for Women's and Children's in Q1 is considerablly lower than the number of PALS received (10 complaints vs. 74 PALS) and this demonstrates that the CBU is effectively dealing with concerns and queries quickly and informally.

Actions resulting from PALS cases

You Said….	We Did….
Concerns were raised in relation to relatives being given conflicting information about the COVID visiting restrictions, in terms of which areas these had been relaxed in.	The concerns were flagged to the Patient Experience Team, who sent out a Trust wide communication via the "good morning message" to reiterate the restrictions in place.
A patient was late to an appointment as they had not been told that building works were being undertaken on the site, which meant that diversions were in place.	Appointment invite letters were updated following the concerns. The appointment letters were amended to give directions and a map was enclosed.

c. Learning from Claims

Clinical Claims

Clinical Claims Received
There were 23 clinical claims received in Q1, a slight decrease from the 27 received in Q4.

Clinical Claims Closed
35 clinical claims were closed in Q1, 6 of which were with damages (totalling £680,108.71) (excluding the costs of instructing Trust solicitors). This is not a concerning feature as the number of claims remain stable. Damages were lower in Q1 than Q4 as fewer claims were closed and the values of the claims closed were lower on average than the previous quarter.

Clinical Support Services	**£20,557.75**
Radiology	**£20,557.75**
Surgical Specialties	**646.302.14**
ENT	**622.302.14**
T&O	**21.000.00**
Urology	**£3,000.00**
Urgent and Emergency Care	**£1,250.00**
Emergency Medicine	**£1,250.00**
Women's and Children's	**£12,000.00**
Paediatrics and Neonatology	**£12,000.00**

4 clinical claims were successfully repudiated and 25 were withdrawn.

Non-Clinical Claims (Employee Liability/Public Liability)

Non-Clinical Claims Received

There were 4 non-clinical claims received in Q1. This is a decrease of 8 from Q4. The learning from these will be provided once they have been closed.

Non-Clinical Claims Closed
There were 2 employer Liability Claims closed in Quarter 4 with no damages paid. There was 1 public liability claim with no damages paid.

Improvements and changes arising from Claims

Following claims investigations for claims closed in Quarter 1, the following themes were identified, and actions implemented. In order to measure the success of the learning, complaints, PALS, incidents and risk are monitored on a weekly basis to ensure a downward trend or appropriate escalation in relation to the themes of the specific learning points noted below. A claims report is provided to each CBU meeting. In addition, there is a clinical claims review group that is attended by various clinicians. A newsletter is also produced which highlights key themes for learning.

Delayed diagnosis of inflammatory hip arthropathy

Within Q1, a claim was closed where it was determined that there was a failure to consider and diagnose inflammatory hip arthropathy following the patient's x-ray and to undertake relevant investigations. Although the staff member involved has since left the Trust, the case has been shared as a learning piece within the CBU to encourage other clinicians to reflect on the patient's presentation and the importance of considering the potential diagnoses associated with inflammatory joint pain.

Failure to identify fracture to finger

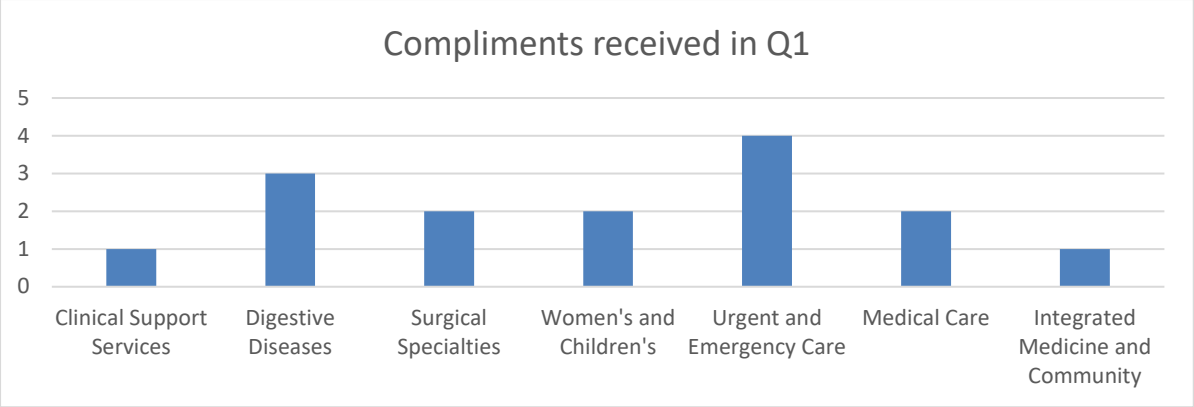
A claim was closed in Q1, where it has been confirmed there was a failure to identify a fractured finger, following a patient's presentation to the Emergency Department. Although an x-ray was undertaken, the fracture was subtle and was missed. The case has been shared for learning with the Emergency Department Team with discussion around how to better identify subtle fractures.

Delay in diagnosing sinus thrombosis and left cerebellar infarct

A claim was closed in Q1 where it was identified that there had been a delay in diagnosis of a sinus thrombosis and left cerebellar infarct as the patient had not been reviewed by an ENT doctor upon presenting to the Emergency Department. A new process has been implemented whereby any patient who presents with ENT complaints to the Emergency Department will be referred for review by an ENT doctor before discharge. Rapid Access Clinics have also been implemented to prevent delays in patients waiting to be reviewed in the outpatient setting.

d. Learning from Compliments

A positive safety culture is one where compliments are fed back to staff in the same way that investigations are. Compliments are a really useful tool for the Trust to be able to identify what areas are working well. In Q1 the Trust received 15 compliments, this compares with 15 compliments which were received in Q4.



The trust is continuing to explore the creation of a 'Greatix' module within the Datix system. This will enable the recording of positive incidents, behaviours and treatment by Trust staff about their colleagues. Feedback will then be provided to the individual staff and departments involved. This will encourage celebration of our staff efforts and identification of positive values and behaviours. We aim to go live with this in Q2 2022/2023 as currently being built and formatted in the system in Q1 2022/2023.

e. Learning from the CBUs

This section highlights points for learning identified in each CBU following the review of incidents, complaints and claims with actions identified for assurance of learning.

Medical Care

We found….
A patients daughter informed the ward that after seeing her dad unwell and drowsy she thought he had been taking his own medications including sleeping tablets as he has previously appeared groggy and taken too much medication at home. Bags checked, zolpidem 10mg box and almost empty bottles of morphine sulphate oral solution found. Naloxone prescribed and given; Medications locked into the ward CD /Meds cupboards
We Acted….
• The ward to produce an admission checklist to include asking a patient if they have their own medications on their person. • Incident and the need to ask patients about having their own medications to be added to the ward safety brief • To be highlighted at the Trust safety huddle and to discuss whether a poster should be created to advise family's / patients if they do have their own medications these need to be given to staff • Safeguarding referral to be completed • Alert to be added to patient records regarding use of medications

Integrated Medicine & Community

We found….
Staff not informed by a previous shift that a patient was scoring on the NEWS chart and required review. Dr's arrived on the ward to review patient with a reported NEWS of 12. Night-time nurse in charge unaware of elevated NEWS. Patient had been scoring for approximately 3 hours

MET call not made. IBleep only to request assistance. Agency nurse caring for the patient reported being unaware what a met call was or how to complete one. Nurse reported had discussed with another member of staff who advised to complete an iBleep. Consultant advises this delay did not affect the outcome for the patient.

We Acted….

- Individual nurse learning: how to complete a MET call, and how to follow the NEWS policy for when to put out a met/ emergency call
- Family informed of the delay in review
- Ward manager to follow up with agency to assess training needs of the agency staff member before booking any further shifts.
- All staff complete a ward induction including how to escalate concerns. ward manager to check this is up to date for all agency staff.

Clinical Support Services

We found….

A gram stain on joint fluid was reported with a gram positive cell + and pus +, on a second check it was deemed that this was not a gram positive cell, the patient had already had an arthroscopic wash out due to clinical indication.

We Acted….

- Education was provided for the operating staff on the correct procedure for obtaining samples (as it was identified that a sample was placed in formaldehyde and was therefore unusable).
- The microbiology team have shares learning and are to advice for second opinions on any questionable sampling reports.
- The quality commissioning mechanism for correct sampling has been shared with the microbiology staff to ensure correct practice is followed.
- The patient had an arthroscopic knee wash out due to clinical indication of infection – including swelling to the joint and a raised CRP therefore was a suitable action despite incorrect GPC result.

Urgent & Emergency Care

We found….

Patient attended Warrington Hospital. Safeguarding concerns were raised in relation to patients personal care from the care home and were discussed with the patients family but not acted upon. The patient sadly passed away on the 13th of February whilst in hospital, safeguarding procedures were not followed through.

We Acted….

- Feedback to Agencies used by the Trust to ensure all agency staff working have had appropriate Safeguarding training.
- Audit induction forms for Agency staff working within the Trust to ensure they have had appropriate Trust information/ local induction.
- Nurse in Charge to check with agency staff on duty in their areas to highlight any Safeguarding concerns and ensure referrals have been sent.
- Add into Safety Huddle any concerns relating to Safeguarding for any patient in the Department.

- Simulation training is in progress alongside NEWS2 refresher training, in progress, alongside a weekly audit of the NEWS2 observation charts in progress the Emergency Department.

Surgical Specialities

We found….

Cluster of Bacillus Spp. results noted in patients who underwent Orthopaedic surgery.
Bacillus is a common environmental organism which can sometimes cause infection.

We Acted….

- Review of all processes in the pathology laboratory, theatre pre-op, peri op and post op
- Completed a full review of Q4 data for 2021 and Q1 data for 2022
- Chased theatre fogging to bring forward
- Clinical Director and governance lead reviewed cases to establish any harm

Digestive Diseases

We found….

Incident reported as "CO2 module failure / put in wrong monitor ", upon investigation the equipment had been checked in the morning of incident as per trust standard and there had not been any faults identified.
-The co2 module did not fail – this was a connectivity issue – it is usually set up to be visible on 2 screens however due to a connectivity loss this was not visible.

We Acted….

- All anaesthetics and ODP are encouraged to check the CO2 prior to starting cases.
- Prior to the start of each theatre the ODP/anaesthetics team are to ensure that all co2 monitors are set up correctly displaying on the ventilator screen
- Staff are to continue to promote " no trace – wrong space" for staff to ensure an ETT space is correctly in situ
- Lessons learnt and feedback from the incident has been shared with all staff members from theatres
- The theatre lead has now set the Co2 monitor back to always showing on 2 screens with the co2 always being visible on the ventilator screen – this is standard across all theatres.
- During the incident, the ODP ensured that the ETT tube was in the correct place and changed to hand bagging or the patient, then reconnected the ventilator when the co2 waveform was back on the screen ensuring no harm to patient.

Women's & Children's

We found….

-There was a lack of awareness the DASH assessment and the risk of harm pregnancy places a woman from the risk of domestic abuse. The form can be completed with the woman or without depending on the level of risk of harm identified within the DASH form.
-There were agency staff covering the ward without substantive cover

We Acted….

- Single point learning shared with ED and Ward C 20
- Safety brief discussions and targeted domestic abuse training for ward staff
- Senior review of staffing to ensure substantive staff are on shift
- Share learning with Agency staff and the agency

f. Learning from our Staff

Schwartz Rounds

Warrington System Schwartz Round

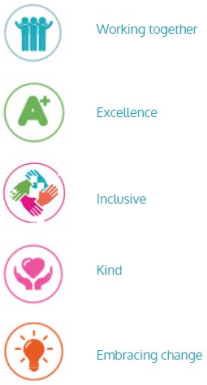
Schwartz Rounds are a multi-disciplinary forum designed for **all** staff to reflect and discuss the emotional and social challenges associated with working in the care system. It is a confidential space to reflect and share common experiences. The Q1 Schwartz round was held on 23rd June 2022.

Behaviour Badges

Our values shape the way that we deliver high quality, safe and effective healthcare for patients. The Extranet has been updated to include the "Behaviour Badge" nomination form.

We like to say Thank You to our staff and encourage patients, public and all of our team to nominate their care givers or colleagues who have gone above and beyond in their work to support quality patient care.

Staff members can nominate someone for a behaviour badge, if they feel the individual has demonstrated and role modelled one of our behaviours. Nominations will be reviewed by a panel and badges awarded accordingly.



Bright Spots

The Bright Spots section is within the daily Trust-wide Safety Brief and is an opportunity to recognise the efforts of our staff and thank them for their hard work. The table in Appendix 2 provides examples of some of the staff featured in the Bright Spots section in Q1.

g. Learning from Patient Experience

Continued focus on learning from patient experiences:

- Introduction of Trust wide digital stories programme to drive quality improvement.
- Continuous engagement with community partners to continually learn and act on experience to improve outcomes.
- Attendance at Carers Event led by the Local Authority to share the Carers passport with the local community. The Carers Passport aims to ensure enhanced communication with carers whilst in hospital and to ensure patients individual needs and preferences are understood

The Patient Experience and Inclusion Team carried out **extensive engagement** with our patients, carers, community partners and other public and third sector organisations to co-produce the Trust first **Patient, Service User and Carers Diversity, Inclusion and Belonging Strategy 2022 – 2025.** Engagement was undertaken in multiple formats to maximise opportunity which included

- Digital surveys
- Internal focus groups with workforce and Staff Networks
- Engagement with members of the Patient Equality, Diversity and Inclusion Sub-Committee
- External workshops, both virtual and physical, which were open to the communities of Warrington and Halton.

h. Learning from Clinical Audit

National Audits

National Audit of Paediatric Diabetes (NPDA)

Summary:
The audit NPDA was established to compare the care and outcomes of all children and young people with diabetes receiving care from Paediatric Diabetes Units (PDUs) in England and Wales. It aims to address a series of questions relating to paediatric diabetes care, which include:

- What proportion of children and young people with diabetes are reported to be receiving key age-specific processes of diabetes care, as recommended by NICE?
- How many achieve outcomes within specified treatment targets?
- Are children and young people with diabetes demonstrating evidence of small vessel (microvascular) disease and/or abnormal risk factors associated with large vessel (macrovascular) disease prior to transition into adult services?

Results:
The majority of WHH sample is made up of type 1 diabetes (96.4%), 10–14-year-olds make up the biggest proportion of the sample (43.8%). The population ethnicity was predominantly white which is 98.5%. An overall health check completion rate for young people aged 12+ was conducted in 91.8% and the national average was 88.6%. The table below shows the percentage of young people receiving the seven care processes for type 1 diabetes:

Key Care Process	Warrington	Northwest	England & Wales
HbA1c	100%	99.5%	99.7%
Blood Pressure	96.3%	96.5%	96.5%
Thyroid	98%	88.6%	87.8%
BMI	100%	99.3%	99.3%
Albuminuria	77.8%	80.6%	79.1%
Eye Screening	68.5%	72.6%	74.5%
Foot Examination	100%	88.3%	84.3%

The following action plan was implemented:

Action Required	Action Lead	Action by Date:	Where reported	Risk Rating (If Action Not Implemented)
Improvement required in training patients for carbohydrate counting at diagnosis (Participate in RCPCH QI)	Paediatric Diabetes MDT team	31st March 2022	CBU governance	9
Increase uptake Diabetes eye screening (Needs communicating to patients at annual screen in clinic visits and escalate to community lead for Diabetes retinal screening lead)	Paediatric Diabetes MDT team	31st March 2022	CBU governance	9
Ensure improved monitoring for coeliac screening at diagnosis (raise awareness with juniors at induction and monitoring by PDSN after discharge)	Paediatric Diabetes MDT team	31st March 2022	CBU Governance	6

All actions have been completed. Awareness was raised at the juniors doctors induction and various department teachings. Communicated and escalated to the eye screening team. The diabetes service participated in Royal College of Physicians (RCPCH) Quality Improvement collaborative on Carbohydrate counting.

Assurance rating:

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

Local Audits

An Audit of the Use of Radiology Alert Codes

Summary:

Radiology has a well-established process for the communication of urgent findings (with a ratified SOP). The reporting clinician will add an 'alert code' to the report either using digital dictation or VR. The alert codes have been reviewed and amended over time as the imaging service has developed. An alert code was introduced to enable Radiology to arrange follow up imaging (July 2020). Most recently an alert code was added for any positive VTE (Jan 2022). The aim of this audit. To ensure that current practice in Radiology is in line with the process detailed in the SOP and to ensure that the current process is safe and reliable.

Results:

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

no.	Standard	Present audit	Recommended
1	Was the alert actioned?	100%	100%
2	Was the receipt documented on CRIS?	81%	100%
3	Follow up Imaging arranged	99.4%	100%
4	VTE nurses alerted	100%	100%

Key Findings:

- Reports are being actioned effectively
- Follow up imaging is being booked appropriately
- The main area for improvement is noting the receipt of alerts/following up on unacknowledged alerts

Recommendation:

- Deep dive into the 45 patients whose alerts were not receipted
- Review the process for actioning alerts, to streamline and standardise the process

Action Required	Action Lead	Action by Date:	Where reported	Risk Rating (If Action Not Implemented)
'Deep dive' into the 19% of patients where receipt of alert was not recorded	G Matthews (Radiology Governance Lead)	September 2022	Radiology Audit and Governance meeting	6
Review of Radiology Alerts Process	G Matthews (Radiology Governance Lead) C Boland (QSI Lead)Dec 2022	December 2022	Radiology Audit and Governance meeting	6

Assurance rating:

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

i. Quarterly Learning Piece

Infection Prevention Strategy 2022-2025

We have a mission to work together to deliver outstanding healthcare by engaging, educating, and empowering healthcare staff, patients, and their carers to prevent healthcare associated infections and a vision of a world in which healthcare associated infections have been reduced to the lowest possible level.

The Strategy has been developed jointly with staff and external partners and is being promoted using the acronym SPACE-R which stands for:

- Surveillance
- Policy/Audit
- Antimicrobial Stewardship
- Clinical Advice
- Education
- Recovery from Covid

There are 3 key objectives which include:

1. Prevention of healthcare associated infections
2. Strengthening Antimicrobial Stewardship
3. Commitment to high standards of environmental cleanliness

Whilst the focus is on preventing infections, when they occur, we also need to control infections to prevent further cases.

j. Patient Quality and Safety Summit

In Quarter 1, the Trust hosted the Patient Quality and Safety Summit (agenda below). This was compiled by the Director of Governance and Associate Medical Director for Patient Safety, chaired by the Deputy Medical Director. The summit was a success and featured presentations from guest speakers around key areas of patient safety and governance. The summit looked at different ways of working across the NHS and celebrated the different initiatives that are being undertaken across organisational boundaries to improve the quality of care and safety provided to patients. This was attended by over 100 clinical and nursing staff. Feedback from the event will be available in the next LFE paper. At the time of writing the report the Quality Academy is due to launch its second event with learning to be shared within the next LFE.

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Patient Quality and Safety Summit

Day: Wednesday 29th June 2022
Time: 9:30 to 15:15
Venue: Microsoft Teams
Chair: Anne Robinson, Deputy Medical Director

Subject	Time	Presenter
Opening remarks	9.30	Kimberley Salmon-Jamieson, Chief Nurse
Learning disability and Autism – Transforming Neurodiversity Support	9:45 – 10:30	George Matuska (RNLD) Learning Disability and Autism Lead Clinical Advisor – Health Education England (South East)
Learning from litigation	10:30 – 11:15	Jessica Neary, Hill Dickinson Trust Legal Provider
Patient Safety Strategy	11:15 - 12:00	Deborah Carter, Project Director Patient Safety
Lunch	12:00-13:00	n/a
Civility Saves Lives	13:00-13:45	Debby Gould, Associate Director of Operations, Liverpool Women's Hospital
Human Factors	13:45 – 14:15	Andrea McGuinness, Head of Improvement, Advancing Quality Alliance (AQUA)
Court of Protection	14:15 – 14:45	Paul Allerston, Hill Dickinson Trust Legal Provider
Medical Examiner Services	14:45-15:15	James Williamson, Trust Chief Medical Examiner
Closing remarks	15:00-15:15	Paul Fitzsimmons, Medical Director

END

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Teaching Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act 2000.

We are WHH & We are PROUD to make a difference

k. Workstreams for Quarter 2

Action Planning

Complaints Monitoring and Improvement

Formal complaint responses continue to undergo close scrutiny through the complaints and senior Governance Team to review the quality of the responses. Where appropriate, the Complaints Team

will continue to encourage staff to seek to resolve complaints via telephone conversations or local resolution meetings with complainants.

The Complaints Quality Assurance Committee (QAG) continues to meet monthly, focussing on a different CBU each time. These meetings are an opportunity for the Chairman to review the Trust's complaints position, and for CBUs to reflect and feedback upon the quality and detail included within their responses. The Complaints Quality Assurance Groups held in Quarter 1 focussed on Women's & Children's, Surgical Specialities and Clinical Support Services.

PALS Improvement work

The PALS Team has maintained an average response time of 2 working days throughout Q1. The focus is now on improving the quality of the PALS service provided. In Q1, the PALS Team have drafted an updated PALS leaflet, to give clearer information on the scope of the PALS service. This is expected to be finalised and circulated in early Q2. The PALS service has also updated their telephone voicemail message, which now gives additional information on ways to contact the PALS service. In Q2, the PALS Team will be introducing a walk-round service, whereby they attend different wards within the hospital, to support ward staff in resolving patient concerns at a local level.

Welcome Booklet

The Patient Experience Team are in the process of redesigning the Trust's "Welcome to our Hospitals" booklet. This booklet provides information for patients, relatives and carers on what to expect from their hospital stay, from admission to discharge. It provides key details around topics including mealtimes, visiting and infection control. The booklet is being redesigned in collaboration with the Digital Communications Team, Complaints & PALS Team and Clinical Teams from each of the CBUs and seeks to address questions commonly asked by patients and relatives. This workstream was paused due to the rise of the Omicron variant. This is currently being re-reviewed by the Patient Experience Team to determine whether work on this can recommence in Q2/Q3 2022/23.

Junior Doctor Incident Training

The Patient Safety Manager has been completing Junior Doctor training to support the understating of governance and how incidents are managed and progressed. During these sessions incidents are pick out to discuss, on occasions the junior doctors have pick out scenarios and completed a presentation these for discussion. The feedback received from these sessions is that they are informative and bring about positive discussion identifying workstreams where we can learn and work together to improve patient care. These sessions will continue in Q2 2022/2023, and plans are in place to extend this to wider health professionals including nurses and AHPs.

3. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report.

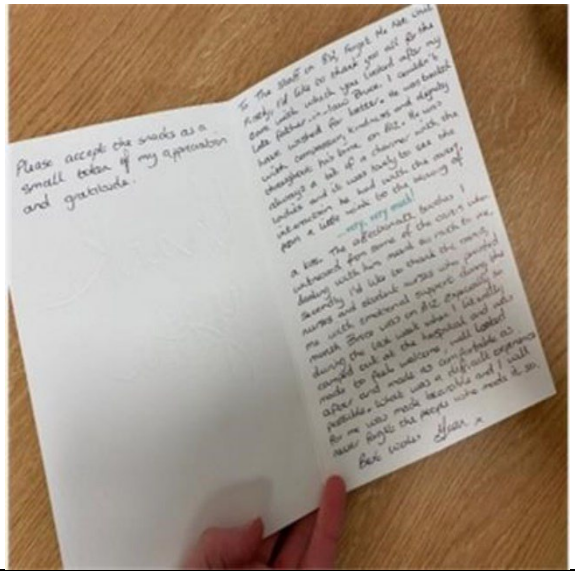
Appendix 1

Never Event List

The Never Event list (2018) as defined by NHS England is as follows (note: this list is not exhaustive):

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-procedure
4. Mis-selection of a strong potassium containing solution
5. Administration of medication by the wrong route
6. Overdose of insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis–selection of high strength midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails
10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients
15. Unintentional connection of a patient requiring oxygen to an air flowmeter

Appendix 2 – Bright Spots Examples

Staff/Area	Feedback	Date
Ward B12	Nicola Armstrong would like to say how proud she is of Ward B12. A relative came in the other day too with a card and some gifts. Keep up the good work B12!  	11/05/2022
Student Nurse	As a student, you are always a little nervous when starting a new placement. But that wasn't the case on the unit. From the minute I started this placement, I was treated with dignity and respect. The whole team was approachable and friendly and made sure that they helped you if you were unsure about anything. Nothing was too much trouble. The manager on the unit was friendly and approachable and had an opened door policy whereby you could nip in if you wanted a chat. My mentor was very eager and willing to help you in any way that they could. All members of the Multidisciplinary team were great role models throughout and showed great teamwork throughout. I am fortunate as a student because I have many years of experience within the NHS and this has helped me in each placement so far. The skills that I have gained over the years could be transferred to newly qualified members of staff within the unit. This Unit should be highlighted as a placement for all students from year 1 to 3 to experience before they qualify or even apply for a job once qualified. The whole team should be proud of how they treat students and keep up the good work. I hope this feedback reaches management and is mentioned to all members of staff on the ward. The changing facilities are great and hopefully, I could one day become a member of staff on this ward. Thank you for a great experience.	30/05/2022
ED	The Patient Safety Team would like to give ED a shout out for their continued work on improving the management of sepsis. After reviewing the May figures in their audit; sepsis screening and administration of antibiotics within the hour have all improved. Well done, Team, despite the continued pressures you are under. We are proud of you!	13/06/2022

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/09/124**	
SUBJECT:	**Infection Prevention and Control Report Quarter 1**	
DATE OF MEETING:	28 September 2022	
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 delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) because of the ongoing COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#1134** If we see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain. **#125** If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	
EXECUTIVE SUMMARY	This report provides a summary of infection prevention and control activity for Quarter 1 (Q1) of the 2022/23 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. Healthcare Associated Infection (HCAI) cases In Q1 were: - • C. difficile 9 cases • MRSA bacteraemia 1 case	

<table>
<tr><td></td><td colspan="3">

- MSSA bacteraemia 6 cases
- E. coli bacteraemia 17 cases
- Klebsiella Spp. bacteraemia 4 cases
- P. aeruginosa bacteraemia 0 cases

Covid-19 cases were : -

- 416 (0-2 days)
- 82 (3-7 days)
- 41 (8-14 days – probable healthcare associated)
- 79 (15+ days – definite healthcare associated)

11 Covid-19 outbreaks, 10 of which were mixed patient and staff and 1 patient only outbreak were reported. Outbreak Control Groups were established to manage the Covid-19 outbreaks with the Planned and Unplanned Care Groups.
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Trust Board is asked to receive and note the report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2">QAC/22/08/214</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">02/08/2022</td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2">The Q1 IPC report was approved</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Partial FOIA Exempt</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">Section 40(2) - data protection</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Infection Prevention and Control Report Quarter 1	AGENDA REF:	BM/22

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 1 (Q1) of the 2022/23 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) thresholds, response to the ongoing Covid-19 Pandemic and progress against the Infection Prevention Strategy.

NHS England/Improvement (NHSE/I) use Clostridioides (Clostridium) difficile (C. difficile) infection rates to assess Trust performance. Both avoidable and unavoidable cases are considered for regulatory purposes.

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

There is a national ambition to halve Gram-negative bloodstream infections (GNBSIs) by 2024. GNBSIs include: - Escherichia coli (E. coli); Klebsiella species (Klebsiella spp.) and Pseudomonas aeruginosa (P. aeruginosa). Apportionment of bacteraemia cases (Gram-positive and Gram-negative) has changed to include community onset healthcare associated cases (patients discharged within 28 days prior to a positive sample date).

NHSE/I set HCAI thresholds for WHH for 2022/23 are shown in table 1.

Table 1: HCAI Thresholds for 2022/2023

HCAI	WHH Threshold 2022/23
C. difficile	37
E. coli	57
Klebsiella spp.	19
P. aeruginosa	6

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

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

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

2. KEY ELEMENTS

Healthcare Associated Infection Surveillance Data

RAG rating of Trust performance for HCAIs by month is shown in Table 2

Table 2 Surveillance Data

Indicator	Threshold	A	M	J	Total	Position
C. difficile	≤ 37	6	5	0	9	On trajectory
MRSA bacteraemia	Zero tolerance	0	0	1	1	One over threshold
MSSA bacteraemia	No target	0	3	3	6	No threshold
E. coli bacteraemia	≤ 57	6	6	5	17	Over trajectory
Klebsiella spp. bacteraemia	≤ 19	1	3	0	4	On trajectory
P. aeruginosa bacteraemia	≤ 6	0	0	0	0	On trajectory

A SIGHT mnemonic campaign is being developed to raise awareness of the importance of timely isolation and testing of patients with symptoms of C. difficile infection.

The GNBSI prevention plan has been revised into a programme of work which includes: -

- Patient education and awareness
- Staff education and awareness
- Hydration
- Oral care
- Continence management
- Catheter care and management
- UTI detection and management
- Hepatobiliary care

Trauma and Orthopaedic Surgical Site Infection

The Orthopaedic Consultant Team escalated concerns about an increase in surgical site infections and the Trust received a letter from UK Health Security Services, noting this increase infections in hip replacement surgery. The infections occurred in the 2021 – 2022 financial year: 4 in Q3 and 2 in Q2. Early review of the infections has not identified a single source that could be targeted to prevent further cases. Patients were under the care of different consultants. Although four of the patient's swabs grew S. aureus, this was not linked to transmission between the cases. A plan is in place to introduce pre-operative screening for S. aureus and to prescribe skin suppression therapy prior to surgery.

Further work is in progress to review patient pathways and outcome of full root cause analysis investigations into each patient case is awaited.

Policy/Guideline/SOP Updates

The following documents have been updated and approved by the Infection Prevention and Control Sub-Committee: -

- Pre-procedure Covid-19 testing prior to elective procedures planned care – revised SOP
- Clinical and non-clinical areas Covid-19 risk rating

- Clinical and non-clinical areas Covid-19 risk rating for staff
- Covid-19 contact letter
- Respiratory viruses testing approach
- Risk assessment for meeting rooms
- HOCI daily cluster outbreak reporting proforma
- Patient Covid-19 contact letter
- Mobile air conditioning units SOP
- Revised SOP for Non-Elective Testing for Respiratory viruses
- Clinical and non-clinical Area Covid-19 risk rating for staff previously identified as CEV
- Updates to face mask guidance for Covid-19 and social distancing
- SOP Covid-19 Lateral Flow Device testing for patients
- SOP for contractors and external representatives visiting Trust premises
- SOP for temporary installation of mobile air conditioning units
- SOP for reusable PPE decontamination and maintenance

Audit

Fifteen infection prevention and control audits were completed with overall scores as detailed in Table 3 and full audit scores included at Appendix 2. Ward environment and ward kitchen scores were lower across a number of areas. Action was taken at the time of auditing to address environmental cleanliness and there is a schedule to upgrade ward kitchens. Audits are repeated if scores are low or in response to concerns about HCAI cases. Support was provided to AMU for a low personal protective equipment (PPE) compliance score and a re-audit is scheduled.

Table 3 Audit Data

Ward	ANDU	The Nest	C23	A5 E	A7	PIU	A5 GU	A8	A8	W THEATRE	B19	A6	A2	AMU	B4
Overall Compliance	85	99	97	99	96	97	97	98	94	91	99	97	99	89	98

Antimicrobial Stewardship

Work is in progress to replace the current PDF Antibiotic formulary with an App.

A web viewer version will also be available. Publication date will be advised through Trust communication channels and at teaching sessions for all prescribers.

The point prevalence antibiotic prescribing audit completed in June saw a decrease in overall prescribing compliance from 92% to 87%. Areas for improvement include ensuring appropriate specimen collection to support de-escalation of antibiotics. High use of Tazocin was identified as an area of concern and an additional ward round will be introduced to review duration of courses and advise prescribing practices.

Compliance by ward is shown in Table 4 and the full audit report is included at appendix 3. Additional engagement from the Consultant Microbiologist and Acute Care Consultants is in place to review and de-escalate antibiotics commenced at admission.

Table 4 Antibiotic Prescribing Compliance with Trust Formulary by Ward

Ward	Compliance June 2021	Compliance Nov 2021	Compliance March 2022	Compliance June 2022
AMU	90% (9/10)	96% (25/26)	96% (22/23)	77% (20/26)
A2	94% (17/18)	78.5% (11/14)	100% (22/22)	87.5% (7/8)
ACCU ward	100% (9/9)	75% (3/4)	100% (14/14)	85.7% (6/7)
ACCU HDU	100% (6/6)	100% (4/4)	100% (3/3)	100% (4/4)
A4	96% (25/26)	79% (11/14)	80% (21/26)	89.5%(17/19)
A5 Elective	100% (1/1)	Nil antibiotics	100% (3/3)	0% (0/3)
A5 Gastro	100% (7/7)	84% (16/19)	100% (16/16)	86.7%(13/15)
A6	92% (12/13)	71% (10/14)	80% (4/5)	87.5% (7/8)
A7	73% (19/26)	80% (8/10)	95% (18/19)	87.5% (7/8)
A8	87% (13/15)	87.5% (14/16)	100% (10/10)	81.25% (13/16)
A9	75% (9/12)	83% (10/12)	100% (16/16)	82.4%(14/17)
FMN unit (B12)	100% (5/5)	100% (6/6)	100% (5/5)	100% (10/10)
B14	100% (2/2)	75% (3/4)	100% (3/3)	100% (4/4)
B18	Closed	87% (20/23)	83% (20/24)	82.75%(24/29)
B19	93% (13/14)	100% (5/5)	57% (4/7)	90% (9/10)
C20	67% (6/9)	75% (3/4)	100% (12/12)	100%(16/16)
C21	90% (9/10)	100% (6/6)	77% (10/13)	83.3%(10/12)
C23	100% (2/2)	100% (2/2)	100% (1/1)	100% (6/6)
K25	78% (7/9)	80% (4/5)	100% (2/2)	50% (1/2)
ITU	100% (11/11)	100% (15/15)	100% (10/10)	100% (11/11)
CAU	80% (4/5)	Nil patients	Not collected	100% (5/5)
Halton B3	100% (5/5)	100% (2/2)	100% (2/2)	100% (2/2)
CMTC	0% (0/1)	100% (1/1)	Nil antibiotics	Nil antibiotics
Paediatrics				
B11	100% (5/5)	100% (7/7)	100% (9/9)	100% (4/4)
NNU	100% (11/11)	100% (4/4)	100% (2/2)	100% (4/4)

Education and Training

Overall compliance with infection control mandatory training was 85% at the end of June. Mandatory training is available via eLearning and 2 taught sessions are provided each week. The Infection Prevention and Control Team have offered additional sessions to support compliance improvements and CBUs have been asked to set trajectories to improve.

Table 5 Mandatory training Compliance

Infection Control Mandatory Training	A	M	J
Level 1 – Non-Clinical	88%	90%	90%
Level 2 - Clinical	78%	78%	79%
Overall % of staff trained	**83%**	**84%**	**85%**

Infection Prevention Strategy Progress and Awareness Raising Events

Infection Prevention Strategy was circulated via Good Morning WHH in June and has been presented at: -

- Nursing and Midwifery Forum
- Medical Cabinet
- Allied Health Professional Forum
- Digestive Diseases CBU
- Ward Managers Meeting
- Housekeeper Forum

There is a plan to present at the remaining CBU meetings.

Environmental Hygiene

Work continues to implement the revised National Cleanliness standards. The Commitment to Cleanliness Charter has been signed by the Chairman, CEO and Chief Nurse/Deputy Chief Executive/DIPC in readiness for display across the Trust.


Our Commitment to Cleanliness

Cleanliness matters and to ensure consistency throughout the NHS this commitment has been made in all hospitals. Keeping our hospitals clean and preventing infection is every staff member, patient and visitors responsibility. Warrington and Halton Teaching Hospitals set out our commitment to ensure a consistently high standard of cleanliness is delivered in all our healthcare facilities. This Cleaning Summary sets out how we would like you to help us maintain high standards.

WE WILL:

- Treat patients in a clean and safe environment and minimise exposure to healthcare associated infections.
- Provide a well maintained, clean and safe environment, using the most appropriate and up to date cleaning methods and at regular times.
- Allocate specific roles and responsibilities for cleaning, underpinned by strong leadership.
- Have named leads who will establish and promote a cleanliness culture within the Trust.
- Constantly review cleanliness to ensure that high standards are met.
- Listen and act on patients and visitors feedback about the cleanliness.
- Provide clear information on measures to prevent healthcare associated infections.
- Provide clear and precise information to the risk of contracting a healthcare associated infection.
- Provide education and training to all our staff on infection prevention and control practices within the remit of their role.
- Design any new facilities with ease of cleaning in mind.

WE ASK PATIENTS, VISITORS AND THE PUBLIC TO:

- Follow good hand hygiene practices.
- Speak to the person in charge of the area if you are concerned about the standards of cleanliness or if you have any questions.
- Work with us to monitor and improve standards of cleanliness and prevention of infection.
- If you are unhappy with the cleanliness in any area, please contact us on 01925 662794.
- Please ask us if you require any further information about cleanliness or prevention of infection by contacting our Patient Advice and Liaison Service (PALS) on 01925 275512 or email whh.pals@nhs.net

Wash Your Hands

ISOLATION AREAS
Signage will be displayed in areas where patients have infections. Additional cleaning is undertaken in these areas.

PROTECTED MEAL TIMES
During 'Protected Meal Time periods' cleaning will be undertaken in areas which do not interrupt the patient's enjoyment or distract Nurses from assisting patients with eating their meals.

Chairman
Chief Executive
Chief Nurse/ Deputy Chief Executive

Incidents

Monkeypox

Seven cases of suspected Monkeypox have been managed by the Trust, two of which were positive. An SOP is in place to guide staff on levels of personal protective equipment and testing arrangements. Two patients tested positive and staff who had contact with the cases have been followed up with active surveillance and post exposure prophylaxis offered and given where accepted.

Covid-19

High numbers of patients being admitted with Covid-19 continued to impact the Trust with details including hospital onset cases as shown in Table 6.

Table 6 Covid-19 Cases

Month	0 to 2 days	3 to 7 days	8 to 14 days	15+ days	Grand Total
Apr	217	53	22	27	319
May	109	12	5	14	140
Jun	90	17	14	38	159

Covid-19 Outbreaks

Eleven Covid outbreaks were reported ten of which affected both patients and staff. Outbreak Control Groups were established to manage the Covid-19 outbreaks with the Planned and Unplanned Care Groups.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. IMPACT ON QPS?

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

5. MEASUREMENTS/EVALUATIONS

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

6. TRAJECTORIES/OBJECTIVES AGREED

HCAI	WHH Threshold 2022/23
C. difficile	≤37
E. coli	≤57
Klebsiella	≤19
P. aeruginosa	≤6

7. MONITORING/REPORTING ROUTES

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

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

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

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

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

Daily monitoring by the Senior Executive Oversight Group during the pandemic.

8. TIMELINES

2022 – 2023 Financial Year

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

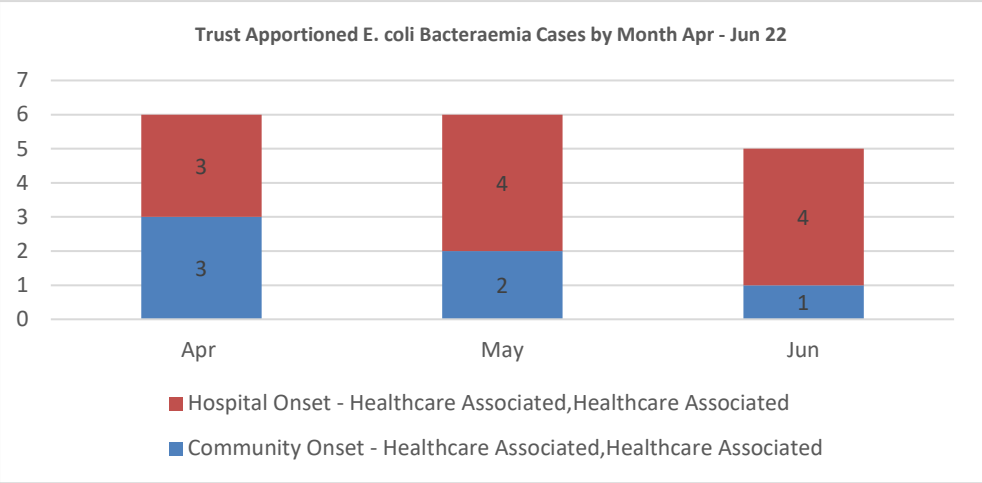
10. RECOMMENDATIONS

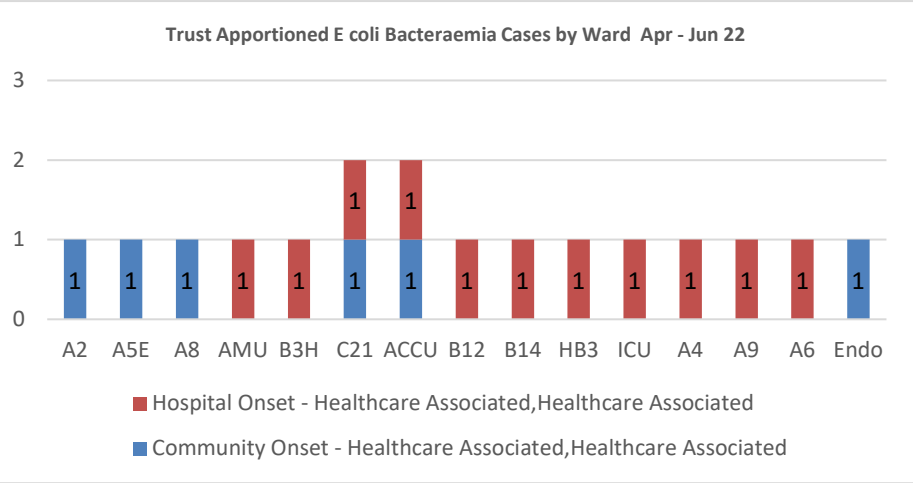
The Trust Board is asked to receive the report, note the exceptions reported and progress made.

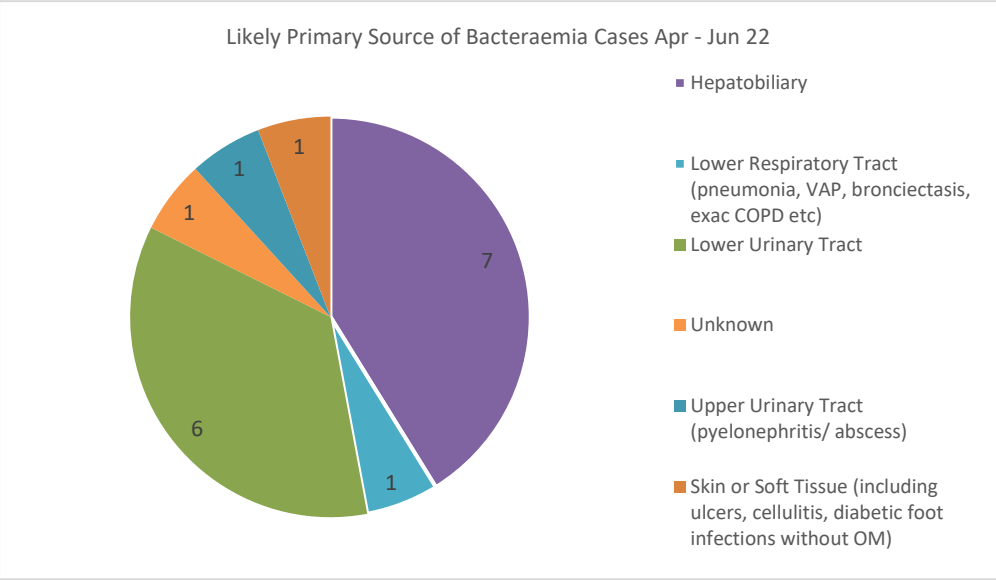
Appendix 1 HCAI SURVEILLANCE DATA

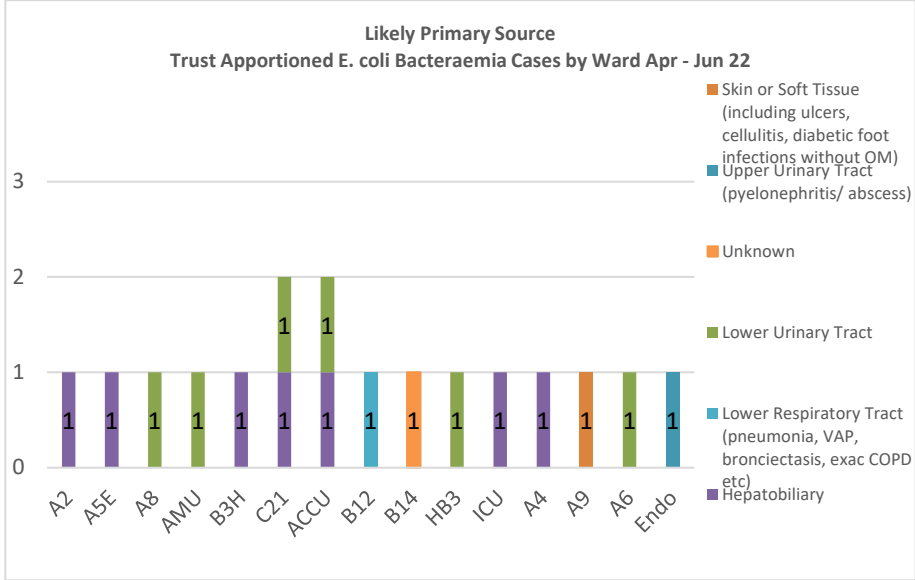
Gram Negative Bloodstream Infection: E. coli

Threshold = 57
FY Total = 17 cases



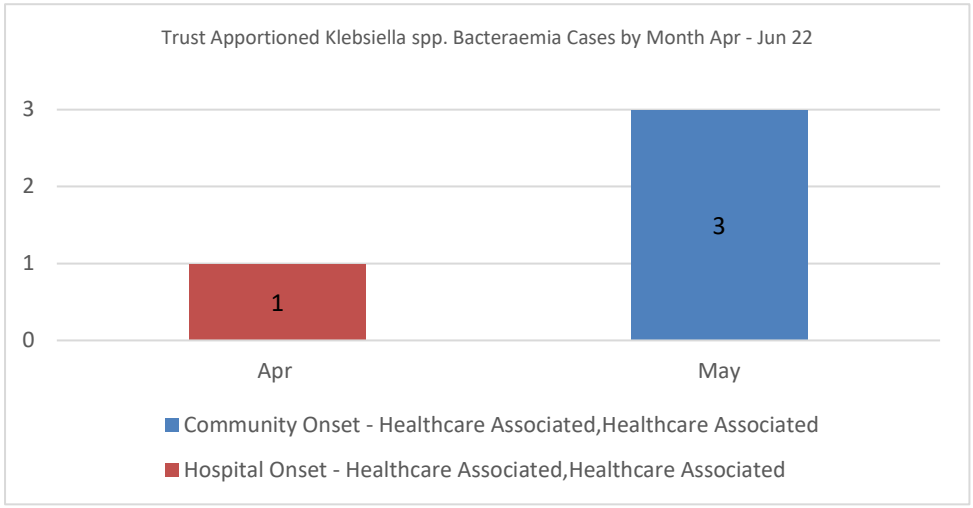


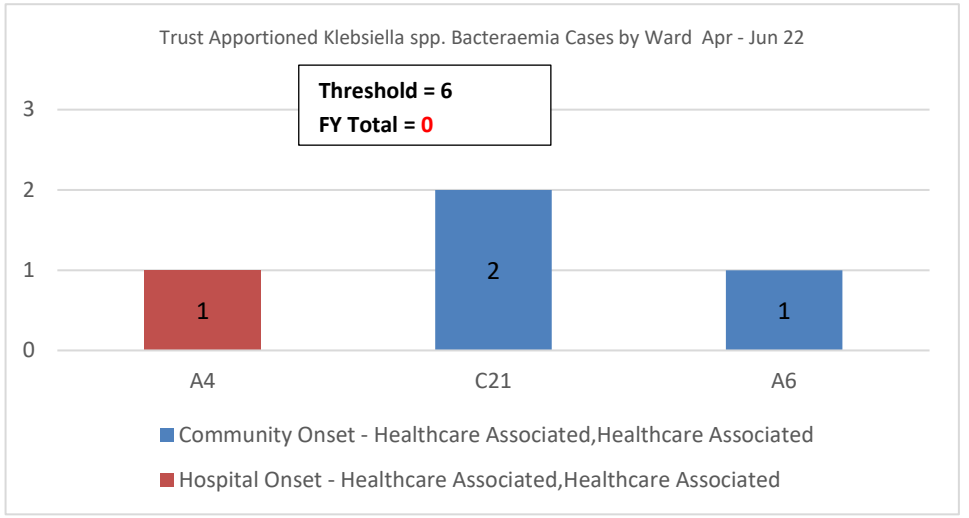


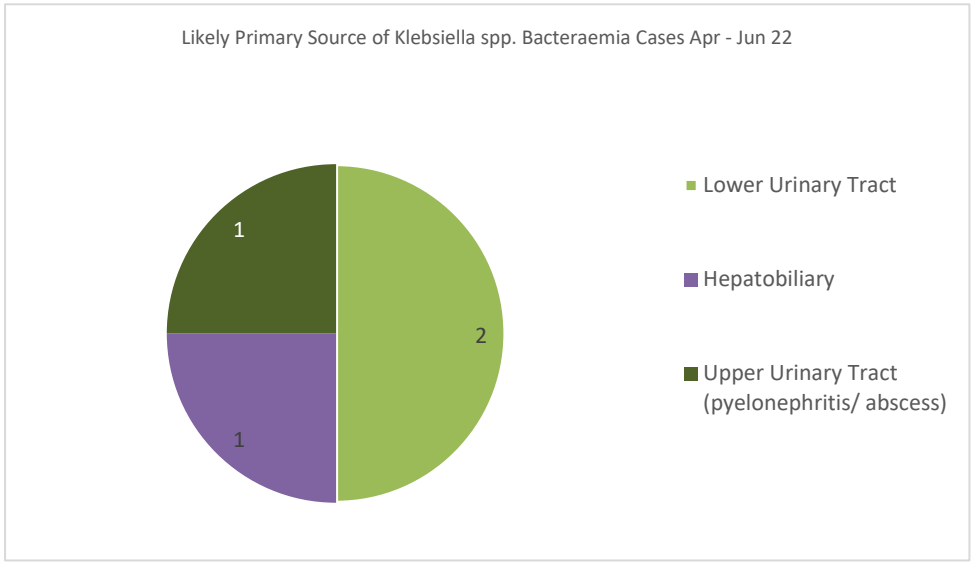


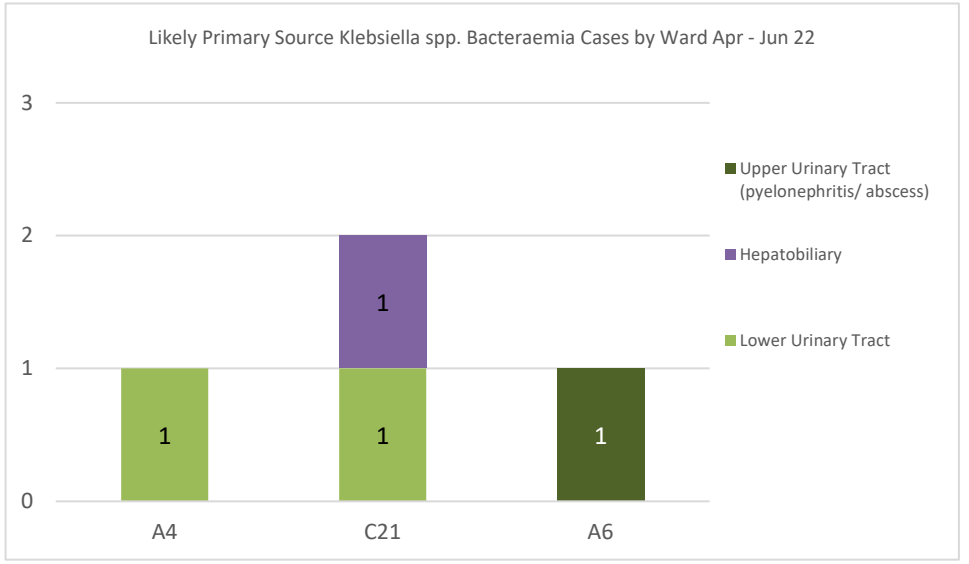
Gram Negative Bloodstream Infection: Klebsiella spp.

Threshold = 19
FY Total = 4 case







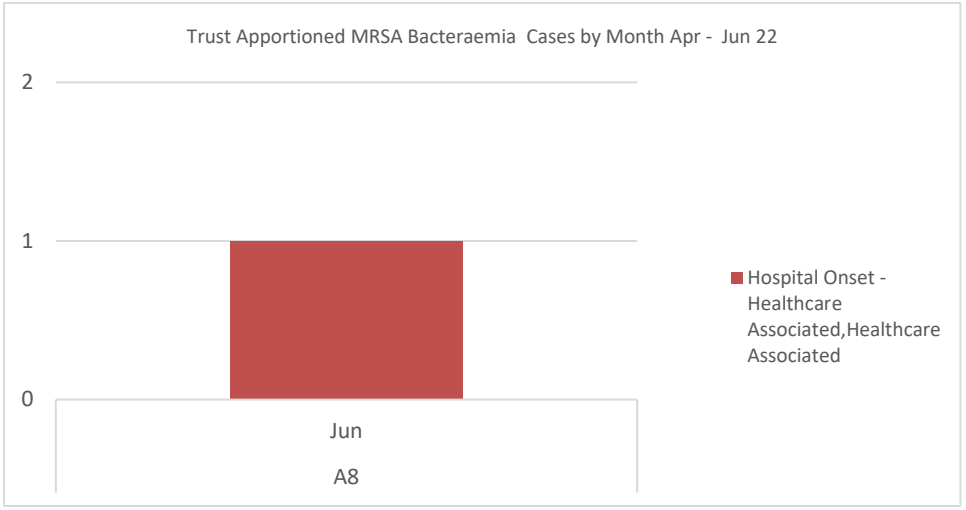


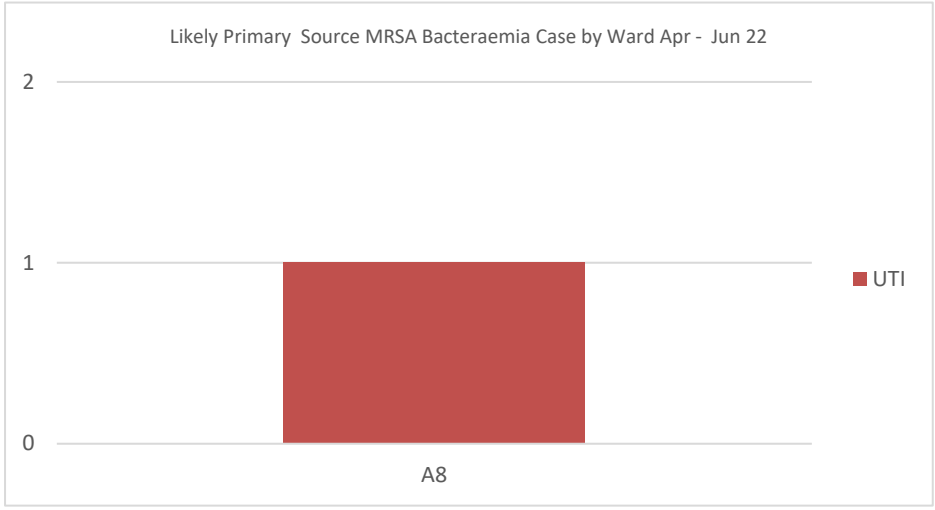
Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa) Apr- Jun 2022

Nil hospital onset cases

Gram Positive Bloodstream Infection: Meticillin-resistant Staphylococcus aureus (MRSA)

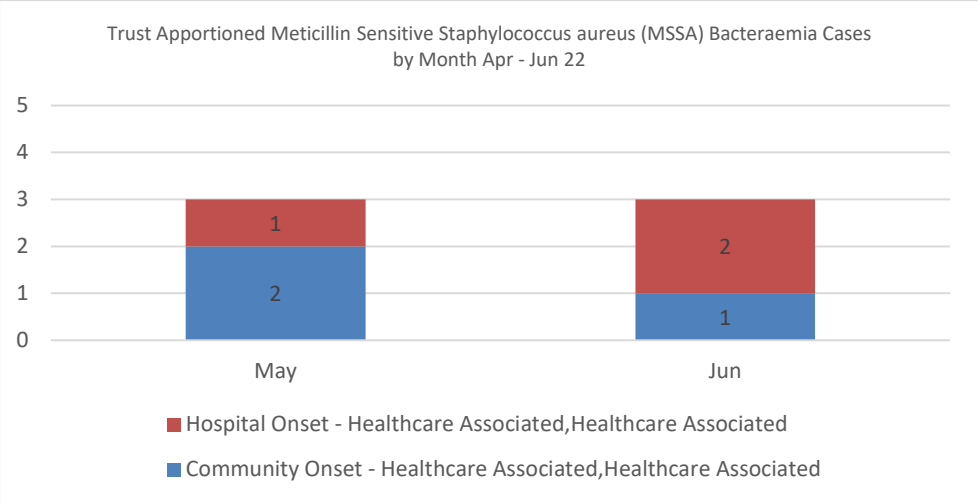
Threshold = Zero Avoidable
FY Total = 1

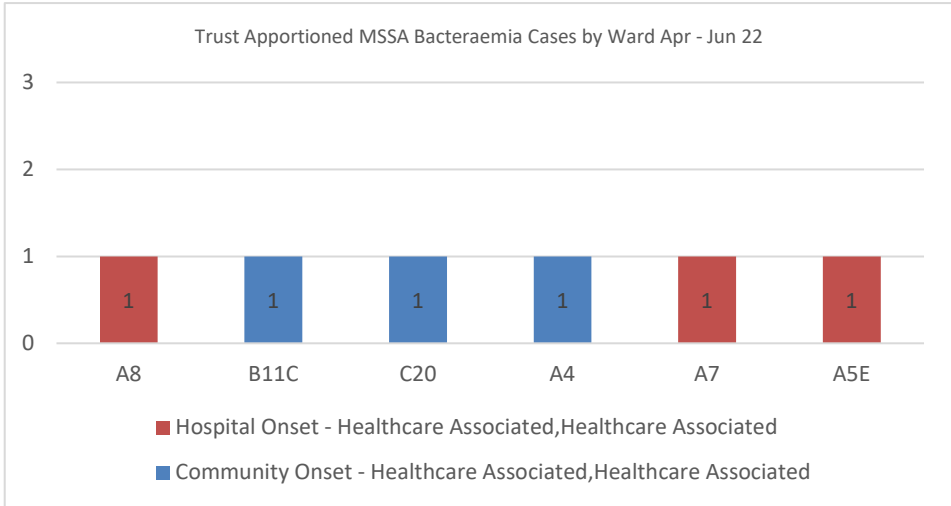


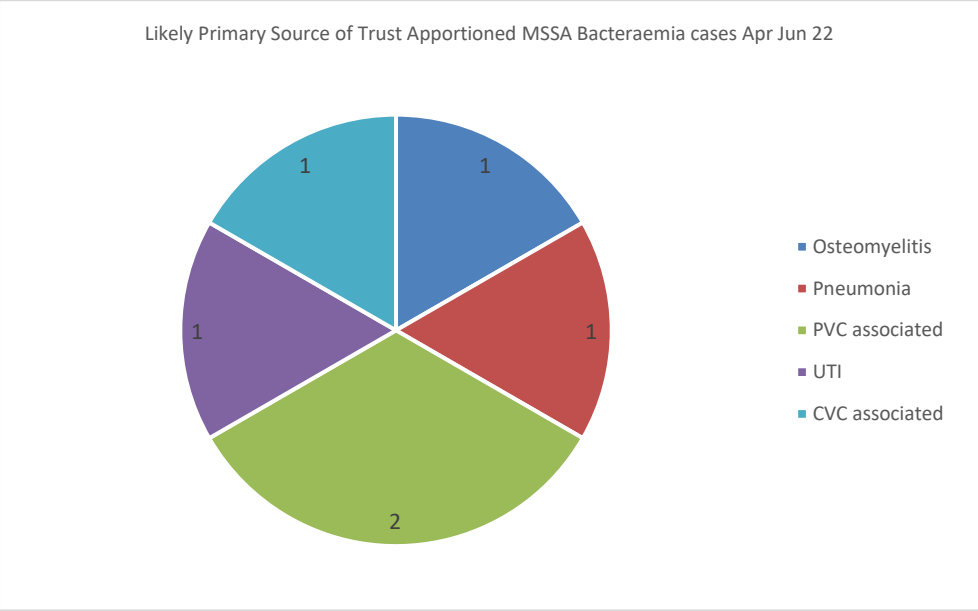


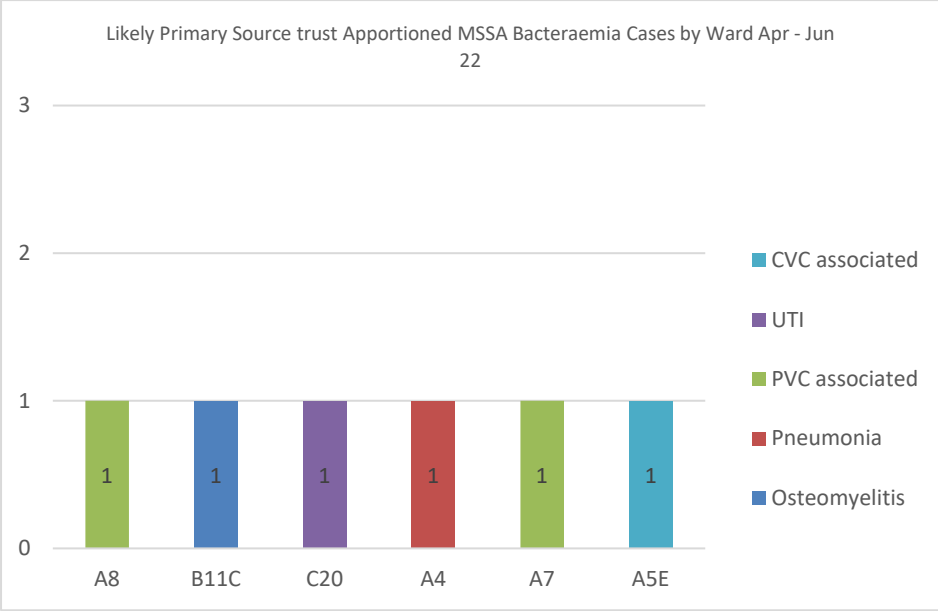
No threshold
FY Total = 6

Gram Positive Bloodstream Infection: Staphylococcus aureus



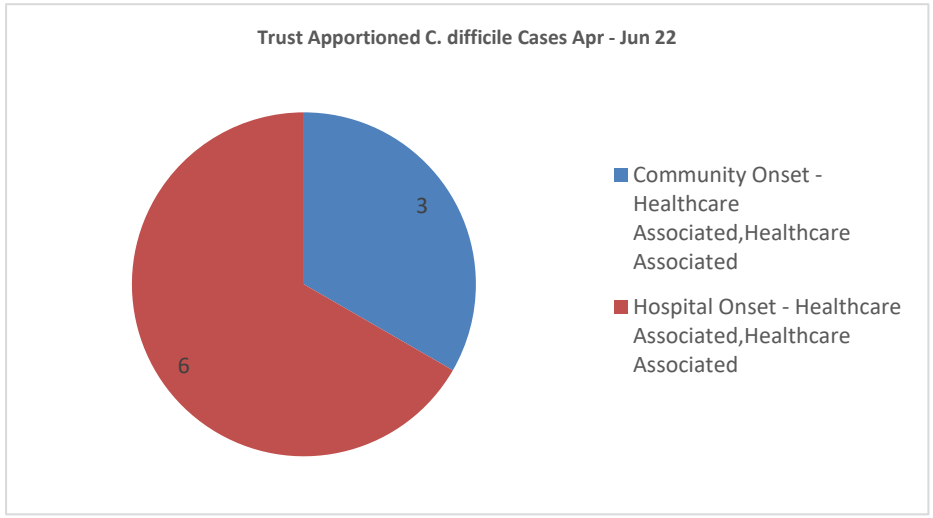


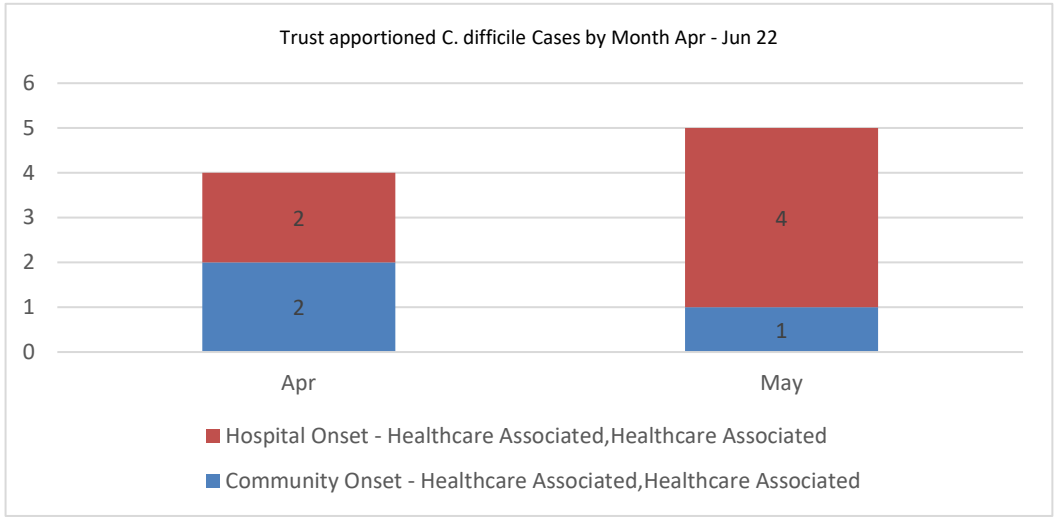


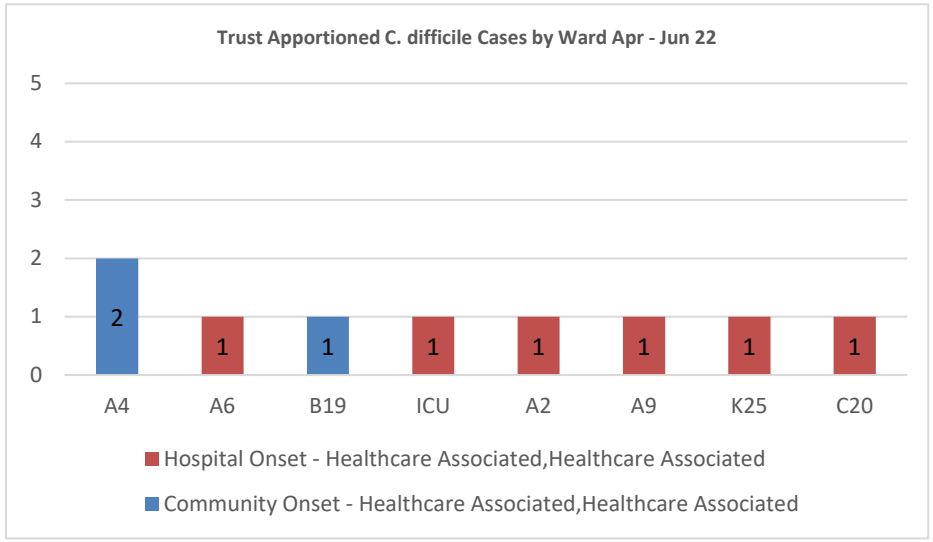


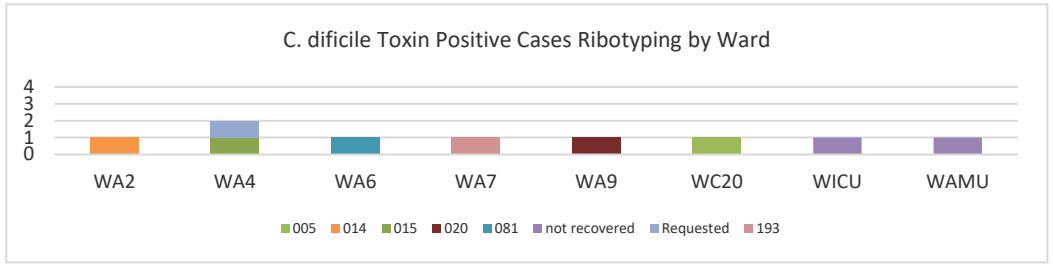
Threshold = 37
YTD Total = 9 cases

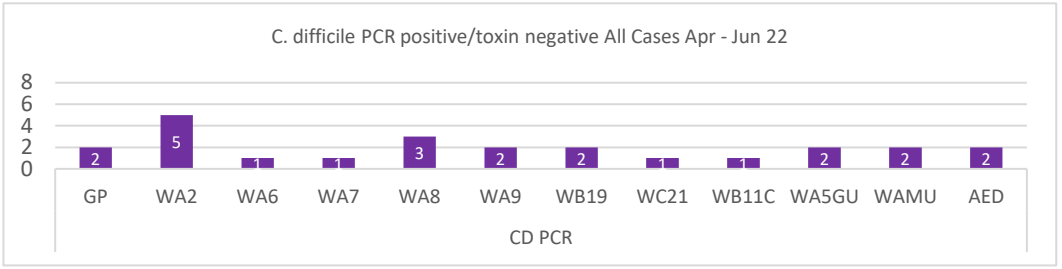
Clostridioides difficile (C. difficile) Toxin



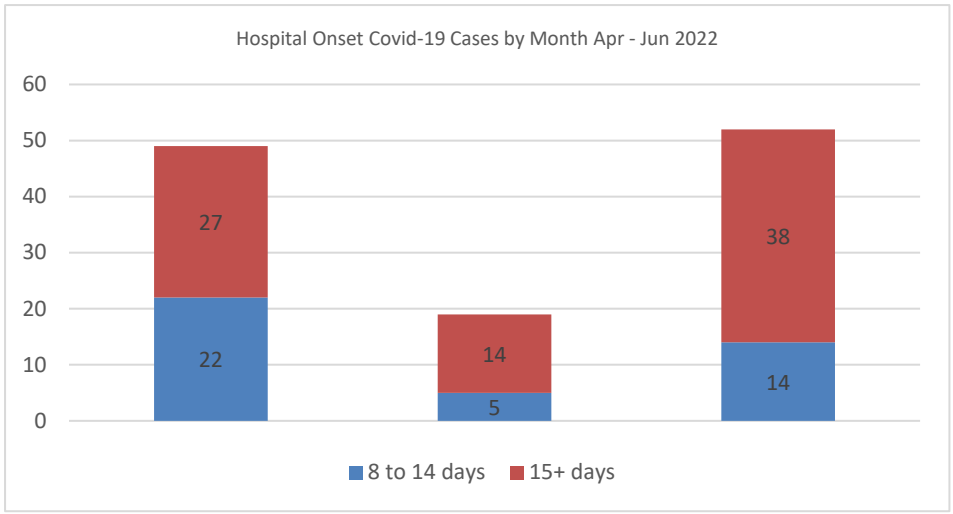


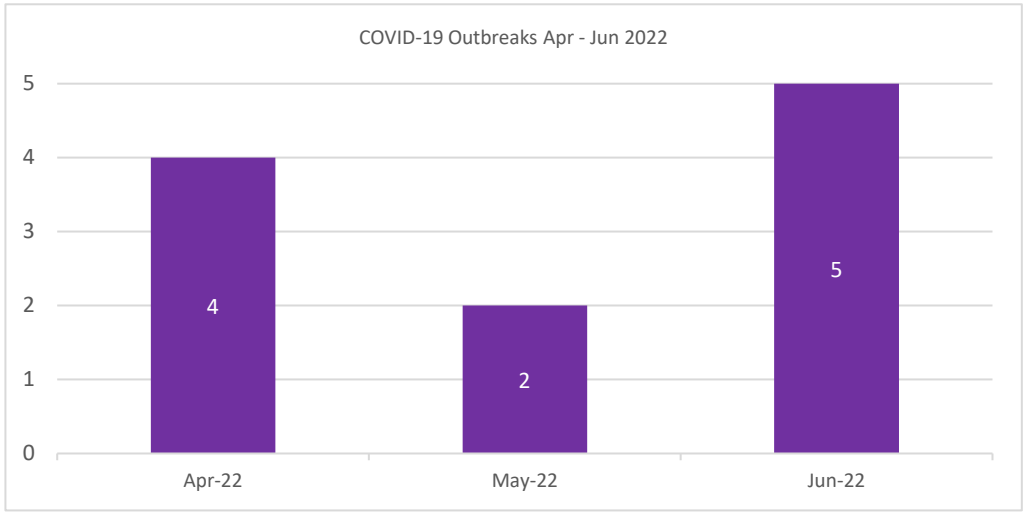


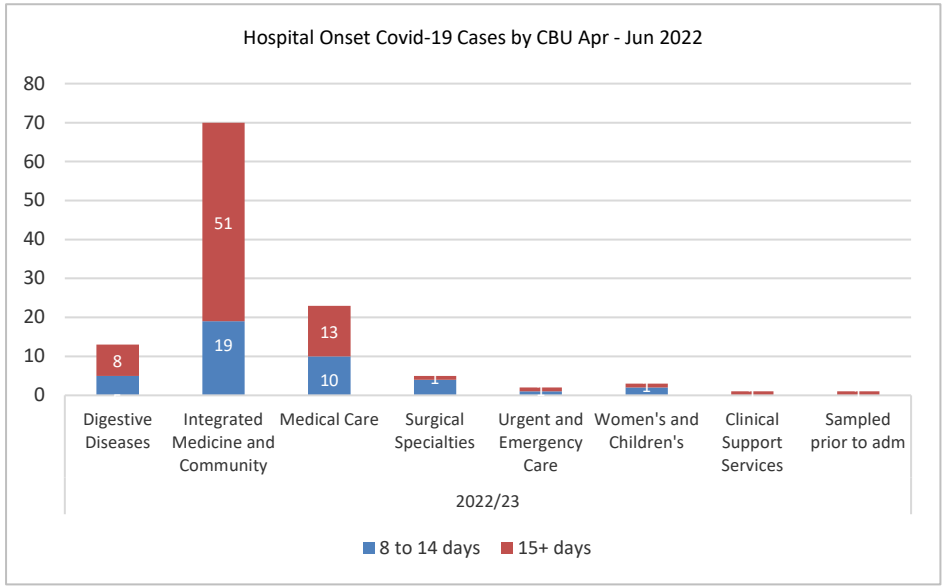


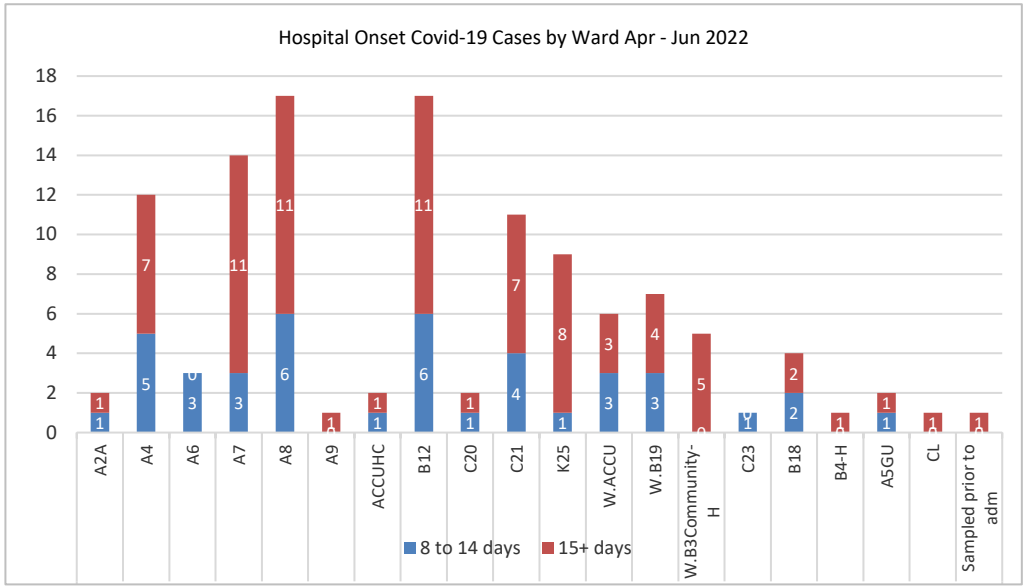


Covid-19 Surveillance Data









Appendix 2 IPC Audit Results

Ward	ANDU	The Nest	C23	A5 Elective	A7	PIU	A5 GU	A8	A8	W THEATRE	B19	A6	A2	AMU
Environment	76	98	87	92	87	90	84	95	76	69	98	92	97	68
Ward Kitchens	N/A	95	96	96	90	93	88	88	78	70	96	93	93	75
Handling/Disposal of Linen	100	100	94	94	94	100	94	100	100	100	100	94	100	100
Departmental Waste	100	100	100	100	100	100	100	100	94	88	100	100	100	100
Safe Handling Disposal of Sharps	100	100	100	100	100	100	100	96	96	100	96	100	100	92
Patient Equipment (General)	90	100	92	100	92	97	97	97	97	88	97	97	100	91
Patient Equipment (Specialist)	100	100	100	100	N/A	100	100	100	100	100	100	100	100	100
Personal Protective Equipment	100	100	100	100	100	100	100	100	93	100	100	100	100	64
Short Term Catheter Management	N/A	100	100	100	100	N/A	100	100	100	N/A	100	94	100	100
Enteral Feeding	N/A	100	100	100	N/A	100	100	100	100	100	100	100	100	100
Care of Peripheral Intravenous Lines	N/A	N/A	N/A	100	100	100	N/A	100	N/A	N/A	100	N/A	100	90
Non-Tunnelled Central Venous Catheters	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Isolation Precautions	N/A	N/A	N/A	N/A	100	N/A	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hand Hygiene	97	97	100	100	97	93	97	100	97	91	1000	97	100	92
Overall Compliance	**85**	**99**	**97**	**99**	**96**	**97**	**97**	**98**	**94**	**91**	**99**	**97**	**99**	**89**

Antibiotic Prescribing Trust Wide Point Prevalence Report

June 2022

Jacqui Ward

Lead Pharmacist in Antimicrobial Stewardship

Introduction, aims and objectives

Warrington and Halton Teaching Hospitals (WHH), as recommended by the Department of Health's (DoH) guidance on Antimicrobial Stewardship "Start Smart and then Focus"[1] has an Antimicrobial Stewardship programme. This programme aims to achieve prudent, evidence-based use of antimicrobials.

Trust wide 6 monthly or annual point prevalence audit is one of the tools recommended by the DoH to assess compliance with the organisation's stewardship programme. This enables the Trust to be provided with assurance that antimicrobial stewardship guidance is followed to deliver satisfactory levels of compliance with national guidance.

The aims and objectives of this audit were to;

1. Evidence compliance with outcomes 8 and 9 of the Care Quality Commission (CQC) framework and criteria 5 and 9 of the Health and Social Care Act 2008[2].
2. Provide assurance for the Trust of compliance with the DoH guidance on antimicrobial stewardship.
3. Determine overall prevalence of antimicrobial prescribing and types of antimicrobials prescribed.
4. Identify priority areas for future antimicrobial stewardship interventions.

1. Method

Data was collected on 13th & 14th June 2022 for all inpatients at Warrington Hospital and Halton Hospital site (encompassing the Nightingale Building and Captain Sir Tom Moore Building). All oral and parenteral antibiotics prescribed were included (topical preparations were excluded). Ward Pharmacists identified which patients were on antibiotics from their EPMA chart.

The data collected was:

Ward-specific:

- Total number of patients on the ward
- Total number of patients who were prescribed antibiotics

Patient-specific:

- Antibiotic(s) prescribed
- Dose, route, and frequency
- Indication documented in the notes/on the prescription chart
- Course length or review date documented
- Whether an allergy status was recorded on the electronic prescribing system
- Whether the antibiotic was compliant with the Trust antibiotic formulary.
- If the antibiotic was not compliant with the Trust antibiotic formulary, whether there was an appropriate reason for deviation documented. Appropriate reasons included the following:
    - Contraindication to formulary antibiotic (e.g., allergy)
    - Documented advice from Consultant Microbiologist

- Culture and sensitivity result (current or previous) to suggest resistance to formulary antibiotic.
- Risk factors for resistant organism
- Failure of therapy recommended in guidelines (therapy escalation)
- Recent exposure to first line therapy
- No local guidance available
- Continuation of therapy started in primary care/another Trust

- Was it the first antibiotic prescribed for the indication?
- If a review was undertaken, what the outcome was.
- If the antibiotic was oral, had it previously been stepped down from IV.

Exclusion criteria

- Outpatients
- Day case patients
- Patients receiving topical antibacterial treatment
- Antifungal or antiviral medications
- Single doses of antibiotics for surgical prophylaxis

2. Results

2.1 Antibiotic overview

Data was collected for 551 patients in total across the two sites on the days of the audit. 100% of all inpatient charts were screened. Across the two sites 185 (33.6%) patients were prescribed a total of 269 antibiotics. This is less than the previous quarter (March 2022) were 34.7% of patients were prescribed at least one antimicrobial. The number of patients audited has increased (551 vs 531) compared to the previous audit.

Table 1: Breakdown of patients audited across sites

	Warrington Hospital	Nightingale Building	Captain Sir Tom Moore Building	Total
% of Inpatients seen on days of audit	511/511 (100%)	31/31 (100%)	9/9 100%	551/551 (100%)
% of Inpatients seen prescribed antimicrobials on days of audit	182/511 (35%)	3/31 (9.7%)	0/9 Nil	185/551 33.6%
Number of antimicrobials prescribed on days of audit	266	3	0	269

Table 2: Antibiotic Overview by Speciality

Speciality	Number of patients on antibiotics	Number of antibiotics prescribed	% of patients with allergy status documented	% of antibiotics that were IV *	% of antibiotics that had a course length documented*	% of antibiotics with a documented indication *	% of antibiotics that were compliant with the formulary or otherwise appropriate*
Medicine	127	176	100	49	59.2	99	85.3
Gastro-enterology	10	14	100	66.7	50	91.7	91.7
Surgery	25	45	100	86.4	38.6	93.2	84
Women's & Children	9	14	100	57.1	42.9	100	100
Orthopaedic	8	9	100	62.5	75	87.5	87.5
ICU	6	11	100	100	9	100	100

* prophylactic antibiotics are excluded from this data

Figure 1. Antibiotic Overview by Speciality

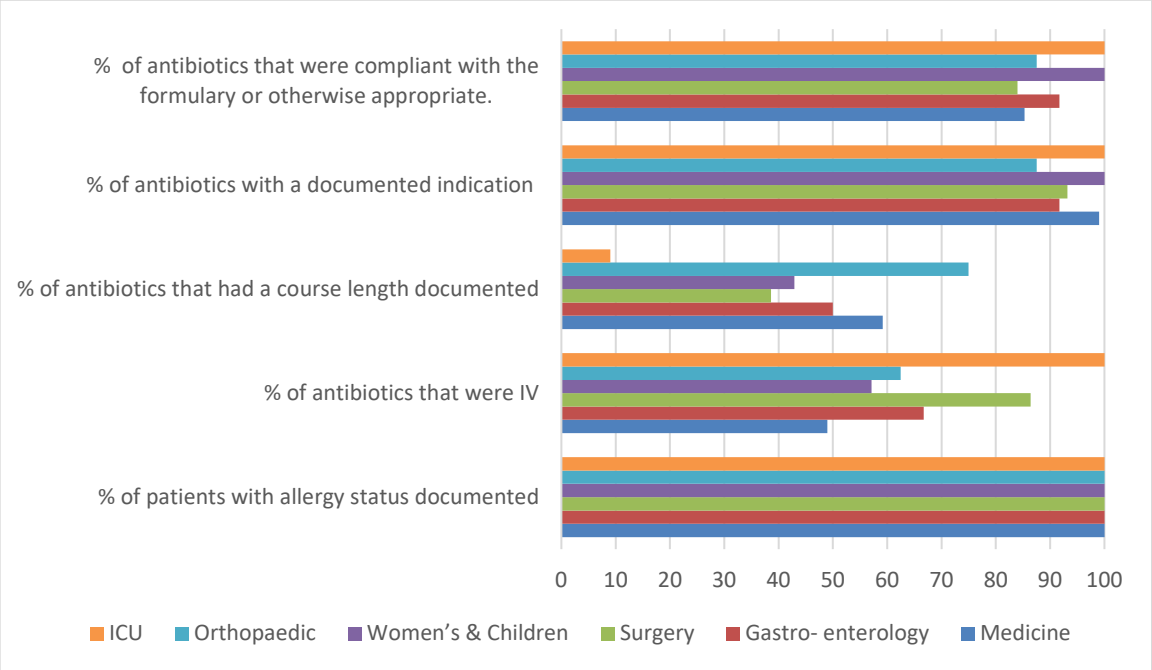


Table 3: Antibiotic Compliance with formulary by ward

Ward	Compliance June 2021	Compliance Nov 2021	Compliance March 2022	Compliance June 2022
A1	90% (9/10)	96% (25/26)	96% (22/23)	77% (20/26)
A2	94% (17/18)	78.5% (11/14)	100% (22/22)	87.5% (7/8)
ACCU ward	100% (9/9)	75% (3/4)	100% (14/14)	85.7% (6/7)
ACCU HDU	100% (6/6)	100% (4/4)	100% (3/3)	100% (4/4)
A4	96% (25/26)	79% (11/14)	80% (21/26)	89.5%(17/19)
A5 Elective	100% (1/1)	Nil antibiotics	100% (3/3)	0% (0/3)
A5 Gastro	100% (7/7)	84% (16/19)	100% (16/16)	86.7%(13/15)
A6	92% (12/13)	71% (10/14)	80% (4/5)	87.5% (7/8)
A7	73% (19/26)	80% (8/10)	95% (18/19)	87.5% (7/8)
A8	87% (13/15)	87.5% (14/16)	100% (10/10)	81.25% (13/16)
A9	75% (9/12)	83% (10/12)	100% (16/16)	82.4%(14/17)
FMN unit (B12)	100% (5/5)	100% (6/6)	100% (5/5)	100% (10/10)
B14	100% (2/2)	75% (3/4)	100% (3/3)	100% (4/4)
B18	Closed	87% (20/23)	83% (20/24)	82.75%(24/29)
B19	93% (13/14)	100% (5/5)	57% (4/7)	90% (9/10)
C20	67% (6/9)	75% (3/4)	100% (12/12)	100%(16/16)
C21	90% (9/10)	100% (6/6)	77% (10/13)	83.3%(10/12)
C23	100% (2/2)	100% (2/2)	100% (1/1)	100% (6/6)
K25	78% (7/9)	80% (4/5)	100% (2/2)	50% (1/2)
ITU	100% (11/11)	100% (15/15)	100% (10/10)	100% (11/11)
CAU	80% (4/5)	Nil patients	Not collected	100% (5/5)
Halton B3	100% (5/5)	100% (2/2)	100% (2/2)	100% (2/2)
CMTC	0% (0/1)	100% (1/1)	Nil antibiotics	Nil antibiotics
Paediatrics				
B11	100% (5/5)	100% (7/7)	100% (9/9)	100% (4/4)
NNU	100% (11/11)	100% (4/4)	100% (2/2)	100% (4/4)

- Wards with less than 90% compliance are highlighted in orange.
- Antimicrobials prescribed for long term prophylaxis have been excluded from the above data.

3.Discussion

3.1 Patients prescribed antibiotics

Overall, 33.6% (185) of in-patients at WHH were prescribed antibiotics during the audit. This is a slight decrease on the previous quarter, 34.7% in March 22.

3.2 Allergy status documentation

100% of patients who were prescribed an antimicrobial had their allergy status recorded on their EPR. No patients were prescribed an antibiotic at the time the audit was undertaken to which they had a documented allergy.

The audit picked up 1 patient who had a documented allergy to penicillin for whom the prescriber determined it was safe to prescribe a penicillin after a discussion with the patient. The prescriber clearly documented in the EPR the nature of the penicillin allergy, which they determined was an

intolerance rather than a genuine allergy and they determined that the benefit of treatment with a penicillin to outweigh the risk.

3.3 Prophylactic antibiotics

18 patients were prescribed a total of 23 antibiotics for prophylaxis. 5 of these antibiotics were initiated during this hospital admission.

4 of the antibiotics were commenced as prophylaxis following initiation of chemotherapy for a haematological malignancy.

1 antibiotic was commenced for U|T|I prophylaxis – the formulary advises If prophylaxis is indicated this should be discussed with a Consultant Microbiologist following a review with the Urology team – on this occasion this process was not followed. Antibiotic prophylaxis for UTI should be reviewed at SIX months.

3.4 Intravenous antibiotics

Of all prescribed antibiotics,59.7% (147) were administered intravenously, this is a slight increase on the previous audit results which also determined that 55% of all antibiotics prescribed in March 2022 were administered intravenously.

In this audit ICU had the greatest percentage of antibiotics (100%) prescribed intravenously; this is an increase on the previous quarter where 70% of antibiotics prescribed within this division were intravenous. Intravenous antibiotic prescribing this quarter has decreased within medicine (49% vs 52%) and women's and children (57.1% vs 82%) Use of IV antibiotics has increased within orthopaedics (62.5% vs 50%), surgery (86.4% vs 65%) and gastroenterology (66.7% vs 44%) this quarter.

In summary intravenous antibiotics accounted for: -

- 100% of all antibiotics within ICU
- 86.4% of all antibiotics within surgery,
- 66.7% of all antibiotics within gastroenterology,
- 62.5% of all antibiotics within orthopaedics,
- 57.1% of all antibiotics within women's & children.
- 49% of all antibiotics within medicine.

The Trust antimicrobial formulary states that intravenous antibiotic therapy MUST be reviewed between 24-72 hours after commencement. If antibiotics are still indicated, there is a table in the antibiotic formulary that helps guide if a switch from intravenous antibiotics to oral antibiotics is appropriate. If a patient has shown clinical improvement, has been apyrexial for 24 hours, infection markers are improving, and oral administration of tablets is feasible then oral switch should be considered. Specific infections are excluded from this, details of which can be found in the antimicrobial formulary.

3.4 Indication documented in Electronic Patient Record (EPR) or on drug kardex

97.6% (240) of antimicrobials prescribed had an indication documented in the EPR or on drug kardex. 4 patients were prescribed a total of 6 antibiotics without a clear indication documented in the EPR or on the drug Kardex. Having a documented clear indication is essential as it aids the ability of the person carrying out the next clinical review to stop, escalate or de-escalate antimicrobials as appropriate. For the purpose of this audit the 6 prescribed antimicrobials with no clear indication have deemed to be non-compliant. Antibiotics prescribed for prophylaxis have been excluded from this parameter.

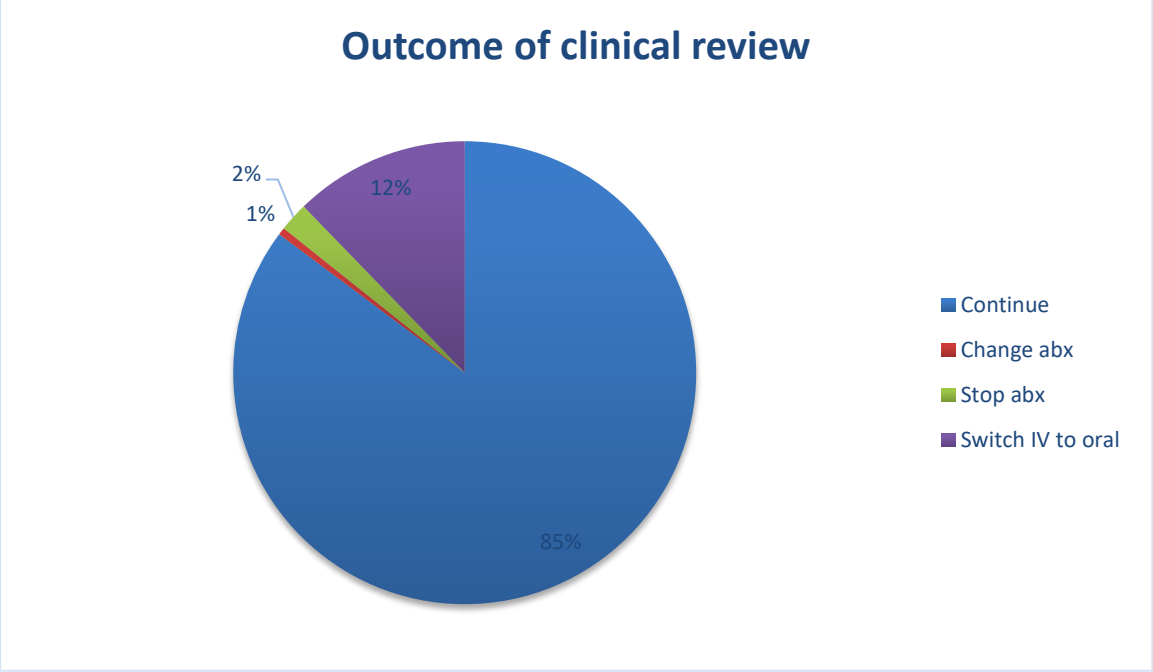
As mentioned previously the Trust is looking at making the indication for antimicrobials a mandatory field in Lorenzo. This has not been possible up to now as the list of indications permitted within Lorenzo is too restrictive and not currently fit for purpose, the EPMA lead pharmacist has been liaising with Dedalus to see if this list can be customised for our Trust. A date for completion of this has not yet been agreed.

3.5 Documentation of clinical review

94.7% (196/207) of antibiotics that had been prescribed for >72 hours had evidence of a clinical review. This is a slight improvement with the previous audit back in March 2022 (94.7% vs 93%). Antibiotics that were prescribed for long term prophylaxis were excluded from this parameter.

3.6 Outcome of clinical review

Of the 196 antibiotics that had a clinical review, the outcome of the review is summarised below.



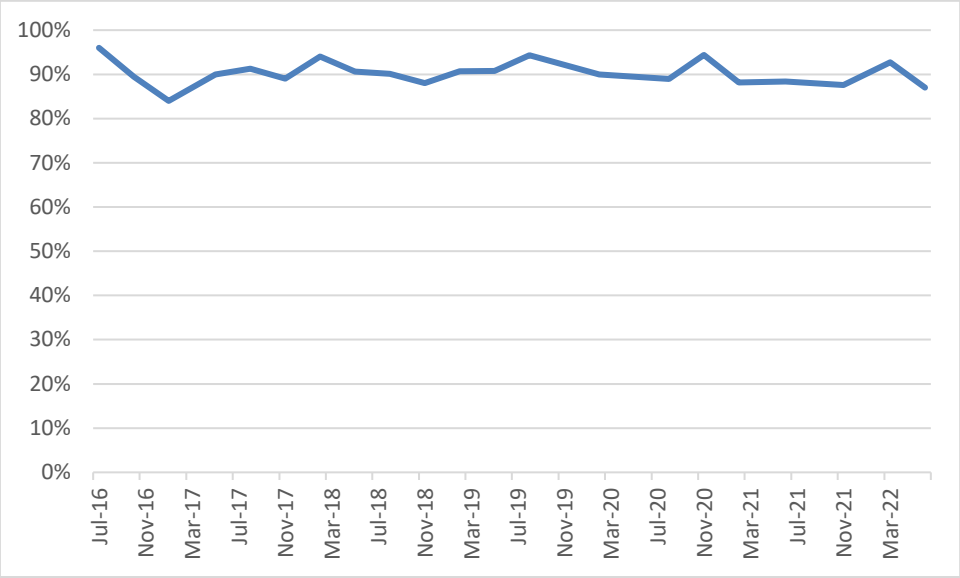
3.7 Documentation of stop date

54.9% (135/246) of antibiotics prescribed had a documented stop date. This is an improvement on the previous quarter where 53% of antibiotics prescribed had a documented stop date. Of those prescriptions with a documented stop date 41 prescriptions were for intravenous antibiotics and 94 prescriptions were for oral antibiotics. This audit consistently shows that it is much more likely that a stop date will be added to an oral antibiotic when compared to prescriptions for intravenous antibiotics.

3.8 Compliance with Trust antibiotic formulary or with an appropriate reason for deviation.

Compliance with the Trust antimicrobial formulary (or otherwise appropriate documented deviation) was 87% across the Trust, which is a decrease on the previous quarter were compliance was 92.7% in March 2022. This is below the Trust's internal minimum compliance target of 90%.

Figure 2. Compliance with the antibiotic formulary per quarter since July 2016



3.9 Non-compliance with the antibiotic formulary.

A total of 32 prescriptions were deemed inappropriate deviations from the formulary, examples can be found below. Some of these should be easy to rectify and this would increase compliance above the Trusts internal minimum compliance target of 90%.

- 6 prescriptions for 4 patients were **deemed non-complaint because a clear indication for antimicrobial therapy could not be found in the EPR**. As a minimum standard all antibiotics should have a clear indication documented and this will be re-emphasized to all prescribers.
- **Inappropriate use of co-amoxiclav**, this is a restricted antibiotic across the Trust due to its increased association with Clostridioides difficile infection.
- 61-year-old patient was commenced on IV Co-amoxiclav for IECOPD. The formulary would advise IV/PO amoxicillin or oral doxycycline if the patient is not known to be colonised with *Pseudomonas aeruginosa.*

- 3 patients who were treated for CAP initially with IV antibiotics and then stepped down to oral co-amoxiclav. The formulary would advise stepping down to oral amoxicillin plus/minus clarithromycin with clinical improvement as per BTS guidelines.

Non-formulary treatment of UTI's

- 3 prescriptions were picked up where the patient was prescribed amoxicillin for UTI/urosepsis. Amoxicillin should not be used for empirical treatment due to high resistance rates locally, it can be used if there is a recent urine sample that shows sensitivity – none of these patients had recent urine samples to guide treatment with amoxicillin.
- 1 prescription was picked up for co-trimoxazole for management of UTI. MSU grew proteus mirabilis which showed sensitivity to trimethoprim. In this case co-trimoxazole would work but it was not clear why the broader spectrum agent co-trimoxazole was picked in preference to trimethoprim.

Non formulary treatment of bacterial pneumonia associated with COVID.

Inappropriate use of Tazocin.

- 11 prescriptions for IV Tazocin were deemed inappropriate. This seems to be the biggest issue within the Trust, and we are consistently seeing inappropriate use of Tazocin. Tazocin should be prescribed as per the antibiotic formulary or on the advice of a Consultant Microbiologist and treatment should be deescalated as soon as it is clinically appropriate to do so, therefore exposing the patients to fewer days of broad-spectrum antimicrobial therapy.

Examples of inappropriate prescribing of Tazocin:

- For treatment of aspiration pneumonia
- For treatment of ? gastroenteritis
- For treatment of CAP and IECOPD
- For urinary retention
- Infected haematoma
- Treatment of infected pressure ulcers
- To cover chest vs abdomen OR chest vs urine

3.9 Limitations

- This audit only sought to determine compliance with the Trust antimicrobial guidelines and did not examine whether an antimicrobial was actually indicated.
- This audit only sought to determine compliance with the Trust antimicrobial guidelines and did not look at whether empiric broad-spectrum therapy could be stepped down to a narrower spectrum agent once microbiological results were available.
- This audit does not consider the quality of the reviews undertaken.
- The audit does not assess total course length of antibiotics or appropriateness of course length.

Recommendations

The findings of this audit will be presented at the next Antimicrobial Steering Group (AMSG) and Infection Control Sub Committee (ICSC). Members of theses groups will be expected to disseminate the information through their directorates. A copy of this audit will also be sent to each Divisional lead for discussion at their next audit meeting

Key issues to address include:

Ongoing assurance with Trust antibiotic guidelines and the need for clear documentation of an appropriate reason for deviation in the EPR.

Achieve and sustain 100% indication documented in EPR.

Improvement of documentation of course length or review date and review of antibiotics between 24-72 hours.

CMM advice should be sought for patients who have received a prolonged course of broad-spectrum antibiotic therapy to ensure appropriate investigations and microbiological sampling is undertaken at point of antibiotic escalation.

De-escalation of antibiotic therapy should be considered whenever a patient is reviewed and if not considered appropriate then the reason for this should be documented.

Inappropriate use of Tazocin – if a patient is prescribed Tazocin then this should be reviewed whenever a patient is reviewed, and antibiotic therapy should be de-escalated as soon as clinically appropriate.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/09/125**
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**
DATE OF MEETING:	28 September 2022
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) because of the ongoing COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#1134** If we see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain. **#125** If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns
EXECUTIVE SUMMARY	To provide the Trust Board with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

RECOMMENDATIONS:	The Trust Board is asked to receive the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/22/09/236
	Date of meeting	6th September 2022
	Summary of Outcome	Submit to Quality Assurance Committee
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Infection Control Sub-Committee

SUBJECT	IPC Board Assurance Framework	AGENDA REF:	BM/22/09/XX

1. BACKGROUND/CONTEXT

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

This assessment has been refined to reflect requirements specified in the Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021/22.

The framework is used to assure the Trust Board of Directors, by assessing the measures taken in line with current guidance and identifies areas where further action is required.

Legislative requirements relating to Covid-19 include: -

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

The risk assessment process will be continuous alongside review of emerging information to ensure that as an organisation the Trust can respond in an evidence-based way to maintain the safety of patients, services users, and staff. Where it is not possible to eliminate risk, assessment and mitigation is in place to provide safe systems of work. Local risk assessments are based on the measures as prioritised in the hierarchy of controls.

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

This assessment has been made against version 1.8 of the Infection Prevention and Control Board Assurance Framework published on 24th December 2021.

2. KEY ELEMENTS

Please see Appendix 1 for compliance assessment.

Please see Appendix 2 for action plan arising from the compliance assessment.

3) ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

- Monitor the action plan to address gaps in assurance until completion

4) IMPACT ON QPS?

- **Q**: Visiting restrictions may have had a negative impact on patient experience. Several communication mechanisms have been implemented. Visiting restrictions have been lifted and returned to pre-pandemic visiting times

- **P**: Risk to staff health and wellbeing from anxiety associated with the unknown situation and risk of infection of self and family members. Risk from continuous high pressure/demand on healthcare services. Staff absence due to infection or vulnerability status

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

5) MEASUREMENTS/EVALUATIONS

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

6) TRAJECTORIES/OBJECTIVES AGREED

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

7) MONITORING/REPORTING ROUTES

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

8) TIMELINES

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

9) ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10) RECOMMENDATIONS

The Trust Board is asked to receive the report.

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
A respiratory season/winter plan is in place: - that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/ placement and safe management according to local needs, prevalence, and care services - to enable appropriate segregation of cases depending on the pathogen - plan for and manage increasing case numbers where they occur - a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan	Triage tool in ED: Molecular Point of Care Testing for Covid-19. Seasonal respiratory testing SOP (including Influenza A/B; RSV and Covid-19) for patients attending ED with respiratory symptoms ED triage and placement according to respiratory/ non-respiratory presentation. Liaison with Patient Flow on Covid status to ensure appropriate isolation or cohorting Covid capacity escalation plan discussed and agreed at Tactical Group meetings Additional side room capacity created with pods inserted in - ED x1 - ICU x5 - B18 x4 Additional side rooms created on Wards - A2 - A3 - A6 - A9 - C21	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	Lateral Flow Device testing introduced for pre-admission elective procedures Lateral Flow Device testing implemented for day 3 and day 5 of admission	Some patients may require assistance with testing and reporting results pre-admission Text message alerts to IPCNs is not in place	Day of admission testing support where required for elective procedures Liaison with Patient Flow Team about positive results	
Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Completed risk assessments			
Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: - based on the measures as prioritised in the hierarchy of controls, including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area - applied in order and include elimination; substitution, engineering, administration and PPE/RPE - communicated to staff	Risk assessments in place for all locations in the Trust Signage on room doors	Risk assessment formatting does not use hierarchies of control Communication of control measures	Revision to risk assessment in progress (draft submitted to IPC Silver Cell 31/01/2022) to provide risk mitigation measures in the order of elimination, substitution, engineering, administrative controls, and Personal Protective Equipment (including Respiratory Protective Equipment) Single page guidance given to all staff at CSTM building	
Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local	All risk assessments are approved via a robust Governance procedure at Tactical meetings			

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1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
governance procedures, for example Integrated Care Systems				
If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	Nil derogation from national guidance			
Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	All completed risk assessments are reviewed by the Head of Safety and Risk			
If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	Risk assessments include RPE and other key items of PPE including eye protection			
Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services	Patients are allocated to wards based on speciality requirements	Learning from nosocomial Covid cases identified concerns about patient transfers	Operational and Patient Flow teams work cohesively to minimise patient transfers as far as reasonably practicable	
The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	- Chief Nurse/DIPC signs off data submissions - Sign off process in place for daily nosocomial SitRep - Daily data validation process for new admissions and inpatient Covid-19 tests prior to forwarding for sign off			

Compliance assessment against version 1.8

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	- BI reports are emailed daily to the Executive Team - RSV dashboards discussed at the IPC/Paediatric Surge planning meetings			
There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas	- Matron and IPC Walkarounds - Senior nursing team checks that action cards are being completed - Executive Team walkabouts - Ward Accreditation with IPC reviewer membership - Challenge occurs at the following meetings: - Tactical - Silver IPC Cell - Quality Assurance Committee - Infection Control Sub-Committee - Senior Executive Oversight Group - Covid NED Group - Increased Microbiology support/ briefings delivered to medical cabinet - Surface wipes and alcohol-based hand rubs are provided for all non-clinical areas			
Resources are in place to implement and measure adherence to good IPC practice.	PPE supply is monitored at tactical Group meetings PPE audit programme in place Health and Safety Team audit programme			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
This must include all care areas and all staff (permanent, agency and external contractors)	Signage is displayed on donning and doffing as an aide memoire for staff.			
The application of IPC practices within this guidance is monitored, e.g.: - hand hygiene - PPE donning and doffing training - cleaning and decontamination	Weekly hand hygiene audits Covid-19 PPE audits (for aerosol and non-aerosol generating procedures) are in place for all clinical areas	Centralised information on PPE training Level 2 clinical IPC training 78% at the end of July 2022.	UK HSA training videos are included in annual mandatory training programmes. Trajectories set by CBU, 2 taught sessions per week, eLearning option	
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	Bimonthly review or sooner if updated Board meeting agenda Board meeting minutes			
The Trust Board has oversight of ongoing outbreaks and action plans.	- Information on outbreaks included in daily executive summary and discussed at the daily Senior Executive Oversight Group Meeting - Learning from Outbreaks included in Nosocomial Board Paper 01 2021 - Nosocomial learning action plan in place reviewed at Silver IPC cell meetings - Covid-19 RCA findings fed back to CBUs with drill down to			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	individual ward learning September 2021 - Outbreak email circulation - Email showing locations where Covid-19 exposure has inadvertently occurred, and bays monitored for further cases			
The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	Fit Testing programme in place and working to ensure all staff are successfully Fit tested against 2 types of mask, using Qualitative and Quantitative testing methods			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)	Task and Finish Group established with Action Plan in place for implementation. Progress will be included in IPC quarterly reports to QAC / Trust Board			
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Communications team are involved in changes and ensure information is cascaded and signage displayed			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Robust audit programme with timely feedback for corrective action as per the national cleanliness standards	Roles and responsibilities for cleaning Displaying star ratings and rectification if audit score is 3 star or less from a 5-star rating	Cleaning responsibilities framework in development as part of the implementation of the revised national cleanliness standards	
Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas	Additional cleaning of outbreak areas including frequently touched surfaces			
Where patients with respiratory infections are cared for, cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	Chlorine based cleaning products are in use as required. Return to use of detergents in May 2022 Hydrogen peroxide Vapour is used following terminal cleaning by a Task Team trained in use of the equipment			
If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	- Alternative disinfectant used in CT scanning room.	Specialist cleaning plan in place in the CT scanning room	- CT Manufacturer provided alternative decontamination guidance - Consultant Microbiologists and IPCNs included in discussions on alternative products to ensure effective against coronaviruses	
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Information on contact time is included in the decontamination policy			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
A minimum of twice daily cleaning of: - patient isolation rooms - cohort areas - donning & doffing areas - 'Frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails - where there may be higher environmental contamination rates, including toilets/commodes particularly if patients have diarrhoea	- Twice daily cleaning in place - Ring the bell it's time for Clinell campaign - Domestic staff record when they have cleaned areas - Enhanced cleaning – all areas, including non-clinical, supplied with desk wipes - Increased cleaning frequency in all public areas including toilets, communal spaces, lifts - Cleaning of workstations is included in the Environmental Action Plan - Domestic staff time cleaning activity when areas are vacant - Increased cleaning included in ICU Bioquell pod SOP - Review of guidance to reduce cleaning in low-risk elective procedure areas and return to use of detergents UKHSA review into IPC guidance - GOV.UK (www.gov.uk)			
A terminal/deep clean of inpatient rooms is carried out:	- Terminal cleaning and decontamination polices in place including guidance on			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
- following resolutions of symptoms and removal of precautions - when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens)	environmental disinfectant required to decontaminate the environment. Decontamination included in the Covid-19 policy - All policies are used in conjunction with any updates provided by COVID-19 national guidance - Terminal Cleaning Guidelines 2018 - Decontamination Policy 2019 - 4 additional HPV machines purchased and in use - CEO meeting and Chief Nurse/Deputy CEO and ADIPC meeting with domestic staff - Associate Director of Estates is a member of Silver IPC cell - Terminal cleaning standards sign off checklist			
- following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)	- Ventilation Group and Ventilation Policy	Ventilation and air changes per hour in all areas is not unknown	Discussion on down time following areas where AGPs are performed based on air changes/hour where known and time extended in areas where mechanical ventilation is not available	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing, or repair equipment.	- Included in Decontamination Policy which incorporates single use and single patient use guidance - Cleaning monitoring audits - Decontamination audits - Policy and certification process to confirm cleaning prior to service inspection or repair - Dynamic mattresses are cleaned off site by contractual arrangements - Green I am clean indicator tape for items cleaned/ decontaminated at ward level			
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Robust audit programme with timely feedback for corrective action as per the national cleanliness standards			
As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance.	Theatre ventilation audits	Trust-wide audit and Action plan required	Requirement for Estate overview discussed at Ventilation Group and action plan to be developed to address non-compliant areas	
The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer	Trust is supported by an Appointed Authorising Engineer/Ventilation. Guidance sought on all capital projects with sign off of plan.			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways		Trust-wide audit and Action plan required	Requirement for Estate overview discussed at Ventilation Group and action plan to be developed to address non-compliant areas	
Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	'Give fresh air to show you care' campaign	As above	As above	
Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	Trial of alternative technology completed Products will be reviewed by the Ventilation Group to ensure fitness for purpose			
When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Discussion on air flow takes place between IPC Team and Estates Team			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Arrangements for antimicrobial stewardship are maintained - previous antimicrobial history is considered - the use of antimicrobials is managed and monitored	- Consultant Medical Microbiology daily Ward Round in Critical Care - Ward based Pharmacist support - Prescribing advice available by telephone (in and out of hours 24/7)	Point prevalence Audit scores in the region of 87%. Some wards have lower than 90% compliance for more than 1 quarter	Business case approved to strengthen stewardship resources. Escalation of decrease in prescribing compliance to PSCE sub-committee	

Compliance assessment against version 1.8

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
to reduce inappropriate prescribing to ensure patients with infections are treated promptly with correct antibiotic.	- Pharmacist prescribing support on all inpatient wards - Infection Control Doctor presentations to Medical Cabinet - Formulary reviewed as evidence/ guidelines are updated - Antibiotic prescribing guidelines for COVID suspected patients have been published - Antimicrobial Management Steering Group Meetings - Quarterly - C difficile outliers ward rounds - Quarterly Point Prevalence audits with concerns discussed at Medical Cabinet and Infection Control Sub-Committee – Process reviewed and point prevalence audits reduced to biannual with more focussed audits in areas where improvement is required - Antimicrobial Stewardship is included in the IPC Strategy 2022 - 2023		Change approach to auditing to provide more meaningful data Changes to first line treatment for CDI included in the SIGHT mnemonic promotional video	
Mandatory reporting requirements are adhered to, and boards continue to maintain oversight	- Mandatory reporting of HCAIs has continued to be completed timely			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Data on HCAIs is included on the Quality Assurance Committee and Trust Board and Infection Control Sub-Committee Dashboards - DIPC reports HCAI data at Trust Board - Information on Data Capture System - Distribution of HCAI surveillance data weekly - Annual UK HAS HCAI reports and monthly dashboards			
Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	- Infection control risk assessments completed on admission and updated in light of microbiology results - Electronic patient record alerting system - IPC Policies/guidelines - IPC on call service			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors	Risk assessment in place Compassionate visiting supported Visiting restrictions lifted and returned to pre-pandemic visiting times 1st June 2022			
National guidance on visiting patients in a care setting is implemented	- Restricted visiting implemented 17 March 2020; Visiting fully suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020. Paper on visiting arrangements taken to SEOG - Visiting the dying guideline in place with training provided by the Palliative Care Team - Trust wide Communication via email on visiting restrictions then cessation - Environmental Safety Plan includes site lock down to restrict access - Compassionate visiting arrangements agreed for the following patient groups where close family and friends visiting may be admitted: - Patients in critical care - Vulnerable young adults		• Guidance regularly updated in-line with national guidance • Visitor risk assessments • Pre-visit symptom screening checklist • Visitor information leaflet • Family Liaison Officer team • Virtual visiting/ iPad • Visiting restrictions lifted and returned to pre-pandemic visiting times 1st June 2022	

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Patients living with Dementia - Autism - Learning difficulties - Loved ones who are receiving end of life care - Signage at entrances - Information on Trust website - FLOgrams - Trial wards agreed to re-introduce visiting week commencing 7 June 2021 limiting numbers and visiting time period of 1 hour - Visiting permitted with booked and timed slot on Christmas Day and Boxing Day with control measures in place on symptom checks and where possible Lateral Flow Device Test (with negative result) - Visiting guidance updated to meet current national guidance – 2 visitors per patient, timed slots, for 1 hour - Visiting restrictions lifted and returned to pre-pandemic			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	visiting times following Guidance on 1st June 2022			
Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	- Guidance on visiting in place - Maternity specific Guidance on birthing partner - Appointment scheduling system implemented to ensure social distancing isn't breached, particularly where there are concerns regarding ventilation/ low air change/hour - Visited restricted during outbreaks			
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and distancing.	Signage across the Trust including at entrances and in public toilets: - Face masks - Hand washing - Social distancing suspended signage from ceilings on all corridors and at entrances/exits - PPE/ mask stations located at entrances/exits alongside alcohol-based hand gels - Facemasks no longer required, and guidance implemented from 13th June 2022		Every action counts campaign signage – roll out plan in place Leaflets on face mask wearing provided January 2022	
If visitors are attending a care area with infectious patients, they should be made	PPE provided at all Trust entrances and entrances to wards			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM	Ward staff assist visitors with PPE where required			
Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	Visitor Risk assessment Sign-in sheet symptom checker Visiting restrictions lifted and returned to pre-pandemic visiting times following Guidance on 1st June 2022			
Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	FFP3 Fit testing for visitors to ICU			
Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted C1116- supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Campaign posters received and roll out plan devised	Images of WHH staff selected for campaign use Wellbeing support area established	Roll out completed January 2022	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Signage is displayed prior to and on entry to all health and care settings instructing	Signage displayed at all main entrances			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.				
Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	- SBAR transfer form in place - Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab - Covid-19 status included on SBAR form - Covid-19 has been added to e-discharge summary template - Pre-admission information provided to patients being admitted electively - Policy for patients being discharged to care homes	Review of guidance published 17/01/22 Stepdown of infection control precautions and discharging COVID-19 patients and asymptomatic SARS-CoV-2 infected patients - GOV.UK (www.gov.uk) Limited number of side rooms	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	
Staff are aware of agreed template for screening questions to ask.	ED triage tool Senior staff in ED Triage Covid screening sign in sheet			
Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment	Visitor risk assessment Review of guidance to perform testing on admission in low-risk elective procedure areas UKHSA review into IPC guidance - GOV.UK (www.gov.uk)		UKHSA Guidance agreed for site specific and lower risk procedures including Halton Ward B4 and Endoscopy Pre-admission testing for low risk elective procedures using Lateral Flow device testing introduced	
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other	Triage tool and molecular Point of Care testing is in use in ED and Maternity.	Out of hours Cover for results from 10pm until am where POC test was	To be discussed	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	ED Triage tool included a question on travel history Positive results are sent by text message to Infection Prevention and Control (IPC) Nurses, who review and put IPC advice in place. PCR testing is also undertaken on admission Respiratory/non-respiratory pathway SOP Infection Risk Assessment in EPR Symptom screening checklist Virtual Ward Pathways	negative, but PCR result is positive Laboratory reverted back from 24/7 to business-as-usual hours		
Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Senior staff triage in ED			
There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved	Compliance reviewed during outbreaks and at nosocomial RCA review meetings BI reporting systems shows swabs due to be taken daily. Daily oversight by senior nursing team to support compliance with admission, day 3 and day 5 testing Weekly testing stepped down 04/2022	Audit of compliance required	Process for reporting of Lateral Flow Device testing numbers to be confirmed	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated	Patient information leaflet circulated in January 01/2022 promoting use of face masks for in patients Facemasks for patients stepped down on 13 June 2022	Some patients exempt from face mask use and some patients decline National restrictions on face mask use lifted on 27/01/22 for public spaces	Communication circulated on 27/01/22 that use of Face masks in healthcare settings remains in place Clear curtains between inpatient beds	
Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result	ED segregation of respiratory non-respiratory areas			
Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing	Prioritisation for side rooms is based on suspected/known diagnosis	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	
Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered	Isolation Policy Isolation of immunocompromised patient s policy Side room optimisation with IPC and Patient Flow using side room isolation tool			
Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes	Virtual Ward Pathways			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 08 2022

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Face masks/coverings are worn by staff and patients in all health and care facilities.	Universal masking policy in place SOP for face mask refusal	Some patients exempt and some refusals to wear masks	SOP to guide staff on actions to take for refusal Poster campaign to encourage use of masks	
Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	- Inpatient bed spacing assessment - Perspex screens in place at reception areas - Facemasks for patients stepped down on 13 June 2022 - Facemasks for standard and contact precautions stepped down on 13 June 2022	Some bed spaces are closer than 2 metres	- Use of clear curtains between bed spaces - Timing of visits to toilet facilities - Use of face masks where tolerated	
Patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff.	Effective systems in place to support prevention of HCAI including: - training, policies, and audit plan: - - Hand hygiene audits weekly - PPE (readily available) audits of AGP and non-AGP weekly - Environmental audits according to risk category - High impact intervention audits - Supplies monitoring of PPE levels - Social distancing check included on the daily Clinical Area Action Card - Spot checks on break rooms			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Signage and refresh campaign aligned to national campaign - Infection Prevention and Control Team visibility on wards			
Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	Testing advice is included on the Antibiotic Formulary for patients with hospital onset Pneumonia Patients are isolated or cohorted promptly	Contact tracing is challenging as there isn't an electronic Patient tracking system	Contact tracing is carried out as far as reasonably practicable. Letters are given to contacts advising them of the Covid contact and includes advice on isolation requirements Publication approval reference: C1630 – isolation of Covid-19 contacts no longer required if asymptomatic. Bays are monitored for 7 days following exposure to detect any new onset cases	
Isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	Testing advice is included in the Antibiotic Formulary for patients with hospital onset Pneumonia Testing protocol in place on admission, day 3, day 5 and weekly thereafter Outbreak reporting in place aligned to NHSE/I HOCI SOP using IIMARCH reporting template Major Outbreak Policy	Contact tracing is challenging as there isn't an electronic Patient tracking system Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	

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5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	- Information provided prior to attending Outpatient Departments and further symptom screening in place on arrival - Virtual appointments where practicable - Temperature checking and symptom screening in place in OPD/ Vaccination centre			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Appropriate infection prevention education is provided for staff, patients, and visitors.	IPC Mandatory training programme Signage for visitors and support provided by staff on duty	Level 2 clinical IPC training 78% at the end of Jul 2022.	Trajectories set by CBU, 2 taught sessions per week, eLearning option	
Training in IPC measures is provided to all staff, including: - the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and	Fit Testing programme			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
- the correct technique for putting on and removing (donning/doffing) PPE safely.	UK HSA training videos shown during mandatory training sessions Aide memoire posters on donning and doffing are displayed in all clinical areas Hand hygiene technique is displayed on all soap dispensers PPE/swabbing Champions (58), training and cascaded roving training on donning and doffing of PPE Training for Helping Hands staff IPC Team out of hours advice IPCN and Consultant Microbiologist Departmental visits to provide support			
All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	Mandatory IPC Training package			
Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	PPE audits in place Concerns identified are addressed at the time of audit			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	Increased auditing schedule during outbreaks			
Gloves are worn when exposure to blood and/or other body fluids, nonintact skin or mucous membranes is anticipated or in line with SICPs and TBPs.	Standard precautions and PPE guidelines			
The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	- Hand air dryers not in place in clinical areas - Access to hand hygiene facilities (stock of liquid soap, hand gel and paper towels is included in the auditing template) - Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan - Hand towel dispensers have been installed and waste collection schedule put in place			
Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Guidance on social distancing re-enforced Risk assessment templates updated to reflect the removal of the requirement for social distancing June 2022			

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6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Staff understand the requirements for uniform laundering where this is not provided for onsite	Guidance included in Uniform Policy and Covid-19 PPE booklet. Scrub suit provided for use in place of uniforms which are laundered by the Trust			
All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	SOP in place for testing staff and or household members HR process in place for reporting to Line Manager and Occupational Health In-house testing is promoted for timey availability of results SOP in place for Lateral Flow Testing prior to return to work in line with revised guidance COVID-19: management of staff and exposed patients or residents in health and social care settings - GOV.UK (www.gov.uk)	Staffing absence due to Covid-19 Some staff use external testing resulting in delay in result turn around time	Staffing meetings held throughout each day to ensure safety in inpatient areas Absence monitoring at Tactical Group meetings In-house testing is promoting – including for household members	
To monitor compliance and reporting for asymptomatic staff testing	LAMP testing compliance data monitored at Tactical Group meetings LAMP testing removed and returned to twice weekly Lateral Flow Device testing	Uptake low approximately 450 staff Uptake of testing unknown	Uptake encouraged at trust wide Team brief, DIPC promotional video Use of asymptomatic testing promoted to encourage uptake	
There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and	Consultant Microbiologist presentations at Tactical Group meetings.			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
for hospital/organisation onset cases (staff and patients/individuals)	Local prevalence data included in Tactical Group agendas BI reports with UpToDate position Datix reporting of hospital onset case, Outbreak reporting as per the NHSE/I HOCI SOP Regional benchmarking using the Cheshire and Merseyside Nosocomial pack UKHSA CCDC attends Infection Control Sub-Committee Silver Infection Control Cell meetings chaired by the DIPC All Covid-19 positive results are communicated by text alert to the IPCNs. Patient records are flagged, and IPC advice documented			
Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	IPC Team monitor incidence and report outbreaks via the web-based reporting system in line with the NHSE/I northwest HOCI SOP Datix reports are completed for all hospital onset cases and where an Outbreak is declared. RCA investigations are completed and reviewed to identify learning and harm. Where concerns are identified regarding harm, referral			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	is made to the Governance Team for further review. PowerPoint feedback reports on learning from incidents shared with each CBU for 2020/2021			

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Patient information leaflet circulated in January 01/2022 promoting use of face masks for in patients Signage on display advising use of face masks Facemasks no longer required for patients, and guidance implemented from 13th June 2022	Some patients exempt from face mask use and some patients decline National restrictions on face mask use lifted on 27/01/22 for public spaces	Communication circulated on 27/01/22 that use of Face masks in healthcare settings remains in place Clear curtains between inpatient beds Communication from CEO 13/06/2022	
Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	Symptom screening on arrival at clinics Pre-attendance advice not to attend if symptomatic.			

7. Provide or secure adequate isolation facilities				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Appointment scheduling to avoid cross over of Covid/non-Covid patients			
Patients are appropriately placed i.e., infectious patients in isolation or cohorts.	Monitoring of Covid testing for patient placement Isolation Policy Isolation of Immunosuppressed Patients Guidelines Side room audit tool Additional side room capacity created with pods inserted in - ED x1 - ICU x5 - B18 x4 Additional side rooms created on Wards - A2 - A3 - A6 - A9 - C21	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	
Ongoing regular assessments of physical distancing and bed spacing, considering	Environmental action plan Clear curtains			

7. Provide or secure adequate isolation facilities				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).				
Standard infection control precautions (SIPCs) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	SOP for respiratory/non-respiratory pathways and PPE requirements Standard IPC precautions Guidelines IPC audit programme in place IPC Mandatory training programme Facemasks no longer required, and guidance implemented from 13th June 2022			
The principles of SICPs and TBPs continued to be applied when caring for the deceased	Care of deceased patients' guidelines			

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Testing is undertaken by competent and trained individuals.	Training on swabbing technique provided verbally and by video Competency assessment tool launched Training provided on use of point of care molecular testing equipment			

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8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	UKAS accredited laboratory with Quality Control checks in place			
Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance	Swabbing SOP in place covering day of admission, day 3, day 5, weekly thereafter if previous results negative, symptomatic, pre-admission elective and discharge screening. Weekly testing stepped down in May 2022 Quadplex testing (Influenza A/B RSV – in addition to Covid-19) for patients presenting with respiratory symptoms Legionella and Pneumococcal antigen testing	- RCAs identified some routine samples are being missed -	- Daily senior nurse oversight to ensure compliance - Electronic systems support identification of patients who have not been screened as per routine testing protocol - Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	
Staff testing protocols are in place	Staff testing SOPs Asymptomatic / Symptomatic – including for household members Asymptomatic LAMP testing in place for staff LAMP testing removed 31/03/22 and returned to twice weekly Lateral Flow Device testing	Low uptake of staff LAMP testing Uptake of testing Lateral Flow Device testing unknown	Uptake encouraged at trust wide Team brief, DIPC promotional video Use of asymptomatic testing promoted to encourage uptake	
There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available	Monitoring at Silver IPC	Reporting frequency	Request made for regular reporting.	

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	- LION BIS used to monitor testing in line with guidance and follow-up of omitted tests on admission/ day 3 /day 5/ weekly from day 5 - Documentation of IPC advice on receipt of positive results - RCA requests for cases ≥ day 8 of admission, with monitoring system in progress - Daily data validation process for Sit Rep sign-off and external reporting - IPC Team Spreadsheet with RCA follow up of all cases ≥ day 8 of admission - Turn around times are monitored at Silver Cell IPC meetings			
Screening for other potential infections takes place	Other routine admission screening (CPE, MRSA, VRE) in place			
That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	All patients being admitted to the Trust have Covid admission tests taken in ED using point of care (Abbot ID Now) testing and PCR swab Point of Care Testing supports ED and inpatient placement			
That those inpatients who go on to develop symptoms of respiratory infection/COVID-19	Covid is considered as a differential diagnosis for inpatients developing respiratory symptoms	A small number of RCA investigation findings	Discussion took place at Medical Cabinet to advise timely testing for Covid when	

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
after admission are retested at the point symptoms arise.		identified missed testing opportunities	inpatients develop Hospital acquired pneumonia Guidance added to the Trust Antibiotic Formulary to test for Covid-19 in any patients who develop HAP	
That all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	Daily monitoring system in place to achieve full screening compliance for admission, day 3 and day 5 swabs Weekly screening implemented Lateral Flow Device testing implemented in June 2022 for day 3 and day 5 inpatient testing	RCAs are identifying a very small number of routine samples are being missed	- Daily senior nurse oversight to ensure compliance - Electronic systems support identification of patients who have not been screened as per routine testing protocol - Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system - PowerPoint presentation on RCA learning fed back to CBUs with drill down of learning at individual ward level	
That sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	- Community prevalence increasing >1400 per 100k/7-day rate January 2022 - Reduced nosocomial case numbers - Increased testing in outbreak areas as advised be the Infection Control Doctor - Daily testing has been implemented on wards during Covid-19 outbreaks			

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8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
That those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	Discharge screening in place with results shared accordingly prior to patient discharge Discharge to care home SOP in place including process to check results prior to discharge			
Those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	Named community facility for care of patients who require continued isolation for Covid-19			
There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	SOP revised to reflect pre-admission Lateral Flow device testing.			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
The application of IPC practices is monitored and that resources are in place to implement	IPC Audit Programmes - Hand hygiene			

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9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	- PPE - High Impact Intervention Audits - Ward audit programme Escalation in auditing schedule where concerns are identified and during outbreaks			
Staff are supported in adhering to all IPC policies, including those for other alert organisms.	- PPE Champions in place supported by training - Clinical advice for management of patients with suspected infections continued - IPC on call service to provide advice 7 days per week - PPE donning and doffing included in Induction and Mandatory training sessions - IPC Team visit areas to discuss concerns raised in relation to national guidance - Alert organisms are flagged on Lorenzo - IPCNs review patients with Alert organisms and provide advice to clinical teams - Discussion with Patient Flow Team on side room prioritisation - Pseudomonas surveillance in place in ICU, NNU			

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9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Prioritisation of side rooms for infections transmitted by the respiratory route and returning travellers from abroad - Isolation and CPE screening for patients admitted by inter-hospital transfer - Signage is displayed on donning and doffing as an aide memoire for staff - Covid-19 PPE booklet			
Safe spaces for staff break areas/changing facilities are provided.	Break rooms are Covid secure risk assessed. Spot checks on social distancing are carried out Removal of the requirement for social distancing June 2022			
Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	- Daily surveillance in place of ≥ day 8 cases and location tested to promptly identifying clusters and initiate outbreak investigation accordingly - Occupational Health and Wellbeing Team monitor for clusters of staff cases - Outbreak meeting agendas, minutes and action plans			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Outbreak reporting reference numbers from NHSE/I via web-based reporting system - Emails to UKHSA; CCG; CQC, WHH Communications Team - Daily HOCI reporting template completed by Ward Managers and submitted to IPC/ Matron for review and action - Datix reporting			
All clinical waste and linen/laundry related to confirmed or suspected COVID19 cases is handled, stored, and managed in accordance with current national guidance.	- Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a HCID. Waste was quarantined and disposed of by incineration - Guidance included in the Coronavirus Policy - Used linen is processed as infected via red alginate stitched bag stream - Linen Policy - Waste segregation, handling, and disposal guidelines - Waste is disposed of via orange waste stream as per updated national guidance			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Waste segregation included in mandatory training - All waste bins have colour coded lids and signage to denote waste category			
PPE stock is appropriately stored and accessible to staff who require it.	- Stock control in place - In and out of hours access protocol in place - Specialist PPE equipment office with access available 7 days/week - National distribution to maintain stock levels			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	SOP for staff and household member Covid-19 testing			
Bank, agency, and locum staff follow the same deployment advice as permanent staff.	Bank, agency, and locum staff follow the same deployment advice as permanent staff			
Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff	SOP in-place to allow return to work in line with NHSE/I guidance			

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10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
isolation: approach following updated government guidance)				
Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Included in mandatory IPC training. Level 2 compliance eat the end of April 22 = 78%	Some CBUs with less than 85% training compliance	IPCN offer to provide additional training sessions. 2 taught sessions per week and eLearning option	
A fit testing programme is in place for those who may need to wear respiratory protection.	Fit Testing programme is in place.			
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: lead on the implementation of systems to monitor for illness and absence. Infection prevention and control board assurance framework - facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce - lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 - encourage staff vaccine uptake.	Outbreak meeting discussions on exposed staff Datix reports on workplace exposure incidents	Review of updated guidance published 17/01/22 COVID-19: management of staff and exposed patients or residents in health and social care settings - GOV.UK (www.gov.uk)		
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	Covid-19 SOP			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. that advice is available to all health and social care staff, including specific advice to those at risk from complications Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	- An integrated self-risk assessment tool has been produced for all staff to identify if they are 'at-risk'. - Following identification (through the tool or the personal information held on individuals), and a subsequent detailed risk assessment is completed for all staff who are within an 'at-risk' group, compliance Sep-21 at 94% and is reported daily - Chief People Officer and Chief Executive Officer and Chairman attended the BAME Staff Network Group in June 2020 to receive feedback - Individual letters have been sent to BAME members of staff, outlining support available - Named midwife contact within Maternity Department provides advice for pregnant staff - All staff who are considered clinically extremely vulnerable are supported by robust workforce support and the Trust are in the process of having one			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	to one discussion to agree support and adjustments - All staff working at home have been provided with a 'working from home pack', including access to mental health support - Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. Service resumed to 5 day working - An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy, and the British Psychological Society - Electronic system in place for Covid-19 Workforce risk assessment - Access to face to face counselling - Wellbeing Wednesday emails			
Vaccination and testing policies are in place as advised by occupational health/public health.	Health Clearance Policy			
Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance, and a record of this training is maintained and held centrally/ESR records	- Fit testing programme, including quantitative and qualitative testing, in place - Qualitative Fit testing SOP - Quantitative Fit testing SOP			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Records are added to a central database - Powered Hoods are offered as an alternative where it has not been possible to fit close fitting face masks Only EN 149:2001 compliant masks are accepted as fit for use for Aerosol Generating procedures			
Staff who carry out fit test training are trained and competent to do so.	Programme of Fit Testing in place which is only carried out by trained Fit testers An accredited Fit2Fit company or the Department of Health virtual training provided staff training			
All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	- Programme of Fit Testing in place - Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021 - Programme of Fit Testing continues with an ambition to ensure staff are Fit Tested against 2 types of FFP3 respirators. Data on 08/10/2021 - Total Number on Database: 3848			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Total Number passed on at least 1 current supported mask: 2422 - Total Number passed on at least 2 current supported masks: 554			
All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	- Programme of Fit testing in progress	- Staff tested against only 1 mask	- Continuous Availability of Fit Testing to achieve the requirement to be fit tested against 2 masks	
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	- Database with Fit testing details including those staff requiring specialist respiratory equipment which is updated as additional fit testing is completed	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records - Trust-wide data held on a spreadsheet	
Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	- Spreadsheet with Fit testing details included	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records	
That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	- Alternative respiratory protection is offered i.e., powered hood - Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed - Provision of specialist PPE equipment is recorded including			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	advice on decontamination of re-usable PPE			
Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	- Alternative respiratory protection is offered i.e., powered hood - Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed - Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE	-	-	
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	- Provision of specialist PPE equipment is recorded	- Documented evidence of discussion and central holding of this record	- Process under review to capture this data	
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	- Spreadsheet with Fit testing details included - Compliance with Fit testing is monitored. Paper submitted to QAC - Email updates provided weekly by the Fit Testing Team Coordinator	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records - Information on Fit testing figures is reported at Tactical meetings and included at Senior Executive Oversight Group Meetings - Report to QAC 02/2021	
Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between	- Staffing reviews undertaken for all COVID areas			

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10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
planned/elective care pathways and urgent/emergency care pathways as per national guidance.	- Staff movements managed by the senior nursing team at daily meetings - Senior Nurse presence 7 days per week 8am-8pm to support staffing management - Planned elective areas have designated teams, who are not moved to any other area in the Trust - Where it is necessary to move staff between different areas to support patient safety, this is discussed with the Infection Control Team. - This cross over has not occurred between Elective and Emergency Care pathways			
Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	- Risk assessment in place to reduce risk - Agile working policy includes home working - Staying Covid-19 secure signage listing mitigation in place			
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	- Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place - Data reported at Tactical meetings			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Staff self-Isolation SOP in place from 08/2021 to enable staff to return to work, if they meet a risk assessed criteria from non-household Covid-19 contact - HR advisors support wellbeing meetings for long-term absence - Return to work advice includes requirement for 2 negative Lateral Flow Device tests from day 6 and day 7			
Staff who test positive have adequate information and support to aid their recovery and return to work	- A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce - The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) - Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. Service returned to 5 days - Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and when required	- Test and Trace Service hours of operation	- Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Retesting is in place as appropriate and is set out in Staff Testing SOP - Occupational Health e-mail to staff and their manager with return-to-work guidance			

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/09/125**	
SUBJECT:	**Safeguarding Annual Report**	
DATE OF MEETING:	28th September 2022	
AUTHOR(S):	Layla Alani, Director of Governance and Quality, Interim Deputy Chief Nurse	
	Katie Clarke, Lead Nurse Safeguarding Children	
	Wendy Turner, Lead Nurse Safeguarding Adults	
EXECUTIVE DIRECTOR SPONSOR:	Kimblerley Salmon-Jamieson, Chief Nurse and Deputy Chief Executive Officer	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken. **#1134** If we see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain. **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Safeguarding Children and Safeguarding Adult Annual Report describes the structures, responsibilities, and activity of the Trust in ensuring that our patients and staff are appropriately safeguarded. The report provides assurance of the monitoring of activity and WHHs response to safeguarding. The report triangulates training data, incident reporting and lessons learnt with the activity data demonstrating a marked increase in safeguarding awareness and responsiveness across the trust. The information provided within	

	this report relates to the financial year 2021/22. Whilst this Annual Report provides many examples of the positive and inspiring progress made in 2021/2022, it is important to prepare for the challenges ahead. Partnership working will continue to raise awareness and find solutions to tackling emergent and persistent safeguarding issues for health such as self-neglect and child exploitation. Work to embed the Mental Capacity Act/Deprivation of Liberty Safeguards into practice will continue, as will promoting a culture of 'Making Safeguarding Personal' and 'Think Family'.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the Safeguarding Annual Report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/09/235		
	Date of meeting	06.09.22		
	Summary of Outcome	The Quality Assurance Committee received and pproved the report.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

Warrington and Halton Teaching Hospitals

NHS Foundation Trust

Safeguarding Annual Report 2021-2022

Contents

1. Executive Summary

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

The Trust is committed to continually providing best practice standards in the delivery of a positive Safeguarding culture and considers this a fundamental component in providing a safe environment for staff, patients and the public.

The Trust's mission is to be 'outstanding for our patients, our communities and each other', with a vision that 'we will be a great place to receive healthcare, work and learn'. The embedding of safeguarding practices across the organisation are fundamental in achieving this.

2. Introduction

This report provides the Safeguarding Committee and Quality Assurance Committee with a summary of the safeguarding activity during the financial year 2021/2022. This Annual Report provides assurance that WHH is meeting all necessary statutory obligations in safeguarding both adults and children.

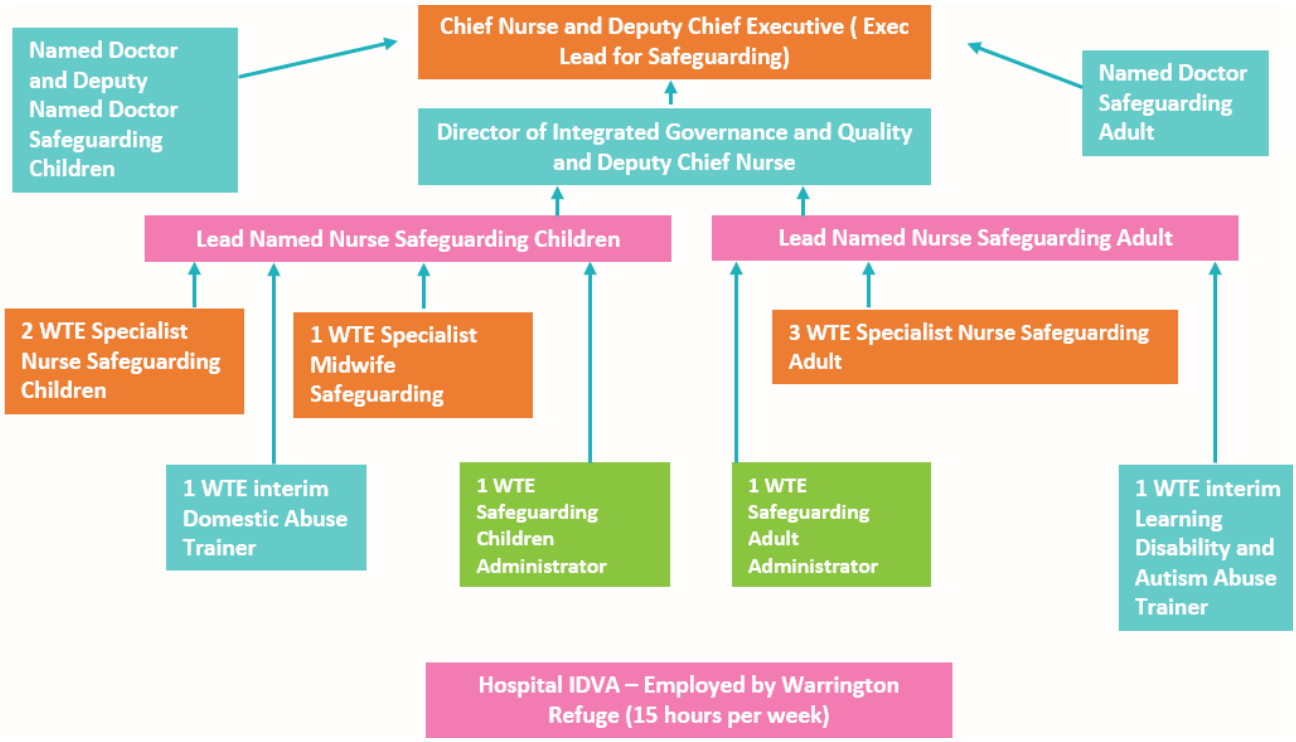
The Safeguarding of children, young people and adults at risk in the NHS, accountability and assurance framework (2019) sets out the safeguarding roles, duties and responsibilities of all NHS organisations and is integral to the safeguarding agenda, thus forming the basis of this report.

In recognition of the legislation as described in the Children Act 2014 and the Care Act 2014, WHH are supported by policies, Standard Operating Procedures, and risk assessments to ensure that all WHH staff are aware of how to discharge their safeguarding duties and responsibilities. The Children Act 2014 and the Care Act 2014 requires the Trust to provide and maintain:

- Safeguarding Children Policy
- Safeguarding Adult at Risk Policy
- Safeguarding Strategy
- Safeguarding Training and supervision
- Processes to support recognition and response to safeguarding situations
- Information resources to support in their decision making
- Subject matter experts that are available to support safeguarding practice

There are safeguarding reporting processes in place to provide assurance of compliance with proactive monitoring and triangulation through existing governance mechanisms.

3. WHH Safeguarding Management Structure

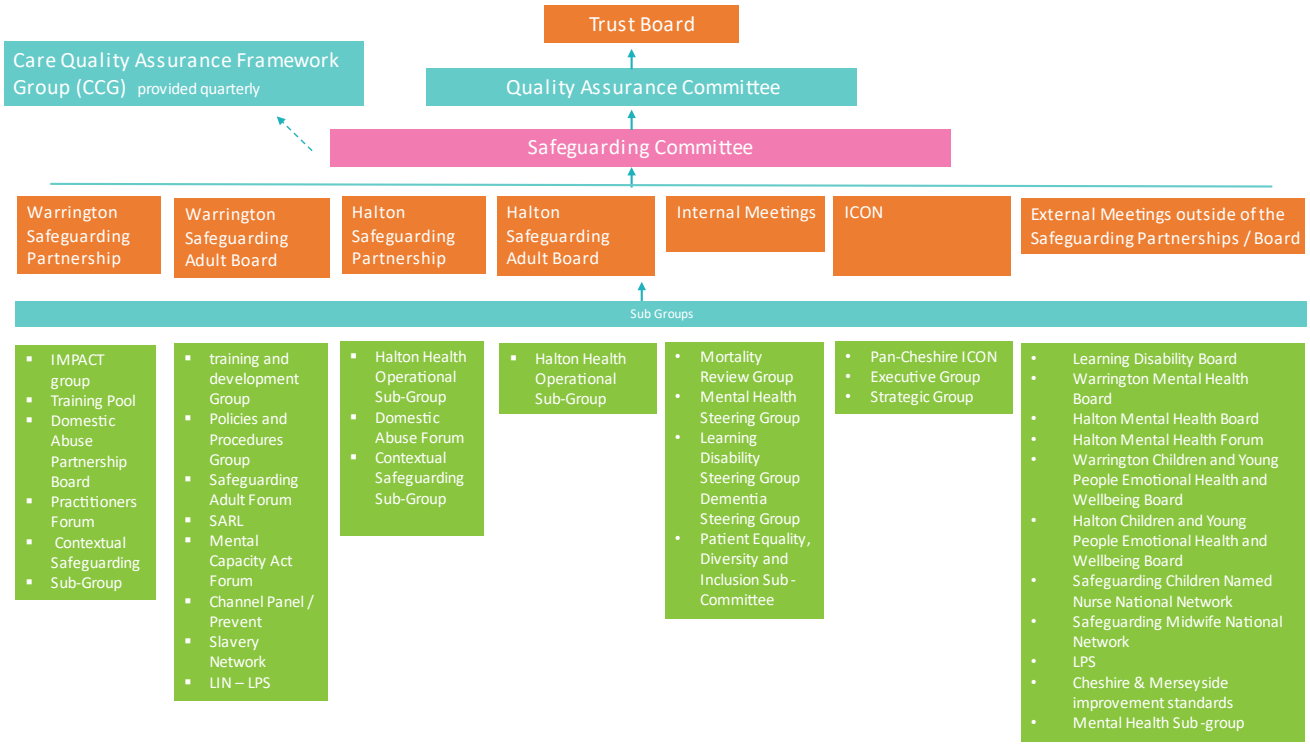


3.1 Safeguarding Committee Structure

The Safeguarding Committee is a sub-committee of the Quality Assurance Committee (QAC). It is responsible for monitoring the development, implementation, audit and delivery of safeguarding throughout the Trust. The Safeguarding Committee receives reports and has responsibility for the ratification of policies. It is in this way that compliance with external organisational requirements such as the Care Quality Commission, Safeguarding Children Partnerships and Safeguarding Adult Boards are managed.

The Chief Nurse and Deputy Chief Executive is the Chair of the Safeguarding Committee which is accountable to the Quality Assurance Committee (QAC) ahead of Trust Board.

The Safeguarding Committee reporting structure offers assurance from internal to external safeguarding partners as detailed in the below chart.



4. Underpinning Legislation

The following regulations underpin the Trust's approach to safeguarding enabling a safe environment to be maintained *(the list is not exhaustive).*

In addition to the Safeguarding of children, young people, and adults at risk in the NHS, accountability and assurance framework (2019) framework there are several key legislative documents which drive and support the safeguarding agenda:

The Children Act 2014	Mental Capacity Act (2005)
Care Act 2014	Mental Health Act (2007)
Human Rights Act (1998)	Children and Social Work Act 2017
Deprivation of Liberty Safeguards (2007)	Mandatory reporting of female genital mutilation (2016)
Sexual Offences Act (2003)	Domestic Violence, Crimes and Victims Act (2004)
Data Protection Act (1998)	Public Interest Disclosure Act (1998)
Modern Slavery Act (2015)	Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework (2015)

5. Safeguarding Strategy

In 2019 the first Safeguarding Strategy was launched. The Strategy demonstrated the significant role that WHH play in educating and supporting staff to recognise and report suspected harm and abuse. WHH are committed to continually evaluating and improving standards of safeguarding expertise and knowledge across the organisation with regards to WHH vision, objectives, and values.

Of the agreed seven objectives outlined in the above strategy six were achieved. The progress of the remaining objective, Liberty Protection Safeguards (LPS), has been delayed due to the national consultation process having been postponed. Section 6.2.3 of this report provides a detail update of the national position and how WHH will support this work.

This current strategy is under review in preparation for the next iteration to be launched in 2022.

6. Safeguarding Activity

The following data describes the activity and provides an analysis of safeguarding during the latter stages of the pandemic restrictions, whilst comparing data from the onset of the pandemic.

Safeguarding notifications to the safeguarding teams are completed using the ICE electronic system. Each ICE notification is reviewed and actioned by a Specialist Safeguarding Nurse. The data collected from the ICE notifications, telephone calls, emails and face to face contacts have been captured to provide the date in this report.

6.1 Safeguarding Unborns, Children and Young People

6.1.1 Safeguarding notifications

When compared to the previous year there has been a 17% increase in ICE notifications to the safeguarding children team (2942 in 2020/2021 versus 3454 2021/2022). Figure 1 provides data for all safeguarding children ICE notifications under the three categories, Children, Maternity and Domestic Abuse. There has been a significant increase across all levels of ICE notifications. The activity generated from the ICE referrals is explained under this section of the report.

Figure 1

ICE Notifications to the children's team	Children's	Maternity	Domestic Abuse (Children / unborns in the Family)
2016/2017	1502	795	126
2017/2018	1520	765	108
2018/2019	1706	955	135
2019/2020	1876	846	103
2020/2021	2021	827	94
2021/2022	2421	901	132
% change 20/21 to 21/22	↑20%	↑2%	↑ 40%

6.1.2 Safeguarding Children Concerns

WHH utilise a 'concerns form' to highlight and ensure compliance with the Laming recommendations. These recommendations set out to safeguard children ensuring best practice is applied. Review of data when compared to the previous year indicated a decrease of 18% (400 in 20/21 versus 338 in 21/22). The age distribution of the 'concerns form' remains similar to previous year, See figure 2. Under 1's accounted for 16% (57) of forms whilst 57% (195) of the forms were completed on 13–17-year-olds, this again is comparable to the previous year. Concerns for children suffering with mental ill health in the over 13 years old continues to increase in numbers and complexity.

Figure 2

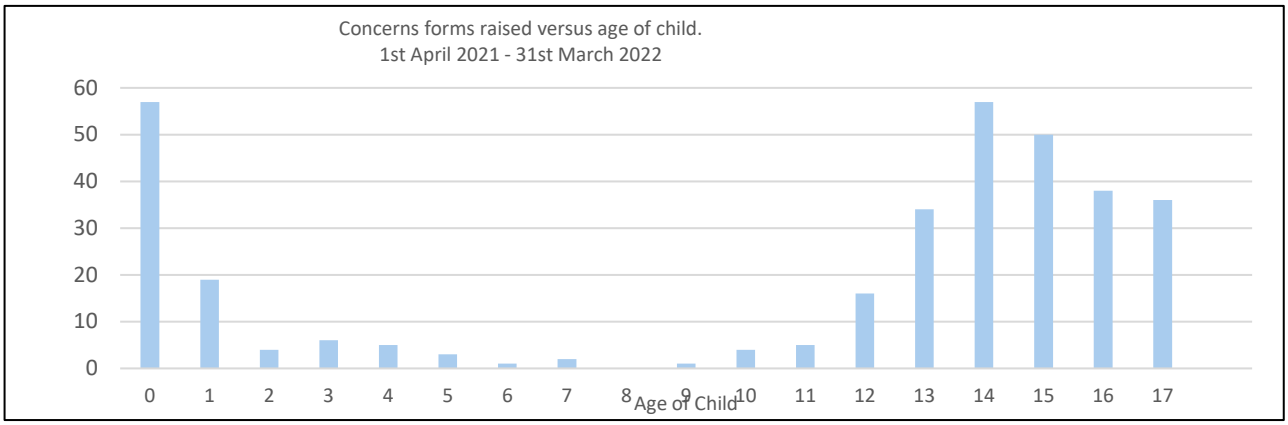


Figure 3

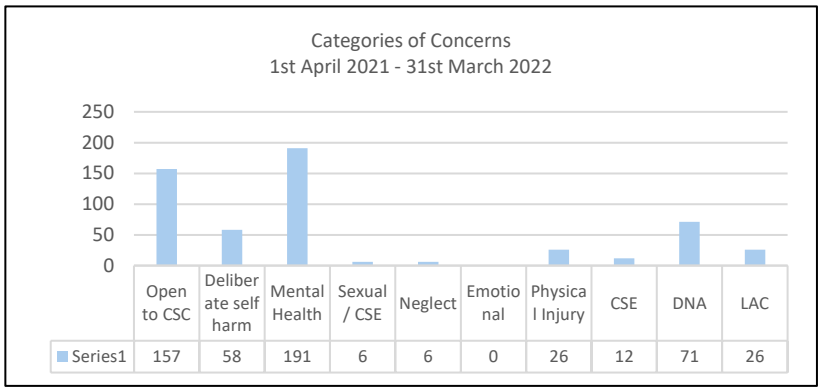


Figure 3 provides an overview of the categories of concern. Several patients identify under more than one category. For example, children who cause harm to themselves could also be known to children's social care. Mental health and children open to Children's Social Care remain the highest reported. Children's mental health is explored further in the report.

6.1.3 Child Protection Medicals

A child protection medical (CPM) assessment should always be considered when there is a suspicion of, or a disclosure of, child abuse and/or neglect involving injury, suspected sexual abuse or serious neglect. The need to consider a medical assessment in these cases arises from section 47 of the Children Act 1989 (and 2004) which places a statutory duty on the Local Authority to make enquiries to enable it to decide whether it should take action to safeguard and promote the welfare of a child. A total of 28 child protection medicals were completed during the reporting period which is another significant decrease from the previous year. Whilst there is no clear rationale for this, national lockdown contributed to the lack of face of face contact with children therefore the potential for abuse to go unidentified was present. It is anticipated the 2022 2023 may see a significant increase in the requests for CPM now all restrictions have been lifted. All child protection medicals are discussed at a monthly peer review meeting. Figure 4 provides the detail regarding the geographical areas of the children who attended for a child protection medical.

Figure 4

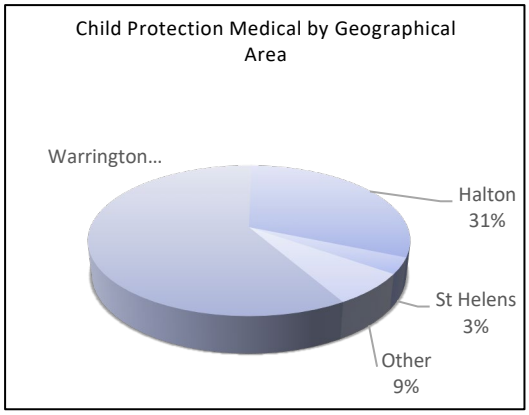
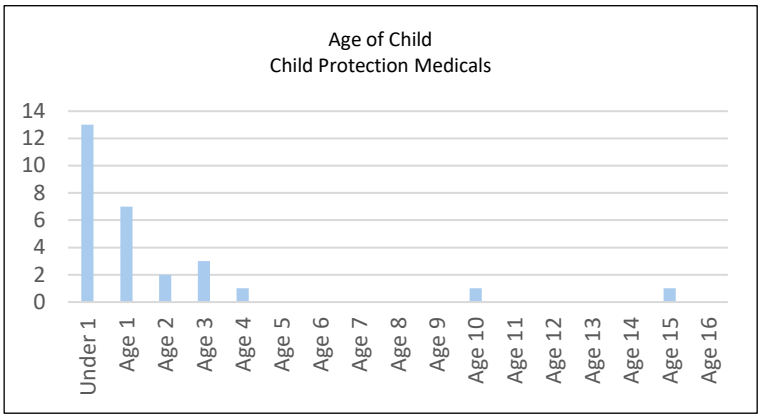


Figure 5



Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014, (Brandon et al 2016) identified that “Infancy remains the period of highest risk for serious and fatal child maltreatment; there is a particular risk of fatality for both boys and girls during infancy” This is replicated within the activity seen in figure 5

6.1.4 Child Death

Working Together to Safeguard Children 2018 Chapter 5 sets the functions and processes of the Child Death Overview Panel (CDOP), which includes the collection and collation of data following the death of a child and subsequent recommendations following data analysis.

The Sudden Unexpected Death in Childhood (SUDIC) proforma & guidelines was updated in 2019. This guidance provides a framework for the investigation and care of families after an unexpected death of an infant or child. Due to confidentially and ongoing investigations / meetings the causes of deaths cannot be documented within this annual report. Bereavement support is offered to the family and the staff involved in any child death incident. Following relevant multi-agency meetings, feedback and learning is presented internally to the Mortality Review Group. Figure 6 demonstrates the number cases which have required WHH input.

Figure 6

	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Number of deaths pronounced at WHH	5	15	3	8	5
Total number of child deaths requiring further information sharing / input from WHH	12	22	19	24	10

6.1.5 Safeguarding Unborns and their families

Safeguarding within midwifery is constantly changing and becoming more complex. Research and experience indicate that very young babies are extremely vulnerable to abuse and that work carried out in the ante-natal period to assess risk and to plan intervention will help to minimise harm. In 2021/2022 there has been a significant increase in the number of women with identified vulnerabilities who are being supporting through their pregnancy as detailed in Figure 7. The Safeguarding Children Team provide a robust channel of communication with external partners and ensure that patient records and care plans are up to date in readiness for delivery of the baby. The data below in Figure 8 provides detailed information regarding the number of special circumstance forms comments and from which geographical area the patients are from. From 1st November 2021, Halton midwifery service transferred over to Warrington and Halton Teaching Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospital NHS Trust. With this there has been an increase in safeguarding cases. In 2020/2021 9% of special circumstances forms account for Halton women, in 2021/2022 this has increased to 14%.

Figure 7

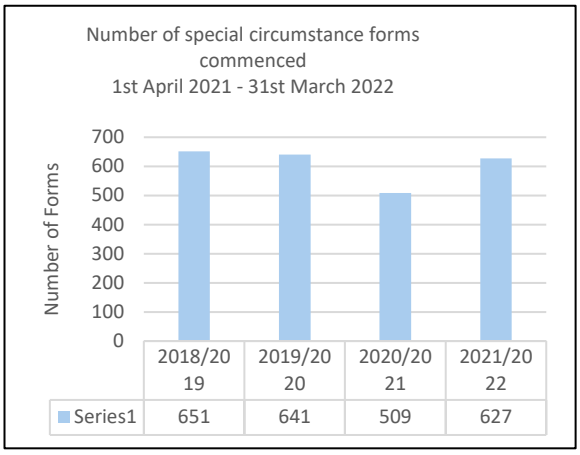


Figure 8

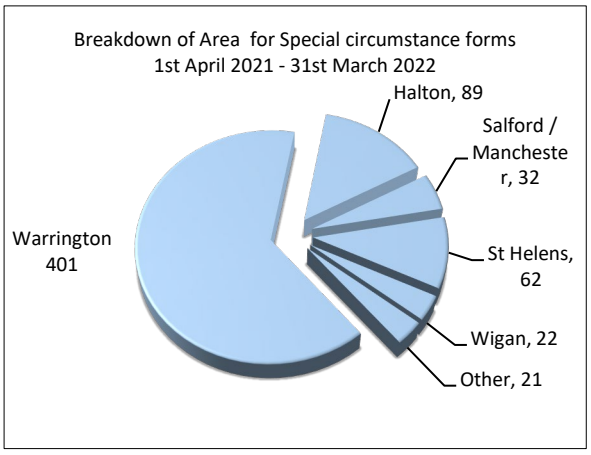
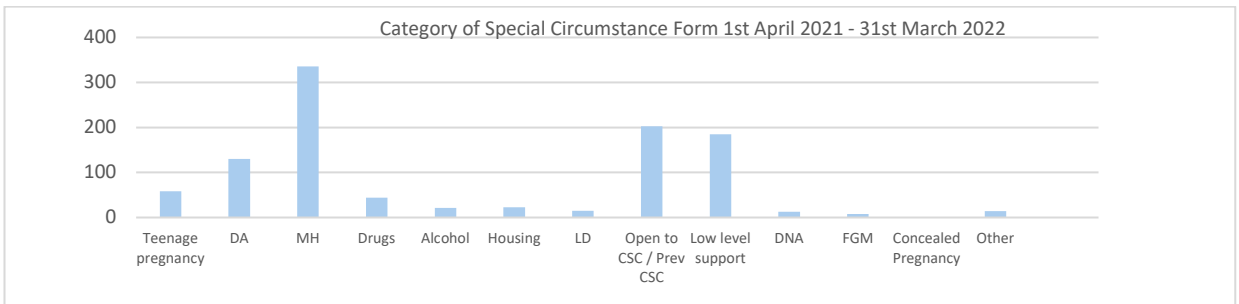


Figure 9 provides a detailed breakdown of the category of concerns raised. Consistent with the previous year's data mental health continues to be the most prevalent reason for concern (53%). The perinatal period, as defined in relation to mental illness, spans the time of conception to when the infant reaches the age of one. Perinatal mental illness is relatively common. The Royal College of Obstetricians and Gynaecologist conducted a survey which showed that 81% of women surveyed had experienced at least one perinatal mental health condition during or after their pregnancy. Low mood was experienced by over two-thirds of the women, anxiety by around half and depression by just over one-third. The severity of the condition will vary from individual to individual and may have some serious consequences if not identified and managed early and effectively. It is positive that so many women have been identified during the antenatal / postnatal period. WHH provides a peri-natal mental health service to support the increasing demand which includes the recruitment of a specialist midwife for mental health.

Figure 9



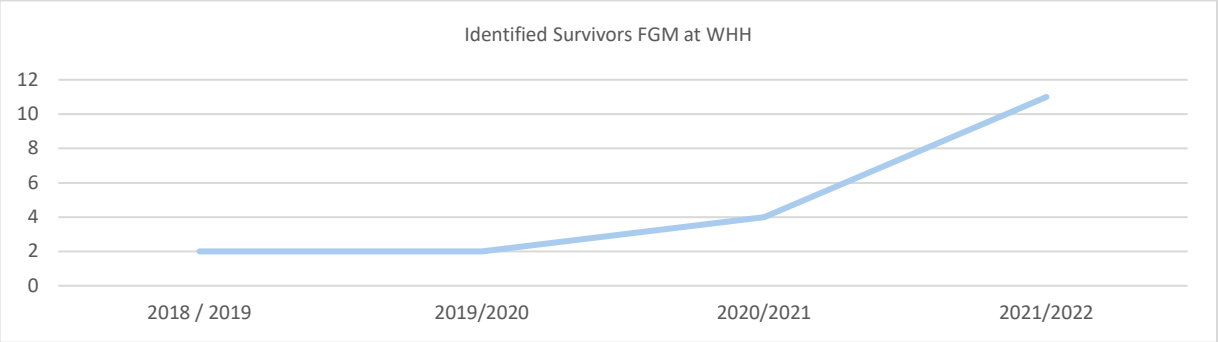
6.1.6 Female Genital Mutilation (FGM)

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

The National Female Genital Mutilation - April 2019 to March 2020 Annual Report identified there were 6,590 individual women and girls who had an attendance where FGM was identified. These accounted for 11,895 total attendances reported at NHS trusts and GP practices where FGM was identified. Nationally the number of total attendances during 2019-20 has remained broadly stable.

Screening for FGM is a routine part of midwifery booking. Within this reporting period, eleven survivors of FGM have been identified via WHH midwifery services. This is an increase of 150% (4 in 20/21 versus 10 in 21/22) Figure 10. The appropriate pathways were followed, and relevant agencies notified to ensure the safety of the unborn and any siblings were assessed.

Figure 10



The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is submitted on a quarterly basis. The dataset supports the Department of Health's FGM Prevention Programme by presenting a National picture of the prevalence of FGM in England.

6.2 Safeguarding Adults at Risk

In comparison to the previous year, there has been an overall increase of activity of 44% (2266 notification 20/21 verus 3266 notifications 21/22). The safeguarding adult team receive ICE notifications under five categories, safeguarding adults, domestic abuse (where only adults are identified), learning disabilities, DoLS and Prevent. The activity generated from the ICE referrals is explained below

6.2.1 Safeguarding Adults Notifications

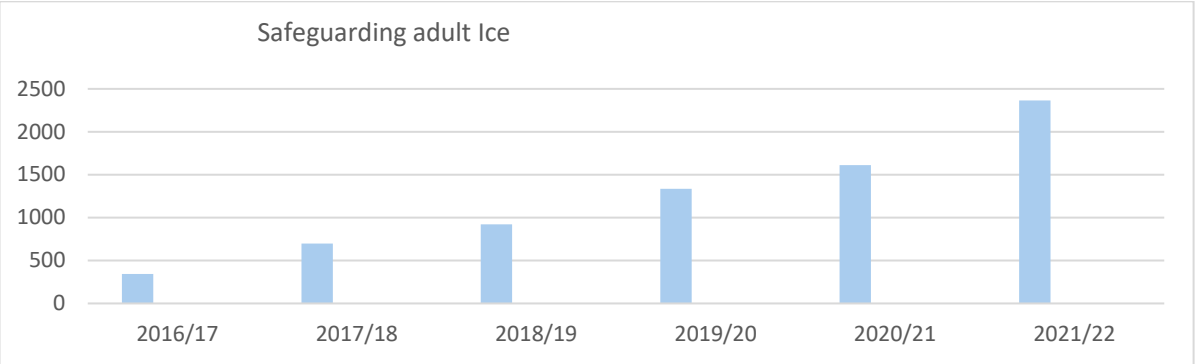
Figure 11

ICE Notifications to the adult's team	Safeguarding Adult ICE	DA Adult Only Cases	LD In-Patients	Prevent	DoLS
2016/2017	343	18	6	0	225
2017/2018	696	71	20	0	629
2018/2019	922	106	79	4 cases	511
2019/2020	1336	116	142	0	525
2020/2021	1611	116	158	1	480
2021/2022	2364	153	198	4 cases	547
% change 19/20 to 20/21	↑47%	↑31%	↑25.31%	↑3 Cases	↑13.95%

The information detailed in the charts above (figure 11) and below (figure 12) describes activity prior to and during the Corona Virus Pandemic, the full impact of the restrictions in place in recent years on victims having been confined to their homes with perpetrators of abuse and on people not having access to their usual support networks and health monitoring processes is still being understood. It is, however, clear that agencies are aware that the expected significant spike in safeguarding cases has exceeded even the most pessimistic estimates.

As expected, Mental Health, Domestic Abuse and Self-Neglect have become areas of focus. Self-neglect has been noted to be an increasingly emerging theme following the COVID-19 Pandemic. Responding to self-neglect can be one of the most complex areas of adult practice for today's professionals, because this can often present within the context of personal choice. WHH have worked in collaboration with external partner agencies to develop a multi-agency self-neglect and hoarding tool. Referrals for domestic abuse, learning disability patients and patients requiring DoLs also evidence significant increase during the reporting period.

Figure 12



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

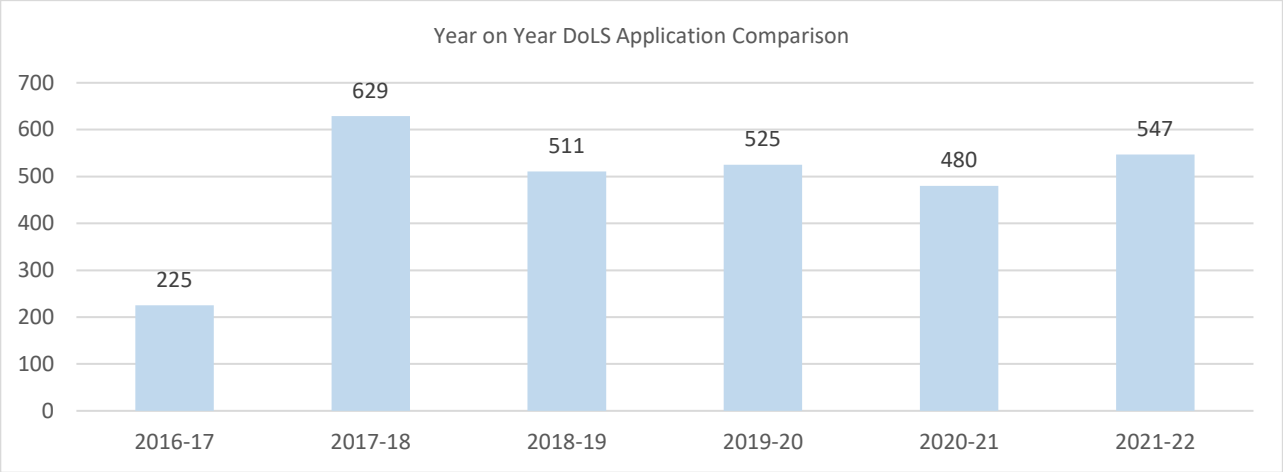
The Local Authority (LA) is the responsible body regarding the assessment and authorisation of DoLS applications. Applications are sent to the LA that the patient lives in. Whilst there was a government policy change to how this statutory duty was carried out during the COVID-19 pandemic, business returned to normal as restrictions ceased.

When a person is deemed to lack capacity and a deprivation of liberty is identified, if appropriate a DoLS is applied for. Applications are completed by wards and emailed to the relevant LA and the WHH adult Safeguarding Team who contact wards to offer advice and education about the management of DoLS. Staff are also advised about advocacy and the court of protection (COP) process where required and have access to an MCA policy and an SOP, applications are audited for accuracy and standard of documentation.

During the reporting period there has been a 50% increase in the number of COP cases all of which were supported accordingly by the adult team with legal advice provided where required; there were 547 DoLS applications made during the reporting period. A database is used to record information about all DoLS applications and the CQC is notified in line with statutory guidance.

Figure 13 demonstrate the number of DoLS applied for in the reporting period with comparison to previous years, followed by a graph describing the LA areas applications were sent to (figure 14).

Figure 13



The information above reflects the effect of an intense program of training that commenced in 2017 resulting initially in a spike of applications that became a little more static as staff developed an increased understanding of their MCA/DoLS responsibilities.

Figure 14

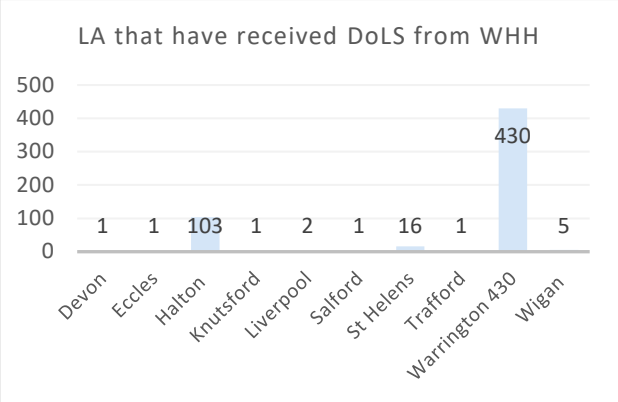
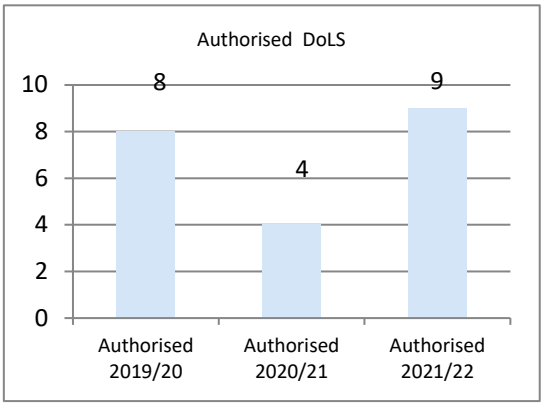


Figure 15



The graph above (figure 15) describes the number of DoLS applications authorised by LA's, this authorisation results in a standard DoLS being issued. The increase noted between 20/21 and 21/22 is linked to the increased number patient cases that were taken to the COP, this is because a court process cannot take place without the authorisation of a standard DoLS. Authorisations are risk assessed by the LA, using a national tool. Only those assessed as high risk were reviewed during the pandemic, patients who became a matter for the court of protection were considered high risk.

Both Warrington and Halton LA's continue to operate with a significant back log of applications, with each application taking approximately 12 hours to complete, the back log increased during Covid as restrictions were placed on who could enter the acute hospital settings. This is a national issue and one of the driving factors in the review of DoLS which resulted in a new statutory process known as Liberty Protection Safeguards (LPS).

6.2.3 Liberty Protection Safeguards (LPS)

On 16th May 2019 LPS received Royal assent and became Law, this replaced DoLS (2007) which had become statute as an amendment to the MCA (2005). DoLS were introduced to protect the rights of people who may lack capacity to make critical decisions for themselves, whilst also ensuring that the care and treatment being delivered was in the best interests of the person concerned. During the years following the implementation of DoLS it became evident that a review was required and LPS were introduced in the Mental Capacity (Amendment) Act 2019. LPS are designed to deliver improved outcomes for people who are or who need to be deprived of their liberty ensuring they enable the rights and wishes of those at the centre of all decision-making are observed, DoLS and LPS observe the European Convention on Human Rights (ECHR). When implemented, the LPS will cause significant changes to the current processes that are in place. The main differences between LPS and DoLS are detailed in figure 16 below.

Figure 16 - Differences between the Deprivation of Liberty Safeguards and the Liberty Protection Safeguards:

Deprivation of liberty safeguards (DoL)	Liberty Protection Safeguards (LPS)
Can only be applied in care homes and Hospitals. A Separate application to the Court of Protection is needed if there is a deprivation of liberty in any other setting and where there is objection of decisions made in a person's best interests	Can be applied in any setting including in a person's own home
Starts from age 18+	Starts from age 16+

Local Authorities act as the responsible body	Creates new responsible bodies. The new responsible body is whichever organisation is providing or commissioning the care. The responsible body could be the ICB, the LA or the NHS Trust/Hospital. WHH will become a responsible body under the new LPS law

The Department of health and social care government ministers have developed A "Code of Practice that will support the implementation and use of LPS legislation. A 16-week consultation period of the new code of practice has recently been completed the feedback will be reviewed prior to the final amended documents being published. This guidance was due to be published late in 2019/early 2020 but was delayed due to the pandemic, there is currently no additional information regarding the implementation date/timeline for LPS following the completion of the consultation. Kenny Gibson, Deputy Director for NHSE/I National Safeguarding Lead, has written an open letter to offer information, recommendations, and support for organisations about LPS, the main themes of the letter are listed below, this has been discussed at WHH Safeguarding Committee.

- LPS system leadership
- LPS workforce planning
- LPS data set
- Delayed DoLS assessments
- Resource planning

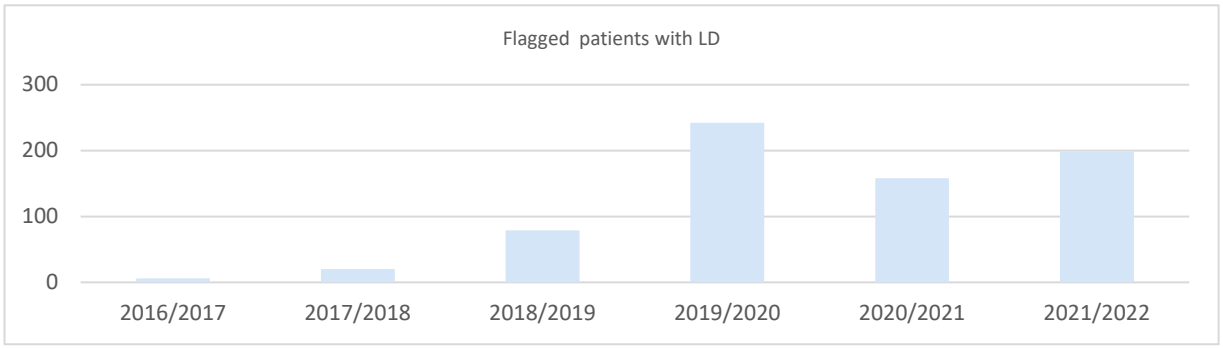
NHSE/I have commenced recruitment of regional LPS Clinical leads. WHH is represented at meetings with partners across Cheshire and Merseyside to review how the new law can be effectively implemented and work is underway to review the impact of LPS on WHH as it becomes a responsible body, the impact is expected to be significant. Preparation to assess required staffing resource and training requirements has begun.

The best preparation for LPS continues to be focusing on legal literacy in relation to the Mental Capacity Act. The National Safeguarding Team and the Central Continuing Healthcare Team have co-designed and launched an LPS System Readiness audit that was completed by each CCG (now ICB) which will, moving forward, become a quarterly activity and will also include Providers. However, these arrangements may be subject to change following final publication of the LPS Code of practice and supporting legislation.

6.2.3 Learning Disability/Autism

It is currently estimated that there are approximately 2000 adults with a learning disability (LD) living in Warrington and Halton. There are 1.4 million people with learning disabilities in the UK, making up approximately 2% of the general population, approximately 347,000 are children aged 0-17. Figures from the Confidential Inquiry into Premature Deaths of People with learning disabilities (CIPOLD, 2013) demonstrated that life expectancy of people living with a learning disability is lower than the general population. The LeDeR program was launched following the publication of CIPOLD. We know that people with a learning disability are twice as likely to be admitted to hospital than the general population. Figure 17 provides evidence that patients admitted with a diagnosed LD increased by 25% in comparison to the previous year, (158 patients 20/21 versus 198 patients 21/22).

Figure 17



LeDeR, the national mortality review program is supported by WHH safeguarding team and Mortality Review Group (MRG). Lessons from LeDeR reviews are relayed to WHH via the MRG newsletter.

National Health Service Improvement (NHSI) published Learning Disability Improvement Standards for NHS Trusts in 2018. The document highlights four overarching areas for improvement; with three of those areas being key to Acute Hospital's.

1. Respecting and protecting rights (5 improvement measures)
2. Inclusion arrangements (5 improvement measures)
3. Workforce (4 improvement measures)

An action plan for improvement in in place and monitored via the internal Learning Disability Steering Group. In line with equality standards, WHH are required to ensure reasonable adjustments are made to support access to health care for people with an LD diagnosis. Alongside the appointment of an LD Specialist Nurse, a program of training has supported staff

6.3 Domestic Abuse – Children and Adults

There are some 2.3 million victims of domestic abuse a year aged 16 to 74 (two-thirds of whom are women) and more than one in ten of all offences recorded by the police are domestic abuse related.

In December 2019 the Government was elected with a manifesto commitment to "support all victims of domestic abuse and pass the Domestic Abuse Bill" originally introduced in the last Parliament. The act aims to ensure that victims have the confidence to come forward and report their experiences, safe in the knowledge that the state will do everything it can, both to support them and their children and pursue the abuser.

WHH, working with the Domestic Abuse Partnership Board, takes its role in helping to prevent domestic abuse and offering support for victims very seriously. WHH supported the development of the Warrington Domestic Abuse Strategy. The strategy sets out intentions for the next three years whereby we aim to create sustainable change across the system through continued partnership work.

In comparison to the previous year the number of referrals has significantly increased by 39% which equals 72 referrals (Figure 18). As normal service resumes and patients now accessing professionals the numbers of referrals were expected to increase. In addition to this, the recruitment of the Domestic Abuse Professional and Trainer has increased awareness of domestic abuse across the trust therefore resulting in a significant increase in referrals. The number of staff members who have disclose they are victims of domestic abuse has also increased. Staff victims have been supported through their workplace manager and the hospital Independent Domestic Violence Advocate

(IDVA). As demonstrated in figure 19, the geographical split of referrals remains Warrington and Halton being the highest.

Figure 18

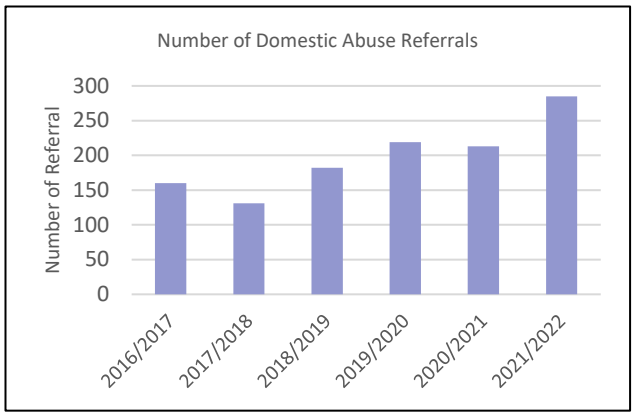
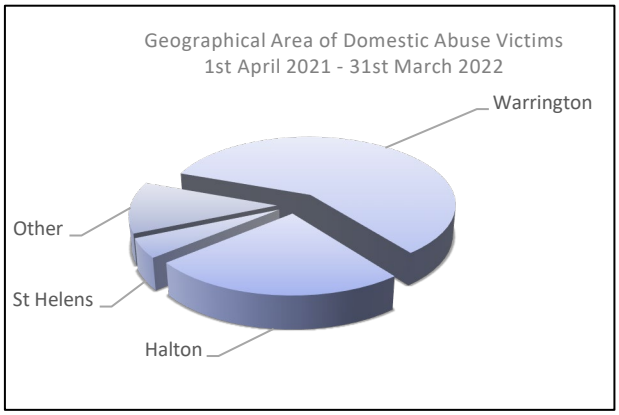


Figure 19



Key statistics for WHH include:

- 285 domestic abuse cases identified
- 16% victims were identified as men
- 46% of cases were referred to the children's team as they had children / unborns in the family
- 54% of cases were referred to the adult's team as they were adult only cases
- 46% cases were referred on to the appropriate MARAC (Multi -Agency Risk Assessment Conference)

7. Incident Reporting

DATIX incidents are responded to in a timely manner in collaboration with the appropriate Clinical Business Unit (CBU). Comparable data shows a significant increase in reporting safeguarding children's incidents by 77% (54 incidents in 20/21 versus 96 incidents in 21/22). The highest reporting category being that an element of the WHH Safeguarding Children policy has not been followed, see figure 20 for breakdown. Adult safeguarding incidents have also increase by 93% (90 incidents in 20/21 versus 174 incidents in 21/22). Figure 21 shows 'concerns about standards of care within WHH' as the highest reporting incident. Each category and theme identified has associated actions monitored at the Safeguarding Committee

Figure 20

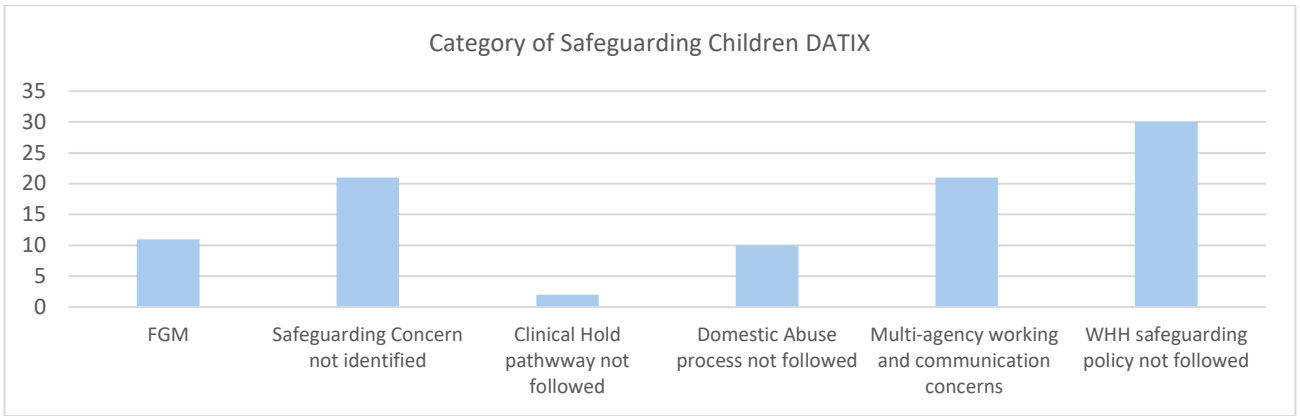
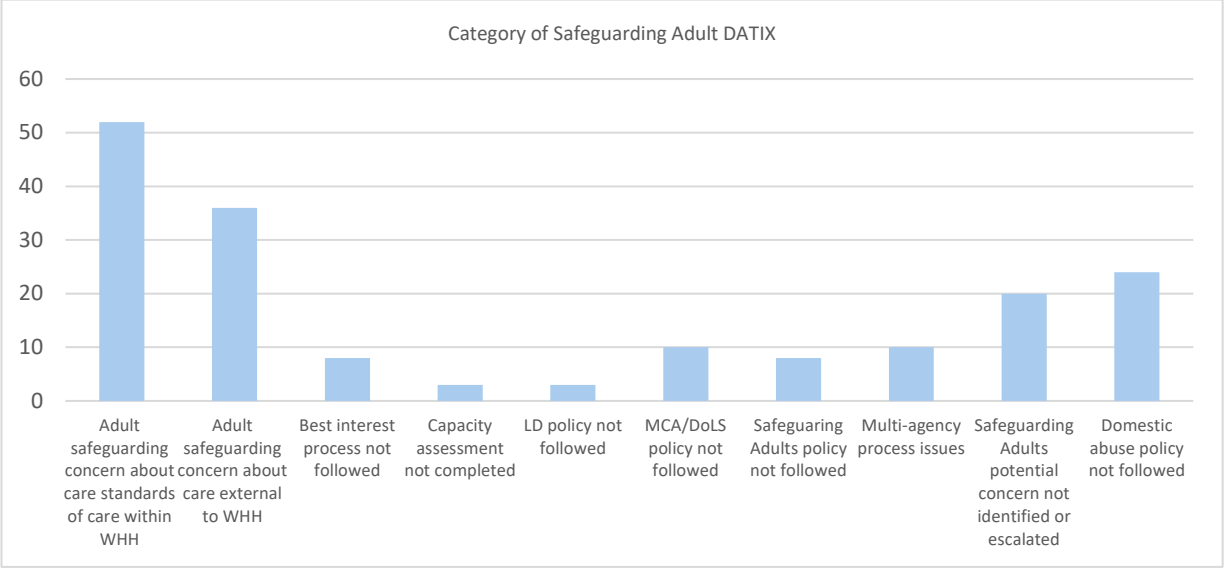


Figure 21

Training – 1st April 2020 – 31st March 2021	Number of people to be trained	Number of people trained	Compliance
DoLS	2653	2349	87.73%
MCA	2715	2486	91.57%
WRAP	1815	1695	93.39%
Prevent Basic Awareness	4360	3855	88.42%
Safeguarding Children Level 1	4360	3843	88.14%
Safeguarding Children Level 2	2610	2037	78.05%
Safeguarding Children Level 3	503	377	74.95%
LD level one (this data is indicative of the training commenced in February 2021)	1411	902	63.93%
LD level two (this data is indicative of the training commenced in February 2021)	2908	1336	45.94%
Autism level one (this data is indicative of the training commenced in February 2021)	1410	904	64.11%
Autism level two (this data is indicative of the training commenced in February 2021)	2909	1307	44.93%
Domestic Abuse Level 1 (this data is indicative of the training commenced in February 2021)	1557	981	63.01%
Domestic Abuse Level 2 (this data is indicative of the training commenced in February 2021)	2956	901	30.48%
Domestic Abuse Level 3 (this data is indicative of the training commenced in February 2021)	2934	861	29.35%
Adult safeguarding level 1 Face to face	4360	2467	56.58%
Adult safeguarding level 1 eLearning	4360	3437	78.83%
Adult safeguarding level 2 Face to face	2720	1580	58.09%
Adult safeguarding level 2 eLearning	2720	2095	77.02%
Adult safeguarding level 3	1109 Please see detail below*	523 staff have completed face to face training	47.16% this figure describes the face-to-face training data only



8. Safeguarding Training

8.1 Training Compliance

The table below provides an update on the training compliance from April 2021 to March 2022. Since April 2021, the number of virtual and face to face training available sessions have increased (with level 1 and 2 adult safeguarding being delivered during evenings and weekends) thus creating greater accessibility for staff attendance in response to operational and staffing pressures. This has proven successful and will continue throughout 2022/23. All training is delivered in line with the Children's Intercollegiate Document and the Adult Intercollegiate Document.

Training compliance is monitored monthly via the safeguarding Committee. The table below (figure 22) describes compliance to 31/3/22. Action plans and training trajectories are provided by Clinical Business Unit (CBU) leads to provide assurance that safeguarding training is high on the agenda across WHH. Domestic Abuse, Learning Disability and Autism training commenced in February 2021 with the current trajectories on target for 2024 (3 year training plan).

Figure 22

The safeguarding training programmes is frequently updated to ensure that learning from case reviews, hospital incidents and National guidance (Intercollegiate Documents) is incorporated in a timely manner.

Saville Training

WHH commissioned Ray Galloway, a former police officer who led the investigation into the Saville events, to present the learning from the investigation. In total 6 sessions were delivered to staff across the trust in this audit period. The one-day safeguarding training course exposed the myths around Savile and reveals the vital lessons that can be learnt from how he operated, how he cultivated influence and how he was able to go undetected for over five decades. The training events were fully booked and received exceptional feedback.

9. Learning and improving

9.1 Safeguarding Reviews

Safeguarding Children Serious Case Review (SCR)

When a child dies, or is seriously harmed, as a result of abuse or neglect, a case review is conducted to identify methods by which local professionals and organisations can improve the way that they work together to safeguard children. As reported in the previous annual report, WHH have been involved with one multi-agency case review which was referenced in the 2020/2021 annual report. The reports from these reviews have now been published and whilst there is no specific learning for WHH, multi-agency learning has been identified and an action plan developed which is monitored through the relevant Safeguarding Children Partnership sub-group.

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

The Local Authority has a duty to investigate when an adult at risk comes to harm as a result of abuse or neglect. The investigation is conducted under section 42 of the Care Act. A Serious Adult Review is conducted in cases that meet section 44 of the Care Act, this happens where multi-agency involvement has contributed to the patients harm or death. Where death is the result of domestic abuse a Domestic Homicide Review is undertaken. At the time of writing WHH are supporting 8 reviews.

9.2 Internal and Multi-Agency note audits

Multi-Agency notes audits have continued throughout the COVID-19 pandemic on a virtual platform with WHH supporting 4 audits in total. The focus for the audits includes emotional abuse, Children's Mental Health, Domestic Abuse and Self-Neglect. Whilst no immediate actions were identified for WHH, learning from the audits is incorporated into training presentations and sessions to ensure that learning is appropriately cascaded and evidenced.

10.Inspections

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

11. Mental Health (MH)

Evidence suggests that some children and young people's mental health and wellbeing has been substantially impacted during the pandemic. Between March and June 2020, a period when schools were closed to most pupils, symptoms of depression and post traumatic stress disorder (PTSD) were found to have significantly increased in children and young people aged between 7.5 and 12 years old compared to immediately before the pandemic.

Within WHH the number of children presenting with affected mental health and/or behavioural concerns has noticeably increased. There has been a significant increase in young people being admitted to the children ward due to there being no suitable placements identified within the community. These children are often very

traumatised children requiring specialist support which cannot be provided on an acute children ward. Highly specialist care is hard to come by nationally and so this issue is only going escalate.

WHH is working in collaboration with Warrington Children Social Care and Warrington Clinical Commissioning Group to explore innovative ways in which we can support children and young people who require intensive support that do not meet the threshold for tier 4 mental health intervention. A new and unique post has been created to support this work. The Children and Young People Liaison Practitioner role has been recruited to and will commence work in July 2022.

Presentations at WHH for adults with mental ill-health have continued to increase in numbers and complexity. Mersey Care NHS Trust provide the CORE 24 service who are commissioned to provide mental health service within WHH.

12.Mortality Review

The Mortality Review Group (MRG) meets monthly and has safeguarding representation to facilitate safeguarding oversight of the cases reviewed. In cases where issues/concerns are found learning is shared and used to update training. All patients who have passed away in the Trust who have a Learning Disability or were on DoLS when they passed away receive a Standard Judgement Review (SJR). The medical examiners review all deaths and those with identified learning are taken to MRG. Patients who have and LD, Autism diagnosis and those that passed away whilst on DoLS receive an additional review conducted by the safeguarding adult Lead Nurse and Safeguarding Adult named Dr that focuses on safeguarding, MCA and DoLS, mental health and LD/Autism practice and care delivery. Learning from this is shared at MRG and with the wider Trust via MRG newsletters and Safeguarding Committee. The LeDeR process is recognised by the MRG, completed SJRs contribute to the overall LeDeR review process. Child death cases are presented quarterly.

13.Prevent

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

In line with National guidance, WHH Lead Nurse Adult Safeguarding is the prevent lead who attends regional and local prevent meetings ensuring that important information and learning is shared via Safeguarding Committee. Following the increase in terror activity in 2017 the Home Office instructed all Trusts of a requirement to achieve 85% training compliance with 3 yearly updates. WHH are currently above the required training target with 93% compliance.

A new arrangement across the Cheshire footprint has been implemented with partners from across Cheshire and Merseyside joining forces to share information and review radicalisation issues. The role of the Pan-Cheshire channel panel has been audited since the last annual report, to ensure the function complies with statutory guidance. The group were congratulated on their work. WHH is represented at the Pan-Cheshire Channel panel and relevant information for sharing is disseminated via Safeguarding Committee. WHH assurance data is reported on a quarterly basis in line with the statutory requirements.

Allegations against staff

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

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

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

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

This guidance is applied when:

- An allegation of assault to a patient has been made about a staff member
- A member of staff has been found to have committed a criminal offence related to an adult at risk
- Staff on staff assault or abuse
- A member of staff has accessed patient records inappropriately

There are currently no open case requiring the support of the Local Authority Designated Officer (LADO).

14.Achievements

In January 2022 the Safeguarding Team were presented with the Chief Executive Award. The safeguarding partnerships manager contacted WHH to express thanks for the work the team had done in assisting with an urgent situation, in which a person sadly passed away. WHH were recognised for protecting a group of vulnerable people keeping them safe through careful engagement and encouragement.

16. Assurance Statement

Whilst this Annual Report provides many examples of the positive and inspiring progress made in 2021/2022, it is important to prepare for the challenges ahead. Partnership working will continue to raise awareness and find solutions to tackling emergent and persistent safeguarding issues for health such as self-neglect and child exploitation. Work to embed the Mental Capacity Act/Deprivation of Liberty Safeguards into practice will continue, as will promoting a culture of 'Making Safeguarding Personal' and 'Think Family'.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/09/127**	
SUBJECT:	**Learning from Deaths Report Q1 2022**	
DATE OF MEETING:	28 September 2022	
AUTHOR(S):	Dr Lalitha Chinnappan, Trust-wide Lead for Mortality Dr Judith Raper, Deputy Lead for Mortality Alison Talbot, Associate Director of Governance	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper summarises 'Learning from Deaths' for Q1 2022, for noting and scrutiny, in compliance with National Guidance requirements on Learning from Deaths. **Key points to note are:** • During Q1 2022, 308 deaths occurred within the Trust. • Of these, 132 met the criteria to be subject to a Structured Judgement Review (SJR). • 97 SJRs have been completed in Q1. • 4 deaths have had a Serious Incident investigation. • HSMR (Hospital Standardised Mortality Ratio) based on 12 months data up to June 2022 is 86.28. This result is a low value outlier. • HES SHMI (Summary Hospital-level Mortality Indicator based on Hospital Episode Statistics) for the 12-month period up to June 2022 is 98.50. This result is not an outlier. Attached as appendices are the MRG themes of the month **(Appendix 1,2)**	
PURPOSE: ***(please select as appropriate)***	Information:	
	Approval:	
	To note: x	
	Decision:	
RECOMMENDATION:	The Trust Board is asked to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/22/08/212
	Date of meeting	2 August 2022
	Summary of Outcome	The Committee noted the contents of the report
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Deaths Q1 2022	AGENDA REF:	BM/22/09/127

1. BACKGROUND/CONTEXT

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

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

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

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

2. KEY ELEMENTS

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

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

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

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

3. MEASUREMENTS/EVALUATIONS

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

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

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

MRG – Forward planning

1) SJR back log- Each SJR reviewer is assigned 5 SJR reviews per month and as such the number of deaths requiring review exceeds the current capacity of reviewers to facilitate completion of SJR within a month of death. To address this the number of SJR reviewers would need to be increased, currently two replacement posts for reviewers has been advertised with interviews planned soon. Further measures have now been taken to address the reviews backlog, review timelines are now being closely monitored and reviewers encouraged to seek support if required.

2) Thematic review and related work-streams- proposal planned following discussion in MRG meeting regarding creating named workstreams where SJR's with common themes can be accumulated. Examples include recurrent clinical issues often identified on reviews like lack of pro-active DNACPR decisions/ discussions, DOLS/ capacity assessment related issues, multiple ward moves etc. This would then enable and assist to develop appropriate work streams to address the issues identified with the aim to bring about clinical changes and positively impact both patient care and trust mortality.

3) Meetings are being held to explore various forums to disseminate learning from death and MRG including speciality governance meetings, trainees' governance teaching etc. Learning from MRG is taken quarterly to the Palliative and End of Life Care Steering Group and hence informs developments including review of P&EOLC Strategy to encourage timely referral to specialist palliative care, recognition of dying, and early Treatment Escalation Planning, and the CPR Decision Making and Discussions Workstream and associated education.

3.1 Mortality Review Data Q1 2022

- During Quarter 1, 132 deaths met the criteria to be subject to a Structured Judgement Review (SJR).
- 97 SJRs have been completed in Q1.
- Of the 97 SJRs completed, 32 were allocated in Q1 and 65 were allocated in previous quarters.
- An additional 50 SJRs were allocated in Q1 compared to Q4, and the completed percentage has fallen by 26.4% compared to Q4.
- The ME Service reported 100% inpatient scrutiny has been achieved in June.
- 132 deaths met the SJR criteria; of those, 117 were assigned to a reviewer in Q1.

Fig. 1 – Key Mortality Data

Total deaths in Q1	Total LD Deaths	Total deaths that were an SI	Those meeting SJR criteria	Number of SJR reviews completed in Q1	Number of SJR Reviews that were allocated in Q1 and completed compared to Q4	
308	10	4	132	64	Q4 – SJRs were completed on 36 out of 67 assigned 53.7%	Q1 – SJRs were completed on 32 out of 117 assigned 27.3% ↓

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

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

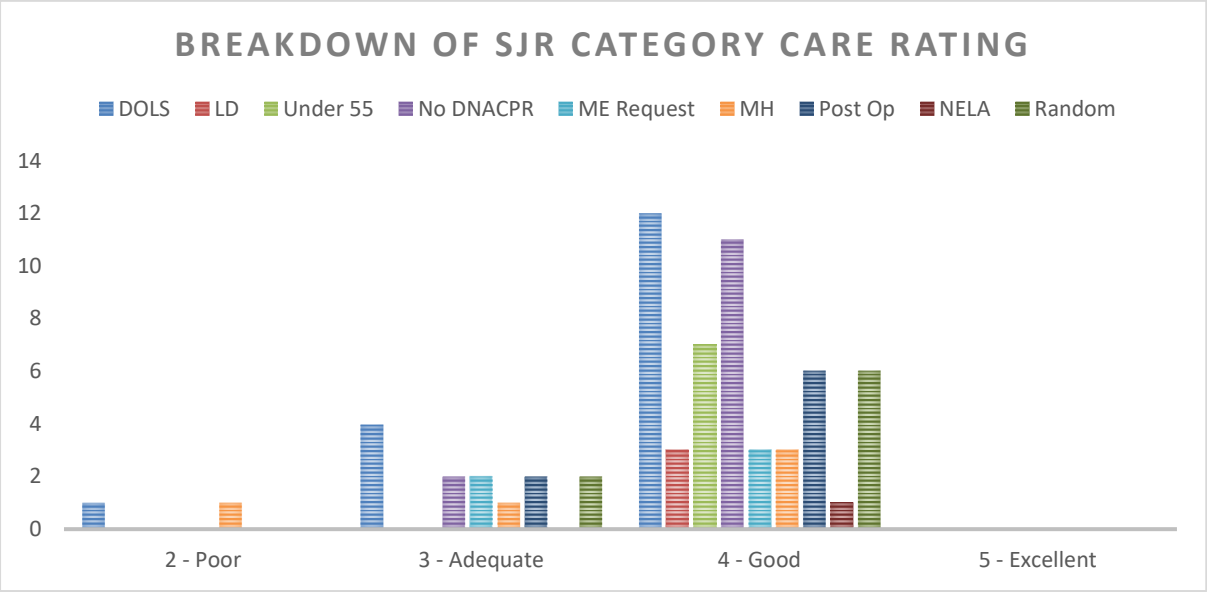
Cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Specialty Governance meetings, a sample of these are also brought to MRG to highlight good care.

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

Phase of Care *	N/A	Very Poor	Poor	Adequate	Good	Excellent
First 24 hours/admission	0	0	1	10	20	1
Ongoing care	3	0	0	8	20	1
Care during procedure	28	0	0	0	3	1
End of life care	11	0	0	4	16	1
Patient records/documentation	1	0	0	9	21	1
Overall care	1	0	1	8	21	1

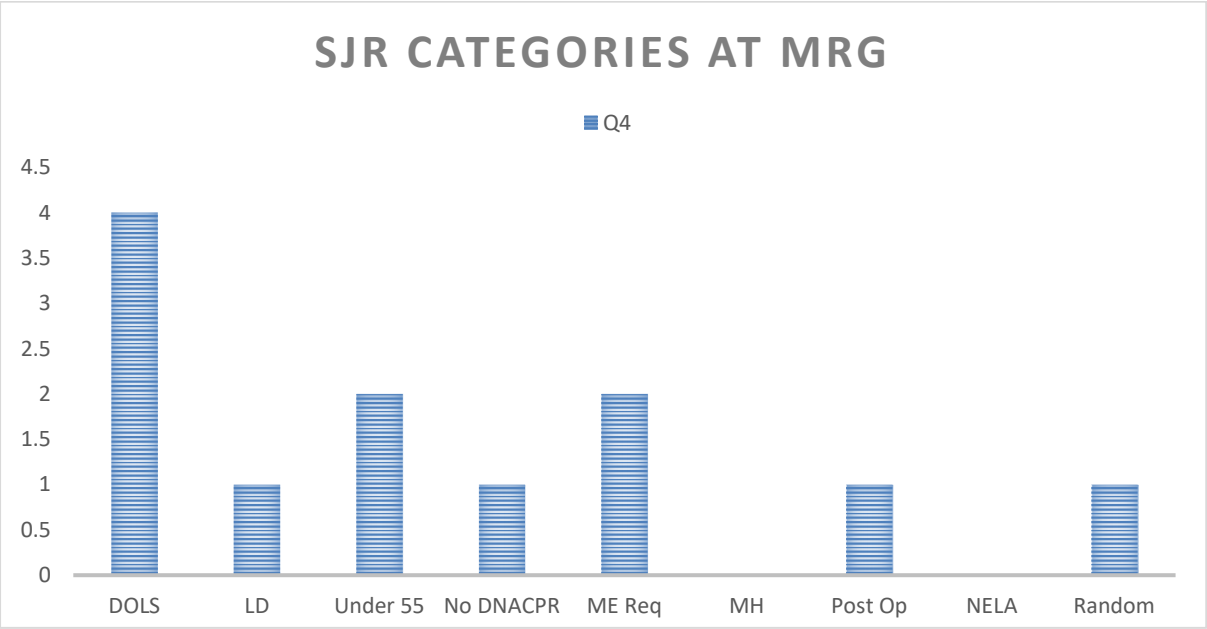
- In SJRs completed within Quarter 1, there have been 2 instances of very poor or poor care at any stage of admission. The case from May was added to DNACPR workstream and underwent a concise RCA which has since been completed. The second case with poor care was discussed in MRG in June and is progressing to further review through RIR.
- The highest number of 'good' care ratings happened during the first 24 hours of admission.
- All phases of care had more 'good' ratings of care than 'adequate'.

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



- Patients who have died aged 55 or under are predominantly receiving good care.
- No DNACPR remains a key focus of reviews with good to adequate care ratings overall.
- Patients who have died with a severe mental health disorder or learning disability are receiving good to excellent care.
- The ME service has identified cases for SJR that have had adequate and good care ratings, evidencing triangulation between the ME service and wider governance structures.

Fig 4 - Shows the frequency of each SJR category presented at MRG in Quarter 1



- The category with the highest number of SJR's requiring further discussion at MRG is patients with DOLs. There is input and representation at MRG from the Safeguarding Team which facilitates learning and development of improvement plans.
- For Quarter 1, two ME requested review was brought to MRG for discussion. This allows triangulation of the ME review with the findings processes.
- One patient death that was randomly selected for SJR were discussed at MRG.

3.2 Learning from deaths

The below describes the learning following recent deaths and the actions taken.

Learning	**Action**
ID: 8831 – Patient moved a total of 8 times in 48 days and it was agreed that multiple ward moves affect continuity of care, especially for an elderly patient, it is quite disruptive.	Multiple ward moves are being tracked through Patient Safety and Clinical Effectiveness Subcommittee now. Sharon Martlow is currently writing a paper on patient flow. A workstream is to be introduced as a result of this.
ID: 8827 – 75-year-old man found unresponsive at home by wife and an ambulance was called and patient was transported to ED. Based on evidence from medical record management this was not in line with current guidance on devastating brain injury. No discussion with critical care or organ donation recorded in notes.	MRG theme of the month newsletter to focus on learning identified from this SJR.
ID: 8545 – Daughter kept ringing for update however, no record of communication or intension to communicate with relatives. A couple of hours later, a visiting doctor sitting at a computer noticed the patient had collapsed and subsequently confirmed he had died. It should have been realised that the lack of response to fluids meant there was a significant chance that he would deteriorate further in the next 12-24 hours.	Disseminated learning through MRG monthly newsletter.
Themes	
Appendix 1 & 2 - identify the themes and learning that have arisen in the MRG meetings for Q1. These newsletters are then included on CBU and Specialty Governance agendas each month. The key themes focussed on in Q1: Introduction to new MRG, effective communication to family cares and organ donation.	

3.3 Learning from Serious Incident investigations:

Incident	Outcome
ID: 167327 – Following an extended wait patient was identified on examination to have an acute surgical abdomen and was in severe pain.	CBU Panel Meeting booked for 11:30 hrs on 06/09/2022. Investigation is in progress with a due date of 22/09/2022.
ID: 164079 – Patient with background history of asthma BIBA with worsening SOB was seen 16hrs after arrival in the ED.	The investigation has identified learning with regards to the importance of completing VTE for all admitted patients.
ID: 167117 – Patient was found sitting on the floor which was wet with spilled urine. Patient stated got out to use bottle slipped and fell resulting in hip fracture.	Panel Meeting booked for 16/08/22 11:30 hrs. Investigation is in progress with a due date of 16/09/2022.
ID: 164457 – CT scan of head performed- devastating traumatic brain injury following a fall at Halton PICU.	Investigation is in progress with a due date of 22/07/2022.

4.0 Mortality Indicators

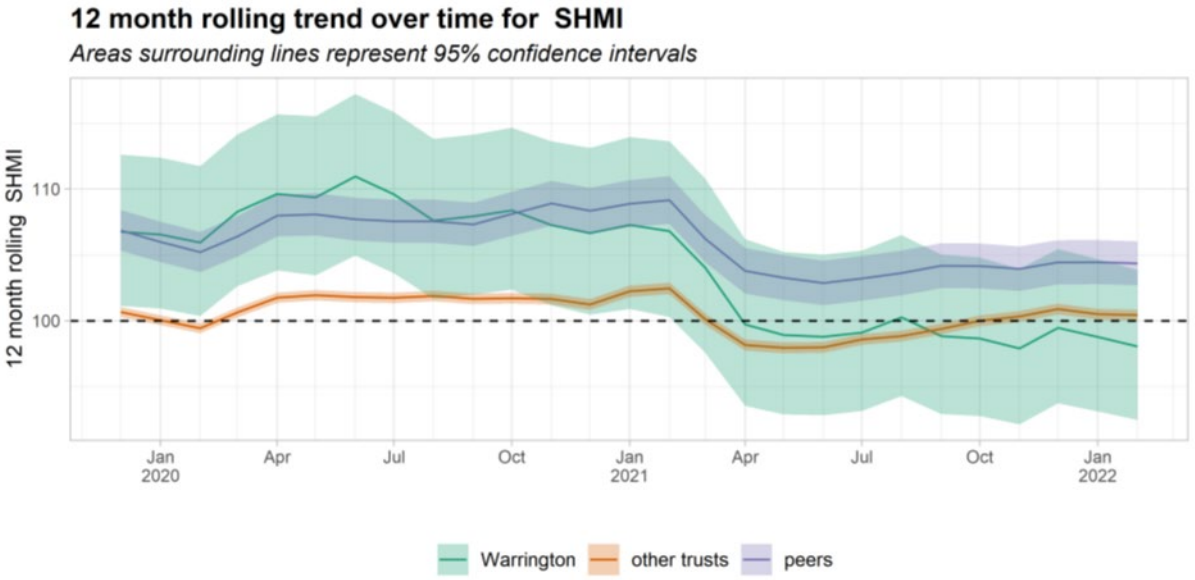
The HSMR is calculated each month for each hospital in England. It includes deaths of patients with the most common conditions in hospital which account for around 80% of deaths in hospital. HSMR is the ratio of observed to expected deaths, multiplied by a 100, from 56 baskets of the 80% most common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

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

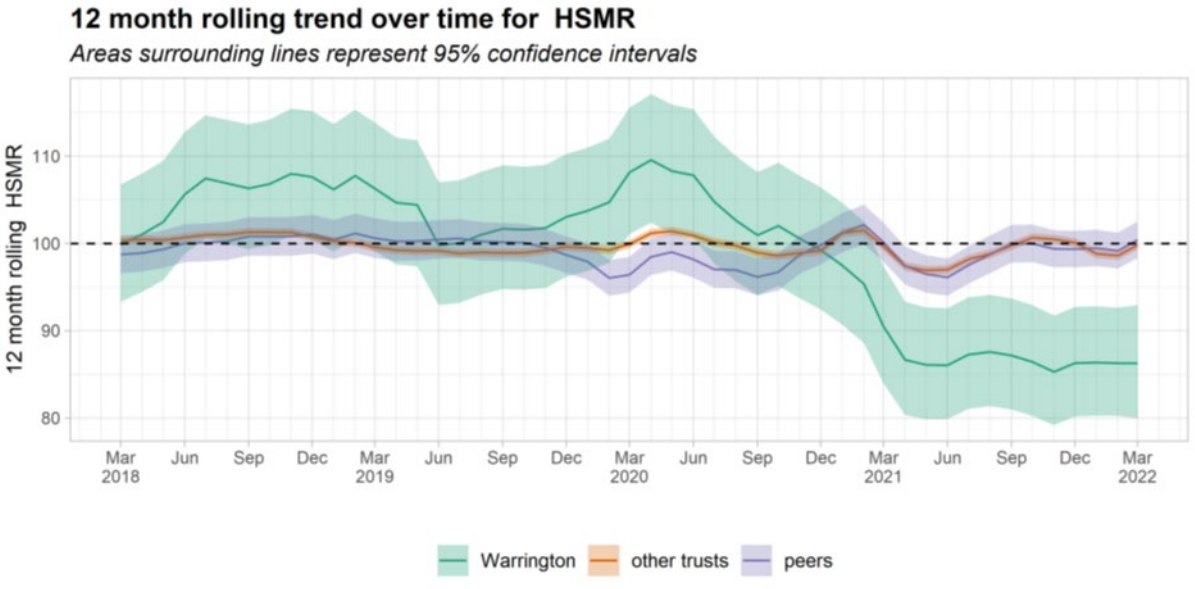
The SHMI data is the ratio between the actual number of patients who die within 30 days following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of patients treated there.
The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.
HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents, and complaints data.

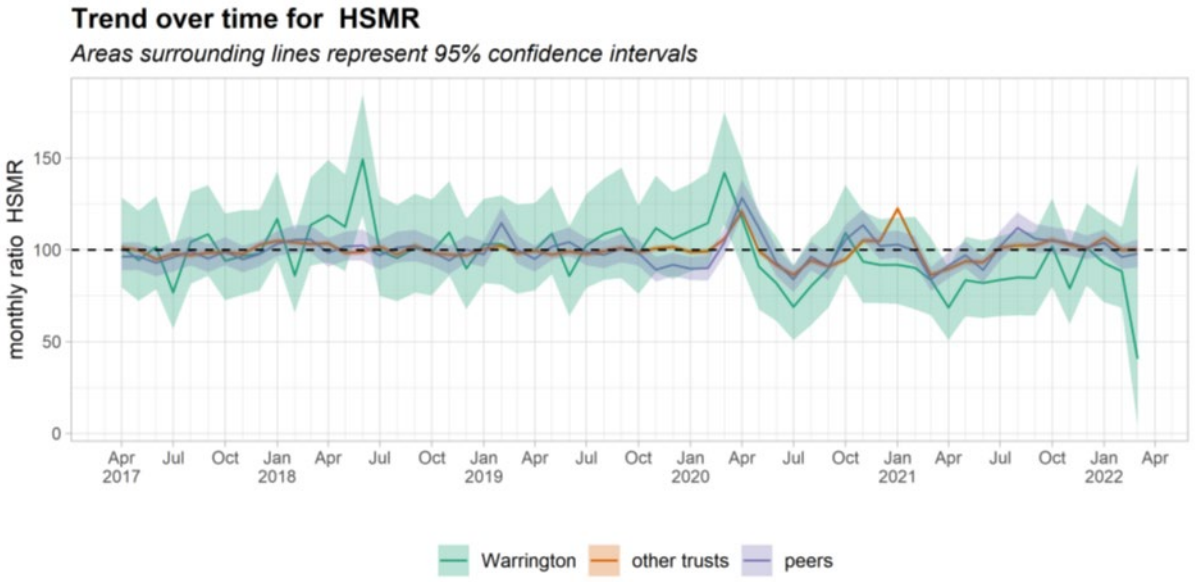
4.1 HSMR and SHMI indicators

Month	HSMR	SHMI	Total Deaths
Apr-22	84.64	99.74	113
May-22	86.48	100.16	90
Jun-22	86.28	98.50	105



HES SHMI (which is based on 12 months data up to and including February 2022) is 98.05 This result is not an outlier using an over-dispersed funnel plot and is not an outlier based on the stricter Poisson method.





Standard 56 CCS group HSMR (which is based on 12 months data up to and including March 2022) is 86.28 for Warrington. This result is a low value outlier based on the Poisson method.

- SHMI shows that deaths are lower than expected.
- HSMR shows that deaths are lower than expected.

The table below shows the SHMI diagnosis groups which fall outside an over dispersed Poisson funnel plot (95% limit) using the last 12 months data.

SHMI - key diagnosis groups excluding small numbers

SHMI diagnosis group	Observed deaths	Expected deaths	SHMI
63 :: Cardiac dysrhythmias	15	6.95	215.76
78 :: Pleurisy; pneumothorax; pulmonary collapse	16	7.96	201.13
130 :: Superficial injury; contusion	13	4.71	275.90

- The case study focused on 63 :: Cardiac dysrhythmias:
  - Deaths occurring in this group are small (15 in 12 months) so analysis should be interpreted with caution.
  - The SHMI for this group is high and increasing, with a VLAD alert in the latest month.

- Observed deaths are consistently in excess of those that the SHMI model predicts.
- Adjusting for palliative care reduces the SHMI.
- Warrington may have a more complex patient cohort that is not taken into account during modelling.
- It may be useful to review the full patient journey for these 'multiple diagnosis' patients, to understand whether they are being assigned to the most appropriate diagnosis group in terms of their overall complexity.

4. MONITORING/REPORTING ROUTES

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

5. TIMELINES

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

6. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/09/128**
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined Report for Q1, 2022/23**
DATE OF MEETING:	28 September 2022
AUTHOR(S):	Mrs Frances Oldfield, Guardian of Safe Working House
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.
EXECUTIVE SUMMARY *(KEY ISSUES):*	The 2016 Junior Doctor Contract is fully established at WHH for all our Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of Exception Reporting via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 1 (April - June) 2022-23, 131 Exception Reports were submitted of which 1 was highlighted as an immediate patient safety concern. The majority 111 (83%) of Exception Reports relate to hours of working. 17 Exception Reports relate to missed educational opportunities and 3 Exception Reports submitted related to service support available to the doctor. The total number of Exception Reports is significantly above the normal variation for the quarter. This rise in exception reporting has been driven by an increase in Trauma and Orthopaedics where a number of contractual breaches have been identified, resulting in fines being levied by the GoSW. A comprehensive action plan to resolve these issues is now in place.

PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked 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. The Trust Board is asked to note increased Exception Reporting and the levying of fines by the GoSW in Trauma and Orthopaedics and receive assurance that a comprehesive action plan to improve contractual compliance and trainee experierience in Trauma and Orthopaedics is in place.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/22/09/101		
	Date of meeting	21 September 2022		
	Summary of Outcome	The Committee noted the report.		
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	PBM/22/09/128	AGENDA REF:	BM/22/09/128

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most medical trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues, Rota Managers, and the Guardian of Safe Working (GSW).

The GSW attends the Regional Guardian Forum to ensure the Trust is performing in-line with its peers.

Most junior doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

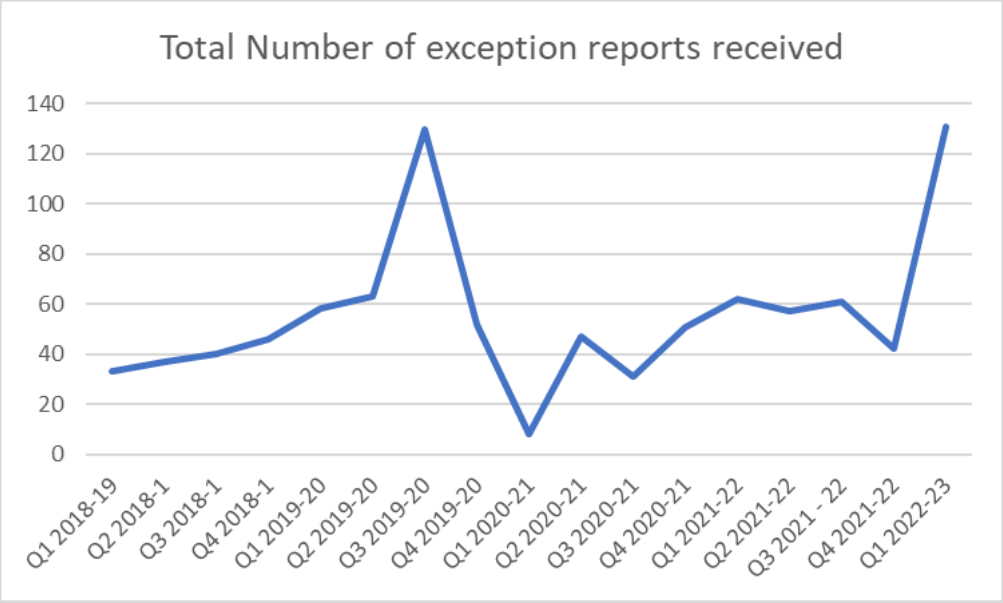
As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relating to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. KEY ELEMENTS

Exception Reporting (April – June 2022)

During Q1, 2022 - 2023, 131 Exception Reports were submitted. This is significantly higher than the last quarter and relates to an increase in reports from junior doctors working within Trauma and Orthopaedics (T&O). In total, 82 exception reports were submitted by Junior Doctors working in T&O (69 of those submitted were by Foundation Year 2 Doctors).

Chart 1 below illustrates pre and post pandemic reporting trends:



Themes for Q1 (April – June 2022)

T&O

When reviewing exception reports submitted by T&O F2 doctors, the GSW identified several contractual breaches of the terms in the Junior Doctors Contract 2016. This resulted in a fine being levied to the Clinical Business Unit responsible for T&O on 21st July 2022. Breaches of the terms "the maximum 13-hour shift length" and "less than 11 hours rest" accounted for most of the reports, resulting in a fine totalling ***£4010.39***. Penalty rates and fines for additional hours worked are set at x4 multiplier of the basic or enhanced hourly rate, with the doctor receiving x1.5 of this. Juniors in T&O had also reported they were unable to take any contractual rest breaks during their shifts. A fine applies if rest breaks are missed on 25% of occasions across a 4-week period. Therefore, this was investigated and a fine imposed for missed rest breaks totalling ***£633.30*** (calculated as x2 the relevant hourly rate). The GSW is responsible for the remaining balance (which is not given to trainees) and this must be used to benefit the education, training and working environment of trainees. The GSW should devise the allocation of funds in collaboration with the employer/host organisation junior doctors' forum, or equivalent. This is only the second time since the Junior Doctors Contract commencement in 2016 that a fine has had to be imposed at WHH.

The GSW and Medical Director met with the CBU Manager and Consultant T&O representatives on 27th July and a comprehensive action plan was agreed. This will be monitored by CBU Manager and updates provided to, Medical Director and Junior Doctors via the Junior Doctors Forum (JDF).

The Medical Director supported by the Foundation Programme Director (FPD) also met with the incoming Foundation Doctors to ensure adequate support and timely escalation of ongoing concerns. The FPD and Foundation Programme Coordinator will continue to support

the Foundation Doctors rotating through T&O and provide regular feedback to the DME, GSW and Medical Director.

Medical Outliers

The ongoing theme of exception reports related to Junior Doctors covering "medical outliers" continued during Q1. The only Immediate Safety Concern report submitted this quarter was relating to understaffing for medical outliers. It is recognised that staff sickness continued to be a contributory factor at all levels, and this significantly impacted medical outlier cover during Q1. The Surgical Junior Doctors Rota has been improved to ensure there is now a formal schedule for cover of the medical outlier patients, removing the ad-hoc nature of previous cover. Timings of ward rounds have also noticeably improved. Positive feedback has been received via the JDF that these changes have led to improved junior doctor morale and continuity of care for medical outlier patients.

Missed Educational Opportunities

There has been an increase in ERs for the quarter relating to missed educational opportunities (n=17), most ERs were submitted by foundation trainees reflecting the busy workload of juniors on the wards, possibly relating to ongoing problems with rota gaps across the trust.

Summary

- Number of exception reports raised = 131
- Number of work schedule reviews that have taken place = 1
- ERs flagged as immediate safety concerns = 1
- Fines that were levied by the Guardian = 1

Exception Reports (ER) over past quarter	
Reference period of report	01/04/22 - 30/06/22
Total number of exception reports received	131
Number relating to immediate patient safety issues	1
Number relating to hours of working	109
Number relating to pattern of work	2
Number relating to educational opportunities	17
Number relating to service support available to the doctor	3
***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.*	

Concerns remain with the delay in signing off reports once an ER has been submitted. The Medical Workforce Administrator sends reminders to the Education Supervisor (ES) if an initial meeting has not taken place within 7 days of receiving the report, despite this at the end of Q1, there were 88 unresolved exception reports.

In order try and improve this the GSW attended the recent Junior Doctors Induction and highlighted the importance of report sign-off. This is also reiterated at every JDF. The GSW and Medical Trainees' Workforce Administrator will continue to monitor outstanding

exception reports and encourage continued engagement from both trainees and educational supervisors. In addition to this, a procedural document for exception reporting and work schedule reviews was ratified at the July '22 Junior Doctors Forum and it is hoped that this will support both trainees and their supervisors in resolving ERs in a timely manner. The document is available on the Extranet and has been shared with all trainees and supervisors.

JDF meetings continue to be extremely well attended and there continues to be strong engagement between Junior Doctors' Representatives, the Chief Registrar, the DME and GSW.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The contractual breaches within T&O are significantly concerning, however appropriate remedial action has been taken.

- The GSW met with the Foundation Doctors within T&O to identify the problems leading to exception reports.
- The MD and GSW met with T&O representatives to report concerns raised
- An action plan was created and agreed following this meeting
- CBU Managers will monitor and feedback progress updates to MD, GSW and JDF

4. MEASUREMENTS/EVALUATIONS

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	21
Total number of overtime payments	30
Total number of work schedule reviews	0
Total number of reports resulting in no action	3
Total number of organisation changes	0
Compensation	0
Unresolved	90
Total number of resolutions	**54**
Total resolved exceptions	**55**

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.*

5. TRAJECTORIES/OBJECTIVES AGREED

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 ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days. Alternatively, the ES can delegate this to the Clinical Supervisor if appropriate
4. The Junior Doctor needs to indicate their "acceptance" or "escalate" to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the MWA will review an issue an email to expedite sign-off in line with the new SOP for exception reporting.

The GSW will be provided with timely data reports to support this role in the coming year, with reference to improvement in response times for ERs.

6. MONITORING/REPORTING ROUTES

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

It is also normal practice for the Trust's Executive Committee (Strategic People Committee) to have sight of the Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

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

7. TIMELINES

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

- Q1 – (end of June 2022) - Submitted September 2022
- Q2 – (end of September 2022) – Submit November 2022
- Q3 – (end of December 2022) – Submit January 2023
- Q4 – (end of March 2023) – Submit May 2023

8. RECOMMENDATIONS

The Trust Board is asked to consider the contents of the report and consider the assurances made accordingly. The GSW will continue to monitor all exception reports to ensure the Trust is compliant with the 2016 Junior Doctor Contract Terms and Conditions and to ensure any persistent issues in departments that arise are addressed. To date, the trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in-line with safe working hours.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/09/129**			
SUBJECT:	**Freedom to Speak Up**			
DATE OF MEETING:	28 September 2022			
AUTHOR(S):	Jane Hurst, Deputy Chief Finance Officer and FTSUG			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future.	x		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	During 2021/22 the FTSU team managed 20 disclosures. The majority of which relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD to support individuals and teams to resolve the issues that are highlighted. In the first quarter of 2022/23 there has been 17 disclosures. The FTSU team continues to engage with medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to make them aware of FTSU. The Wellbeing Services across the Trust continues to offer a good resource for FTSU to sign post staff to access further support. The national FTSU Guardian has released a number of key documents to bring to the attention of Trust Board.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the update and approve the policy			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.			
	Date of meeting	21/09/2022		
	Summary of Outcome	Noted the update and supported the policy		
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt			
FOIA EXEMPTIONS APPLIED:	Section 41 – confidentiality			

1. BACKGROUND / CONTEXT

The purpose of this paper is to update the Trust Board on the activity of the Freedom To Speak Up (FTSU) Team. 2021/22 saw a total of 20 disclosures and the first quarter of 2022/23 has seen 17 disclosures brought to the Team.

The majority of the disclosures last year and year to date relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with HR and OD to support individuals and teams to resolve the issues that are highlighted.

FTSU continues to welcome new Champions with regular meetings to improve communication, there are currently around 25 Champions. The FTSU Guardian continues to meet with Executive and Non-Executive FTSU leads and the Chairman to give updates.

This paper also highlights the latest documents from the National FTSU Team including a revised policy.

2. DISCLOSURES

The last report to the Board related to 1 April 2021 to 31 December 2021. The full year of 2021/22 the FTSU team received the following disclosures.

Table 1 Disclosures in 2021/22

Quarter 1	4
Quarter 2	8
Quarter 3	6
Quarter 4	2
Total	**20**

The cases can be grouped as follows:-

Table 2 Types of disclosures in 2021/22

Behaviour, culture and relationships	15
Process	2
Patient safety	1
Staff levels	2
Total	**20**

There has been 1 patient safety concern raised relating to Emergency Department demand and staffing, which was escalated immediately to the Chief Nurse & Deputy Chief Executive. Following a review, it was concluded that there was no patient safety issue and the concerns highlighted had already been managed through usual management support.

One of the themes from the bullying disclosures has been the training for managers, as clinical staff progress into managerial roles they don't always get the training they need to manage, lead and motivate a team. The HR and OD Directorate are rolling out training for this group and have given bespoke training and coaching to some of the cases raised.

In Quarter 1 of 2022/23 the themes continue along similar issues however the numbers have been significantly higher.

Table 3 Disclosures in 2022/23 (Q1 April to June)

Behaviour, culture and relationships	14
Process	1
Patient safety	1
Communication	1
Total	**17**

The patient safety concern related to the utilisation of the cardiac catheter lab as an inpatient faciality when the hospital was at full capacity. The issue was immediately escalated to Chief Nurse & Deputy Chief Executive and Medical Director. The Chief Nurse visited the staff in that area and discussed next steps with the Chief Operating Officer and senior nursing team and the Medical Director. A review of the datix log for the ward was undertaken.

The 17 disclosures have been across a variety of operational and corporate areas. The professional groups of staff who have spoken up can be broken down as follows:-

- 1 midwife
- 5 administration (A&C) / managers
- 2 nurses
- 5 AHP
- 3 Medical
- 1 other

It was unusual to receive 5 A&C disclosures from 5 different corporate areas and the issues were not related. It was encouraging to see the Medical Teams accessing the FTSU service. Where there has been a need to escalate to senior leaders in the Trust the response has been supportive and action taken. In operational areas FTSU continues to check in with the People Directorate on a weekly basis to check the progress in particular in W&C and Therapies.

3. ACTIVITY

The FTSUG and Champions continue to talk at events across the Trust, in particular to the rotational doctors, preceptorship nurses and international nurses. October is National FTSU month. We will be raising awareness of FTSU through Safety Huddle, GMWHH, Ward visits and stalls at both Warrington 3rd October and Halton 11th October.

4. DEVELOPMENTS

The national FTSU team have produce and circulated several new documents, including a new simplified policy, reflection tool kit and a guide for leaders. The draft policy is attached in Appendix 1 for the Trust Board approval. It has all the key points the old policy had but is much simpler and shorter for easy of reading.

The senior lead for FTSU in the organisation is responsible for completing reflection tool, this was last completed 2018/19 and is recommended to be reviewed every 2 years. This revised reflection and planning tool is designed to help identify strengths in FTSU Leads, our leadership team and our organisation and any gaps that need work. Completing this improvement tool will demonstrate to our senior leadership team and Trust Board the progress we have made developing our Freedom to Speak Up arrangements.

Over the coming months FTSUG will work with the Executive Team and Senior Leaders to complete the reflection tool. B1245_iii_Freedom-To-Speak-Up-A-reflection-and-planning-tool_060422.docx-RC_RW_Final_Arial12.docx (live.com)

It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading. https://nationalguardian.org.uk/wp-Content/uploads/2022/06/B1245_ii_NHS-FTSU-Guide-eBook.pdf

5. LESSONS LEARNT

Lack of or incorrect/inappropriate communication continues to be one of the main reasons for FTSU disclosures. Staff members may not realise the impact that their words or the tone can have on colleagues or team members. The compassionate leadership work undertaken by the People Directorate does supports this however, when issues escalate to FTSU we work with HR to put extra support in those areas. Changes in management structure and style can also impact on teams and how they work together, highlighting how any change needs to managed carefully.

The inappropriate language and behaviour escalated to the Medical Director has been addressed in a supportive way to help individuals make changes in their styles whilst making it clear what is and is not acceptable.

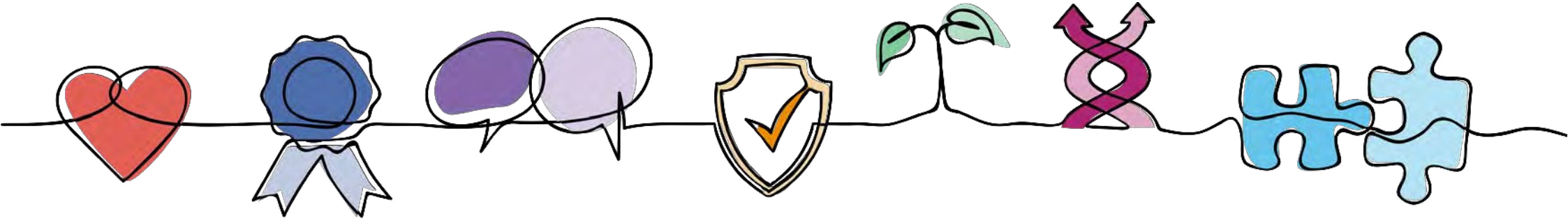
6. RECOMMENDATION

The Trust Board is asked to note the update and approve the new policy.

Publication approval reference: PAR1245_i

Freedom to Speak Up policy for the NHS

Version 2, September 2022



Contents

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Speak up – we will listen

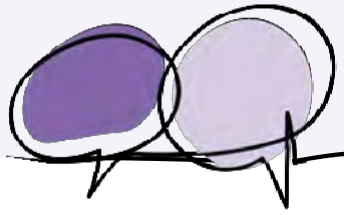
We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.
This policy is for all workers and we want to hear all our workers' concerns.

We ask all our workers to complete the online training on speaking up. The online module on listening up is specifically for managers to complete and the module on following up is for senior leaders to complete.

You can find out more about what Freedom to Speak Up (FTSU) is in these videos



This policy

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

What can I speak up about?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients.

Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality). As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

We want you to feel safe to speak up

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

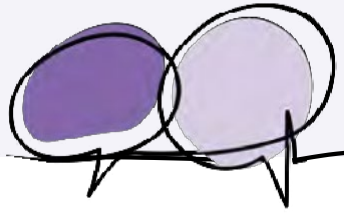
Who can speak up?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

Who can I speak up to?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.



However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you and depending on the size of the organisation you work in.

- Senior manager, partner or director with responsibility for the subject matter you are speaking up about.
- The patient safety team or clinical governance team (where concerns relate to patient safety or wider quality) TBC].
- Local counter fraud team (where concerns relate to fraud)
  Michelle Moss Tel: 07825858685 Michelle.Moss@miaa.nhs.uk
- The HR team [TBC].
- Our Freedom to Speak Up Guardian Jane Hurst Jane.Hurst@nhs.net, who can support you to speak up if you feel unable to do so by other routes. The guardian will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the guardian role here.
- Our senior lead responsible for Freedom to Speak Up [Kimberley Salmon-Jamieson kimberley.salmon-jamieson@nhs.net - they provide senior support for our speaking-up guardian and are responsible for reviewing the effectiveness of our FTSU arrangements.
- Our non-executive director responsible for Freedom to Speak Up Julie Jarmin Julie.Jarmin1@nhs.net – this role provides more independent support for the guardian; provide a fresh pair of eyes to ensure that investigations are conducted with rigor; and help escalate issues, where needed.

Speaking up externally

If you do not want to speak up to someone within your organisation, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.
- NHS England for concerns about:
  - GP surgeries
  - dental practices
  - optometrists
  - pharmacies
  - how NHS trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)
  - NHS procurement and patient choice
  - the national tariff.

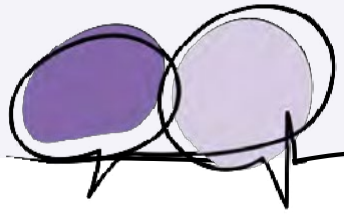
NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

- NHS Counter Fraud Agency for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix C contains information about making a 'protected disclosure'.



How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.
- **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

Advice and support

You can find out about the local support available to you at [either link to organisation intranet or reference other locations where this information can be found]. Your local staff networks [include link to local networks] can be a valuable source of support.

You can access a range of health and wellbeing support via NHS England:

- Support available for our NHS people.
- Looking after you: confidential coaching and support for the primary care workforce.

NHS England has a Speak Up Support Scheme that you can apply to for support.

You can also contact the following organisations:

- Speak Up Direct provides free, independent, confidential advice on the speaking up process.
- The charity Protect provides confidential and legal advice on speaking up.
- The Trades Union Congress provides information on how to join a trade union.
- The Law Society may be able to point you to other sources of advice and support.
- The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

What will we do?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix B.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

Senior leaders' oversight

Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian and champions.

Appendix A:
What will happen when I speak up?

We will:

Thank you for speaking up

- Help you identify the options for resolution
- Signpost you to health and wellbeing support
- Confirm what information you have provided consent to share
- Support you with any further next steps and keep in touch with you

Steps towards resolution:

Engagement with relevant senior managers (where appropriate)

- Referral to HR process
- Referral to patient safety process
- Other type of appropriate investigation, mediation, etc

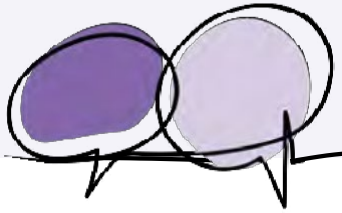
Outcomes:

The outcomes will be shared with you wherever possible, along with learning and improvement identified

Escalation:

If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for FTSU or the non-executive lead for FTSU

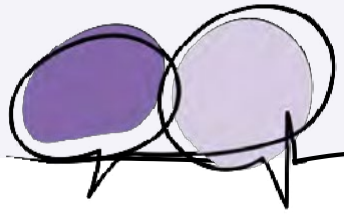
- Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body, such as the CQC or NHS England



Appendix B:
Making a protected disclosure

Making a 'protected disclosure'

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from the Protect or a legal representative.



REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/09/130**	
SUBJECT:	**Emergency preparedness, resilience and response (EPRR) annual assurance 2022**	
DATE OF MEETING:	28 September 2022	
AUTHOR(S):	EPRR Manager	
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) because of the ongoing COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken. **#1134** If we see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain. **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety **#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability	

	to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position. **#125** If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a rwduction in compliance and possible patient safety concerns **#1579** If the North West Ambulance Service is unable to provide the expected response times for critical transfers due to demand then the Trust may not be able to transfer patients with time critical urgent care needs to specialist units which may result in patient harm			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report will:- • Provide an overview of the Emergency preparedness, resilience and response (EPRR) annual assurance process for 2022-23 • Provide an overview of Warrington and Halton teaching Hospital's compliance with the EPRR Core Standards • Provide an overview of the deep dive into evacuation and shelter • Outline a workplan to ensure the Trust continues to move towards full compliance whereby 100% of the NHS EPRR Core standards are met with full compliance			
PURPOSE: ***(please select as appropriate)***	Information	Approval	**To note** **X**	Decision
RECOMMENDATION:	The Trust Board is asked to note the EPRR Annual Assurance submission			
PREVIOUSLY CONSIDERED BY:	**Committee**	Clinical Recovery Oversight Committee		
	Agenda Ref.			
	Date of meeting	21/09/22		
	Summary of Outcome	**Approval**		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Emergency preparedness, resilience and response (EPRR) annual assurance 2022**	**AGENDA REF:**	**BM/22/09/130**

1. BACKGROUND/CONTEXT

The 2022 EPRR NHS England core assurance framework has been refreshed along with the EPRR Framework (July 2022).

The NHS core standards for EPRR cover 10 domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

Organisations, including acute trusts are asked to undertake a self-assessment against individual core standards relevant to their organisation type and rate their compliance for each.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. There are 64 standards applicable to acute trusts.

The compliance levels for organisations are defined as:

Organisational ratin	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Self-assessment takes place for each appropriate standard (for acute providers) standard using the following criteria:

Compliance level	Compliance definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Not compliant	Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.

Deep dive

The topic included in the deep dive for the 2022 assurance is evacuation and shelter. The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating; these are reported separately.

Action to take/next steps

- All NHS organisations should undertake a self-assessment against the 2022 updated core standards (attached) relevant to their organisation. These should then be taken to a public board or, for organisations that do not hold public boards, be published in their annual report.
- ICBs are required to work with their organisations and LHRP partners to agree a process to gain confidence with organisational ratings and provide an environment that promotes the sharing of learning and good practice. This process should be agreed with the NHS England regional head of EPRR and their teams.
- NHS England regional heads of EPRR and their teams to work with ICBs to agree a process to obtain organisation-level assurance ratings and provide an environment that promotes the sharing of learning and good practice across their region.
- NHS England regional heads of EPRR to submit the assurance ratings for each of their organisations and a description of their regional process to the National Director of EPRR Friday 30 December 2022.

Peer reviews will take place in October 2022. The final date for submission to the ICB is 28th October 2022.

What has changed since 2021?

Governance

- Removed reference to Non-Executive Director
- Removed reference to EPRR resource being proportionate to size of organisation
- Explicit about the requirement to review and embed learning as part of continuous improvement process

Duty to Risk Assess

- Specific reference to Community and national risk registers

Duty to maintain plans

- Critical and major incident plans merged into one standard
- Heatwave and cold weather planning merged into one standard for adverse weather
- Pandemic Influenza changed to "New and Emerging Pandemics"

Command & Control

- Trained and up to date staff are available 24/7

Training and Exercising

- Refers to "responder training" to reflect that **ALL** responders must be trained and maintain a CPD portfolio as per the MOS
- References "key decision makers" and not just on call staff
- *NEW STANDARD* Staff Awareness Training

Response

- Focus on importance of maintaining personal decision logs and use of trained loggists

Warning & Informing

- Domain has been reviewed and refreshed to reflect significant lessons in crisis communications during incident response

Cooperation

- Emphasis on AEO attendance at LHRP
- Highlights NHSE guidance on MACA

Business Continuity

- Business Continuity Plans standard split into 2 sections:
- Plans
- Testing & Exercising

CBRN

- No significant changes as overall CBRN workplan is being reviewed

2. KEY ELEMENTS

For 2021/2022, the EPRR Core Standards compliance level was self-assessed at **SUBSTANTIAL** compliance with Warrington and Halton Teaching Hospitals rated as being fully compliant against 89-99% of the relevant NHS EPRR Core Standards.

This year, considering the refreshed standards, the EPRR Core Standards compliance level was self-assessed at **SUBSTANTIAL** compliance once again and a summary of compliance levels is tabled below. Warrington and Halton Teaching Hospitals was rated as being fully compliant against 89-99% of the relevant NHS EPRR Core Standards (94% Fully compliant and 6% partially compliant).

Appendix 1 includes the full template for the annual EPRR Core Assurance.

Please choose your organisation type	Acute Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	11	0	0	0
Command and control	2	2	0	0	0
Training and exercising	4	4	0	0	0
Response	7	6	1	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	7	3	0	1
CBRN	14	14	0	0	0
Total	**64**	**60**	**4**	**0**	**4**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Evacuation and Shelter	13	13	0	0	0
Total	**13**	**13**	**0**	**0**	**0**

Percentage Compliance	94%
Overall Assessment	Substantially Compliant

EPRR Core Standards

Overall the Trust is self-assessed as **FULLY COMPLIANT** in 60 out of 64 core standards. There are 4 Core standards with partial compliance. The deep dive indicates the Trust is fully compliant (100%) with evacuation and shelter agreements.

The 4 **PARTIALLY COMPLIANT** EPRR Core Standards in 2022/2023 are:

Decision Logging

- *To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure:*
- *1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy.*
- *2. Has 24-hour access to a trained loggist(s) to ensure support to the decision maker.*

Action plan

Loggist training was provided by Merseycare in May 2022, however this coincided with the Jubilee Bank Holiday week and many administrators identified for loggist training were on annual leave. The EPRR Manager will continue to identify appropriate colleagues and opportunities for loggist training. A model to support 24-hour access to trained loggists must be developed and mutual aid via the ICB be considered. Some organisations have an on-call process in place. This is not currently funded at WHH.

Business Impact Analysis/Assessment (BIA)

The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).

The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme.

Documented process on how BIA will be conducted, including:

• the method to be used

• the frequency of review

• how the information will be used to inform planning

• how RA is used to support.

The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA:

• Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption.

• A consistent approach to performing the BIA should be used throughout the organisation.

• BIA method used should be robust enough to ensure the information is collected consistently and impartially.

Action plan

The Trust Business Continuity Plan, Care Group Business Continuity Plans and Corporate Business Continuity Plans are currently being refreshed and this process will support the activities associated with the Business Impact Analysis/Assessment (BIA).

Data Protection and Security Toolkit

Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.

Evidence

• Statement of compliance

• Action plan to obtain compliance if not achieved

Action plan

The Trust's DSPT submission has been reviewed by Mersey Internal Audit Agency and given an assurance rating of Substantial Assurance. An assurance rating of Moderate Assurance was provided for the Trust's overall compliance across the National Data Guardian's 10 data security standards. There is one action to be added to the action plan and this continues to be managed by the Head of Digital Compliance.

BC audit

The organisation has a process for internal audit, and outcomes are included in the report to the board.

The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.

• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation

• Board papers

• Audit reports

• Remedial action plan that is agreed by top management.

• An independent business continuity management audit report.

• Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle.

• External audits should be undertaken in alignment with the organisations audit programme.

Action plan

The Trust Business Continuity Plan, Care Group Business Continuity Plans and Corporate Business Continuity Plans are currently being refreshed and this process will support the activities associated with the Business Impact Analysis/Assessment (BIA). A joint approach with the Governance department will enable the BC audit to be aligned with the WHH audit programme.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The EPRR workplan for 2022-2023 shows a timeline for training and reviews in order to support the progress towards full compliance across all EPRR Core standards. The workplan is attached as Appendix 2.

The workplan is monitored through the Event Planning Group who meet monthly, and updates are shared with the group as per the workplan.

Lead Officers

- Dan Moore- Chief Operating Officer is the designated Lead Executive Director with responsibility for Emergency Planning within the Trust.
- The Accountable Officer is currently supported by Rachel Clint, EPRR Manager.

4. IMPACT ON QPS?

As identified in the outcomes of the asdsurance process.

5. MEASUREMENTS/EVALUATIONS

The NHS England Core Assurance Process is attached and outlined in Appendix 3.

6. TRAJECTORIES/OBJECTIVES AGREED

To move towards being fully compliant across all NHS EPRR Core Standards.

7. MONITORING/REPORTING ROUTES

EPRR updates continue through the Event Planning Group and the Finance and Sustainability Committee.

8. TIMELINES

This report is presented annually to the Finance and Sustainability Committee / Clinical Recovery Oversight Group (as deemed appropriate) and the to the Board. The EPRR workplan details the monthly priorities identified by the EPRR Manager along with Local Health and Resilience Partners.

9. ASSURANCE COMMITTEE

Event Planning Group, held monthly.

10. RECOMMENDATIONS

The Board are asked to note the EPRR Annual Assurance self-assessment rating at **'SUBSTANTIAL COMPLIANCE'** and support the workplan in moving towards full compliance with all 64 standards.

Appendix 1- Full assurance document

working Copy of B1069_ii_NHS core st

Appendix 2 – EPRR Workplan

EPRR Workplan 22_23.xlsx

Appendix 3- Annual assurance cycle documentation

B1664_i_Emergency preparedness resilie

B1664_ii_Emergency preparedness resilie

B1069_i_NHS Core standards for emerg

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/09/131**	
SUBJECT:	**Summary Report from Digital Strategy Group (DSG)**	
DATE OF MEETING:	28th September 2022	
AUTHOR(S):	Tom Poulter, Chief Information Officer	
	Sue Caisley, Deputy Chief Information Officer Alison Jordan, Associate Director of Information	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Digital Strategy Group (DSG) met for the first time on 12th September 2022. As per proposals approved by FSC earlier this year, the DSG has replaced the Digital Board with updated membership and new Terms of Reference. The DSG is focussed on development and delivery of a new Digital Strategy for WHH and the digital work programmes that are being planned and delivered at ICB regional and Place levels. Links to WHH strategy and transformation team activities have also been strengthened, with consistent RAG status reporting on any digital workstreams. This report provides a summary of updates received from the new DSG feeder groups, providing the following assurance status for key delivery areas: • **ICS Digital Update** Moderate Assurance • **Place Digital Updates (Warrington Together & One Halton)** Moderate Assurance • **Digital Transformation Group Highlight Report** Substantial Assurance • **Digital Service Delivery Highlight Report** Moderate Assurance • **Digital Analytics Update**	

<table>
<tr><td></td><td colspan="4">Substantial Assurance

All Digital work areas that have previously been reported to FSC with an internally assessed assurance rating are included within scope of the new Digital governance arrangements. The new Digital Care Delivery Group is due to commence in October 2022 when assurance reporting on clinical system optimisation and the expanded scope of Digital Clinical Safety processes will be provided to DSG, with escalation to FSC as appropriate.

Items to escalate to the Trust Board include:

• Data quality and reporting problems related to the Maternity Services Dataset (MSDS)
• An unplanned outage of the LiON portal (business intelligence reports)
• PACS system Antivirus update
• Cancellation of the “Patient Aide” project
• A Task & Finish Group to be established for trust-wide Print Reduction CIP schemes
• An unplanned approx. 8 hour outage of all Dedalus systems (Lorenzo, ORMIS & One Response) on Friday 16th September, causing significant disruption to trust services

Minutes of the Digital Strategy Group meeting are attached as Appendix A to this report for reference.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
X</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to note the contents of the report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Finance + Sustainability Committee</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2">FSC/22/09/152</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">21 September 2022</td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2">The Committee noted the report.</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Partial FOIA Exempt</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">Section 43 – prejudice to commercial interests</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Digital Strategy Group Update – September 2022	AGENDA REF:	BM/22/09/131

1. BACKGROUND/CONTEXT

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

As per proposals approved by FSC, the Digital Strategy Group has now replaced the Digital Board, with newly configured feeder groups providing highlight reports and items for escalation as appropriate. The new arrangements are intended to :

- Enable more focus on a WHH Digital Strategy review and refresh process, ensuring comprehensive stakeholder engagement and alignment with ICS, place and trust corporate and clinical strategies
- Improve oversight of ICS regional and place level digital programmes that WHH are involved in
- Provide a clearer distinction between programmes and projects that are being delivered to advance digital transformation and service improvement and the "BAU" activities related to ongoing management and development of production systems (i.e. the "live" environment)
- Provide a clearer remit and responsibilities for the new Clinical group, with more decision-making authority on standardisation and optimisation of clinical content in existing systems and a wider scope of Digital Clinical Safety processes to be applied across all clinical systems
- Improve engagement and alignment with corporate strategy and transformation team projects, ensuring that digital workstreams on major projects being planned and delivered outside of digital are well-managed with consistent highlight reporting
- Improve engagement with CBU management with a more customer focussed approach to reporting digital activity and performance via new Service Level Agreements
- Develop vendor management processes to ensure that all business-critical systems have adequate arrangements in place for supplier performance management

Systems and processes for consistent and reliable highlight reporting are being put in place, in parallel with the new groups being established. A full set of the new Terms of Reference for DSG and its feeder groups will be included in the November 2022 update for FSC.

2. KEY ELEMENTS

a. **ICS Digital Update : Moderate Assurance**

The broad narrative of the new Cheshire & Merseyside Digital & Data strategy was presented and agreed. It focusses on provision of strategic platforms (e.g. CIPHA for population health analytics) with an expectation that detailed planning and delivery will be undertaken primarily at "place" level. The ICB expect to publish the final version in Q3 2022/23 following approval via the relevant ICB governance processes. Place-level digital plans for Warrington Together and One Halton are

expected to be developed in line with the vision and objectives of the ICB strategy, structured in line with the 7 What Good Looks Like (WGLL) standards.

b. Place Digital Updates (Warrington Together & One Halton) : Moderate Assurance

WGLL baseline assessments have been completed by all partners within the Place arrangements. This has enabled a combined digital maturity assessment to be conducted and has highlighted strengths and weaknesses within current digital strategies and work programmes. A key area highlighted for further attention is "Empower Citizens", which includes a range of patient-facing developments such as patient portals, Apps and digital channels such as Attend Anywhere. Key work programmes being delivered at Place level include:

- Virtual Wards
- Person Held Records
- Shared Care Records
- Collaboration tools for integrated teams

WHH are the lead organisation for Warrington Together's digital plan, for which the following next steps were highlighted:

- Recruit Place Based Digital Programme Manager
- Digital Enabler Group to finalise place baseline WGLL assessment actions and plan
- Update WT Digital Strategy by October 2022 (pending ICB feedback on initial submission)
- Work with the ICS to develop business case for shared care record and citizen facing portal

c. WHH Digital Strategy Refresh

The content of the Strategy would be structured in accordance with the WGLL framework, this model is being used at Place level and ICB level, also to measure Digital Maturity. A new Digital Maturity Assessment is due to be launched soon, for which a baseline assessment has already taken place for each individual partner organisation and combined to give an overall Place view.

A thorough review of the existing Digital Strategy (2019-2022/3) has taken place in conjunction with the enabling strategies and clinical strategy updates. Stakeholder engagement will take place as part of the wider Trust strategy refresh.

A presentation to the next meeting of DSG will outline further details of the proposed strategy development process and timetable. This is expected to include a Board Development session focussed on Digital (tbc with Executive Team).

d. Strategic Programme Updates

An overview of projects being planned and delivered by the Strategy Team was presented.

Shopping City and Warrington Living Well Hubs were highlighted as being well attended by IT colleagues, representation and communication is key to making the projects and programmes successful.

e. **Digital Transformation : Substantial Assurance**

This Digital Transformation Delivery Group report provided a progress update on digital transformation projects that underpin the Digital Strategy aligning with WHH's Quality, People and Sustainability and What Good Looks Like Aims and Objectives.

Paperless Care

- To commence procurement planning and developing a specification for the end of life (June 2024) Winscribe Digital Dictation resulting in an Options Appraisal for review
- The reprioritisation of Lorenzo Patient Aide with ICS Patient Held Record Amity and this recommendation was accepted by the Group.
- To initiate a Trust wide task and finish group to scope out removal of paper and printers across CBU and Corporate Services and consider best suitable SRO (big cost reduction incentive scheme) All care groups are in support of the removal of papers as part of the CIP presentation given at FRG. Plan will be shared next week as comms and procurement will be involved in this project. A deep dive will take place as this is currently being worked on in small areas.

Digital Infrastructure

- SAN DR refresh early warning potential project slippage if orders not placed by end of September flagged to capital planning group – cloud migration options appraisal to be concluded by the end of September

Place (Warrington Together & One Halton

- Digital Enablement Group (DEG) to request deployment and road map updates from regional leads to plan future rollout plans

f. **Digital Service Delivery: Moderate Assurance**

This new Digital Service Delivery Group first meeting was held 5 September this report provides a progress update on service level activity (SLAs) performance reporting, cyber security, and vendor management that underpin the Digital Services business as usual (BAU) workstreams and delivery plans.

Digital Services SLA:

- Continuing to enhance the SLA dashboards and fine tune to encourage CBU attendance
- Agreeing a plan for the deployment of 'self service' tool to remove email logging facilities to enable calls to be included in overall SLA reports

Root Cause Analysis:

- Firm up PACS anti-virus deliver date in conjunction with Radiology

The Digital Strategy Group is also asked to note:

- Strong systems in place keeping cyber security and threats under control
- No vendor breaches within this period to the EPR SLAs set out in the respective contracts
- 1 Fraxinus unplanned outage, affecting eOutcome and Lorenzo Extensions. RCA completed no further reoccurrences of this incident have been seen to date

g. Digital Analytics : Substantial Assurance

The team has completed a number of complex deliverables during the month of August, including:

- Elective Recovery Fund Dashboard – summary of Financial baseline position by POD

- Final 4 systems for the move to the new TIE Infrastructure
- RTT Weekly PTL replaced with WLMDS uploads via the Data Landing Portal

Digital Analytics also reported on two key items that have been highlighted for escalation to FSC in this report, for information only : LiOn Portal outage and MSDS reporting challenges.

3. ESCALATIONS/ACTIONS REQUIRED

The Trust Board is asked to note the contents of the report, including assurance levels where relevant. The following items are highlighted for escalation to the Board Committee, but for information only.

- Data quality problems were highlighted on the May 2022 submission of the Maternity Services Dataset (MSDS), due to a combination of the transition to Badgernet and some SNOMED coding related bugs in the national dashboard system. A plan has been developed to ensure the July 2022 data to be used for CNST reporting is generated from Badgernet only (not partially from Lorenzo as required in May) and is fully compliant for submission at the end of September 2022.
- An unplanned outage of the LiON portal (business intelligence reports) was caused by changes made by a third-party supplier. This impacted on operational services, but the incident was managed via Digital Analytics providing workarounds for access to critical information until the LiON portal was fully restored. A root cause analysis will be conducted in accordance with new SOPs.
- Following extensive technical investigations and escalation to the regional Cyber Security Group, the trust's PACS system has been updated to enable full installation of Antivirus, with a target date to complete this by mid October 2022
- The "Patient Aide" App supplied by Dedalus has not been sufficiently developed for implementation and a decision has been made to cancel this project, focussing instead on the regional AMITY patient held record (PHR) solution providing equivalent functionality
- A Task & Finish Group is to be established for trust-wide Print Reduction CIP schemes, with the aim of reducing all printing devices, activity and associated costs. The group will be sponsored by the Executive Medical Director with monthly highlight reporting to both Digital Strategy Group and FRG
- There was an unplanned approx. 8 hour outage of all Dedalus systems (Lorenzo, ORMIS & One Response) on Friday 16th September, causing significant disruption to trust services. The incident was due to a problem with the Amazon Web Services (AWS) hosting platform (sub-contratced by Dedalus). A detailed Root Cause Analysis (RCA) is being conducted and the findings of this will be discussed at Digital Strategy Group

4. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report.

Appendix A

DIGITAL STRATEGY GROUP
Minutes of the Meeting: Monday 12th September 2022 13:30-15:30
Microsoft Teams Meeting

Attendees:

Paul	Fitzsimmons	Executive Medical Director	PF
Tom	Poulter	CIO	TP
Sue	Caisley	Deputy CIO	SC
Emma	O'Brien	Head of Programmes and ePR	EOB
Andrea	McGee	Chief Finance Officer & Deputy Chief Executive	AMG
Ellis	Clarke	Clinical Safety Officer	EC
Patricia	McLaren	Director of Communications & Engagement	PM
Stephen	Bennett	Head of Strategy and Partnerships	SB
Louise	Ainsworth	Corporate Information Manager	LA
Elaine	Czarnecki-Wilson	Project Support Officer (minutes)	ECW

Apologies:

Val	Doyle	Associate Director of Planned Care	VD
Sharon	Kilkenny	Associate Director – Unplanned Care	SK
Hilary	Stennings	Associate Director - Clinical Support Services	HS
Zoe	Harris	Director of Operations and Performance, Deputy Chief Operating officer	ZH
Daniel	Moore	Chief Operating Officer	DM
Adam	Drury	ICS	AD
Kimberley	Salmon-Jamieson	Director of Nursing - Chief Nurse	KSJ
Alison	Jordan	Associate Director of Information	AJ
Lucy	Gardner	Director of Transformation	LG

Agenda items.	Action
WHHFT/DSG/1 - Introductions and Apologies Apologies noted above. It was discussed that the new format updates will be provided by the chair of the meetings	
WHHFT/DSG/2 - Notes of Previous Meeting All agreed as accurate. **Action Log:** 388: PF spoke to MJ, RIS procurement is now complete, contract commences Jul 2023, Philips continues to supply - Closed 394: TP updated that Capital plan is being worked on, several meetings held to work on plan, as part of ongoing process with finance colleagues – Action Closed to be picked up through CPG/SLT (multi-year capital plans are in progress) – **Short presentation/overview of Capital schemes as currently understood to be given at next meeting (Agenda Item)** 397: as 388. - Closed 404: LA to follow up with AJ - Open 405: Dashboard on track to be presented at the next meeting - Open 410: To be reviewed -Open 411: successfully upgraded ICE over the weekend, still pursuing managed cloud server with Clinisys 412: covered in slides – Closed ToR - Comments to be taken forward, and pack of feeder group ToRs will be reviewed at the next meeting	

WHHFT/DSG/3 - ICS Digital Strategy Update

TP presented the slides. Unfortunately, Adam Drury was unavailable to present at the meeting.

The slides detail the change in focus to a more regional and place-based approach for the refresh of the WHH Digital Strategy. ICB arrangements have come into effect as of 1st July 2022 - the Digital team have been working on a strategy refresh to reflect the national and regional policies.

The approach is detailed in the slides, including mapping and Digital Maturity Assessment.

The summary provided on slide 4 details the Vision, Mission and Objectives of the Strategy and what is required to achieve these. The Digital Strategy Group members were asked to review the slides and feedback if any further information is required. There are specific work programmes planned or running which will link into other items in the agenda.

The place-level plans are expected to be developed in line with the vision and objectives of the ICB strategy, the detailed delivery will be organised at Place level – This will be further detailed in the Warrington Together and One Halton update in the agenda.

WHHFT/DSG/4 - Place Digital Updates (Warrington Together/OneHalton)

TP presented the slides – the DTDG will give a report on the place-based programmes. The funding arrangements and implementation timetables are still being worked on, and updates will be provided at future meetings.

The Warrington Place Plan was presented to the Warrington Together Board on 20th July 2022. Digital Strategy Group are asked to note Warrington Together's next steps:

- Recruit Place Base Programme Manager
- Digital Enablement Group to finalise place-based plan
- Complete Strategy by September 2022
- Work with the ICS to develop business case for shared care record and citizen facing portal

The Cheshire and Merseyside Draft ICS Digital and Data Strategy Summary was presented to the Digital Enablement Group (DEG) by Associate Digital Specialist, ICS. The Digital Strategy Group are asked to note:

- Confirmation that Managed Convergence is now in the policy and the guidance is currently being worked on. Formal sign off to the ICB in October 2022 then publicised shortly after that
- During August, the strategy will be circulated and discussed with relevant stakeholders prior to formal approval to the ICB in October 2022
- A presentation was held by ORCHA, a platform which holds a library of approved Healthcare Apps. An offer has been made to Warrington to join the ORCHA platform. DEG to Conduct baseline map of apps (including wearable devices) in use across Warrington providing a conscious and prioritisation.
- Virtual Wards: Respiratory target go live October 2022; Frailty workshop session planned 3 August target go live January 2023

Digital Strategy Group are asked to note the key priorities being worked on:

- Share2Care
- Teams Connect
- Virtual Wards
- Amity (PHR)

WHHFT/DSG/5 - WHH Digital Strategy

TP presented the slides.

The What Good Looks Like (WGLL) Framework was shown as a reminder. The content of the Strategy would be structured in accordance with the framework, this model is being used at Place level and

ICB level, also to measure Digital Maturity. A new Digital Maturity Assessment is due to be launched soon, for which a baseline assessment has already taken place for each individual partner organisation and combined to give an overall Place view. A thorough review of the existing Digital Strategy (2019-2022/3) has taken place in conjunction with the enabling strategies and clinical strategy updates. Stakeholder engagement will take place as part of the wider Trust strategy refresh. Board Development Sessions – TP has discussed with John Culshaw and requested a slot for a session to focus on Digital as an activity to feed into the Strategy Refresh. PM asked if TP and/or team could join a meeting to discuss the stakeholder engagement. PM also added that the Governance team are interested in the Digital Strategy and that "Citizen Empowerment" is a main focus. TP added that the plans are at Place Level, there are discussions about patient engagement and how to approach it, whether from Warrington Together/ One Halton vs. WHH. SB added that work is required on the "top down" work, the Digital Strategy will need to be interwoven through the Trust rather than a separate Digital "Agenda". It will need to identify priorities and requirements from CBUs to support their needs from an operational perspective and also to support their strategic needs and direction of travel. This will align with what is happening nationally and regionally. AMG added that the review of the ICS Digital Strategy claims "We want to be the most digitally advanced ICS" but what does this mean to patients and staff/why is it important? Contradicted by NHSX What "good" looks like, where are we aiming to pitch the Strategy? TP added that the ICS Team would have been best placed to explain the slides, aligning all the strategies makes it complex – e.g. lack of reference to EPR Convergence. PF keen to develop strategy that is understood and engaged with by our staff and patients but still aligned with the ICS strategy. Next Steps: Currently finalising a timetable for the refresh process with the Strategy Team. TP in discussion with John Culshaw about Board Development Sessions, to be discussed at future meeting to design and run a session to improve Board and non-exec engagement. **ACTION: An outline of the strategy review and timetable will be brought back for review** **ACTION: Design Board Development session**	
<u>WHHFT/DSG/6 - Strategic Programme Updates</u> The Strategy Programme was shared with the Group and presented by Stephen Bennett. This document is produced every couple of months. There is a need to join up with a number of corporate operational teams from the beginning of the development of work, including the Digital Services and Analytics teams, Finance and Workforce. Shopping City and Warrington Living Well Hub working groups are well attended by IT colleagues, representation and communication is key to making the projects and programmes successful. The Digital Strategy will be an enabler for a lot of new projects, linking to what is going on regionally and nationally, so it is key to communicate well and invite the right people to be involved in the projects at the right time. TP added that the report was helpful to see the context of further projects and programmes where there is significant Digital involvement, particularly where it could impact other priorities and/or resourcing.	

WHHFT/DSG/7 - Digital Transformation Delivery Highlight Report

SC presented the slides.

The Digital Transformation Delivery Group is a new feeder group, and the report provides a progress update on digital transformation projects that underpin the Digital Strategy aligning with WHH's Quality, People and Sustainability and What Good Looks Like Aims and Objectives. The slides contained in the report provides individual project highlight reports and recommendations. The Digital Strategy Group is asked to note the overall programme governance and delivery status (the path to green mitigations) and support the following recommendations from the Digital Transformation Delivery Group:

Paperless Care

- To commence procurement planning and developing a specification for the end of life (June 2024) Winscribe Digital Dictation resulting in an Options Appraisal for review
- The reprioritisation of Lorenzo Patient Aide with ICS Patient Held Record Amity (see slide 4) - concerns with lack of development of PatientAide. Amity also aligns with ICS and is a better use of resources.
- To initiate a Trust wide task and finish group to scope out removal of paper and printers across CBU and Corporate Services and consider best suitable SRO (big cost reduction incentive scheme) – AMG added that this should be led by another department, SC confirmed a Trust-wide deep dive scoping exercise will take place as currently only working on small areas. PM added that procurement and comms would be involved, plan to be shared next week. PF added that this aligns with the Paperless Care Programme, linked with the support of other departments. AMG confirmed that all Care Groups are in support of the removal of paper as part of the CIP presentation given at FRG – Digital should be an enabler for this – use FRG and Finance Wednesday to resolve issues/get buy in.

ACTION: An Agenda item to be presented on the next meeting from the Project Group, presentation going to FRG for further details.

ACTION: Printing information gathering/analysis to be brought to Finance Wednesday next week.

Digital Infrastructure

- SAN DR refresh early warning potential project slippage if orders not placed by end of September flagged to Capital Planning Group – cloud migration options appraisal to be concluded by the end of September. Pre-approved waiver if needed.

Place (Warrington Together & One Halton)

- Digital Enablement Group (DEG) to request deployment and road map updates from regional leads to plan future rollout plans

Paperless Care – Projects ongoing to enhance eWhiteboard capability, patient flow and inpatients, for example the Exemplar Ward project and digitisation of the Nursing Care Plan Booklet. Slide 4 details the rationale for the recommended pausing of the PatientAide project – SC confirmed the next step would be Amity – the functionality is not yet available to seamlessly integrate with the EPR – a deep dive is due from the regional team. EOB confirmed that there are no patient safety concerns with pausing the programme and that a Trust-wide review of Amity's functionality will take place, the first area to be reviewed will be Pre-op as they are particularly struggling with their current lengthy process. It was agreed during this meeting to pause/cease the Lorenzo PatientAide work.

Place:

- Person Held record – awaiting outcome of pilot. Front door patient engagement to be arranged to maximise NHS App usage – to be arranged with Comms and Patient Experience.
- Virtual Wards – respiratory due to go live October 2022, frailty planned for Jan 2023
- Shared Care Records – further work to investigate what is available regionally

– Integration across MDT/Organisational boundaries – connect 365 for co-located teams (WHH/Bridgewater/ Council) Digital Infrastructure: – contingency based approval of £13k additional Business Case for CISCO phase 2 – SAN DR - £200k risk if order not placed by end of September – SC working with Finance to conclude options appraisal – Device Refresh – 160 devices deployed, phased development on track to deliver Q3 – Comms Cabinet Phase 3 – on track to complete Q3 TP added that the Digital Diagnostics programme has some significant £20m funding, business cases are due to be signed off by the ICB in Q3, with the expectation that systems and services are implemented this financial year – meetings are taking place with Finance colleagues. AMG attended a meeting of the Cheshire Finance Directors, there have been bids submitted by LUFHT. TP confirmed that he attends the DDCP group, however only recently, and therefore has requested a deep dive review session on 26th September. The decision making was agreed by the regional networks and representation at these meeting is being arranged as needed.	
WHHFT/DSG/8 - Digital Service Delivery Highlight Report SC presented the slides SLA dashboards need to be enhanced – to improve engagement with CBUs to encourage attendance at DSG. Supporting a plan for the delf service tool – to log self-service calls. PACS antivirus plan to be firmed up with Radiology – date to be agreed **ACTION: Agree date with Radiology to reinstall AV on PACS** Slide 3 – SLAs to be refined – all green as agreed at DSDG. Limited CBU attendance due to operational pressures continue to enhance the agenda to encourage interest. Self Service tools are being planning to provide a facility to remove email logged service requests, and these to be captured on the dashboard. EPR dashboard is also in development and will be presented to the October working group. CAB – 12 August RfC successfully completed, 1 open RCA (PACS) install anti-virus scheduled to take place in September Cyber Security – strong systems in place to keep threats under control. 1 CareCERT (Advanced) – no threat to WHH. To note – Windows OS ATP score increased 7 points to 41. Audits performed on primary backups and full Virtual Machine restore test with no issues. Vendor Management – Dedalus - 2.22 on track for Sept 2022 (ED Messaging) Fraxinus – Patient flow developments planned for Q3/Q4 TP added that the vendor management process has been extended to other key vendors, e.g. Microsoft	
WHHFT/DSG/9 -TBC This meeting will take place from October 2022 onwards.	
WHHFT/DSG/10 - Digital Analytics Update LA presented the document Deliverables August 2022	

The team has completed a number of complex deliverables during the month of August. There were two delayed deliverables (RTT Dashboard & Stranded Patients) and two suspended deliverables (FIT Metrics & Trolley Waits)

Deliverables September 2022
A list of deliverables for September can be found in the paper.

LiOn Portal Outage
On the evening of 10 August going into early hours of Thursday 11 August due diligence work was being undertaken by a 3rd party supplier brought in to review the infrastructure as part of the Digital Analytics priority deliverable. Unfortunately, an unexpected event occurred which caused the dashboards to no longer load to the portal. The data remained available to the Trust by way of Pivot tables, and this was communicated to relevant stakeholders.
An incident management process was implemented, and a fix was successfully applied on Tuesday 16 August 2022. A full incident review including Digital Services Colleagues and the 3rd party supplier was undertaken Friday 26 August 2022. A full lessons learned report will be shared at the October Digital Strategy Group meeting.

Statutory Reporting
An issue has occurred with May 2022 Maternity Services Data Set (MSDS) submission which relates to the implementation of BadgerNet. A briefing note has been prepared for the Executive Team.

Risks
The risk identified with regards to the BadgerNet reporting issue is on the Trust risk log.

An issue was raised with the July submission of the Maternity Services Data Set (MSDS), which is the dataset that will be used as the basis for our Clinical Negligence Scheme (CNST) payment.

Background of the MSDS submissions:

- A maternity dataset is extracted monthly from our PAS system and submitted to NHS Digital.
- The move to the BadgerNet system required the Digital Analytics team to merge the maternity dataset from Lorenzo with the dataset extracted from BadgerNet, and to then dedupe the records.

The Issue:

- Merging the 2 MSDS files and deduping to continue to populate the 32 submission tables has proved to be a more complicated task than the testing led us to believe.
- Following the submission of May's data we received the CNST report for that month evidencing that we had failed Safety action 2.

The solution:

- The clinical project team and Digital analytics have been working to understand the issue and, following discussions with colleagues at another Trust and NHS Digital, we have refined the process and submitted a second file for July.
- The indicative CNST report received for that new upload shows a significant improvement, and the Trust is now only failing 2 of the 6 measures.

Of the two indicators we have failed:
CQIMBMIDQ – Number of women who reached 15 weeks gestation (105 days) in the month, with a valid BMI recorded
This indicator links back to previous MSDS submissions to check for the BMI if there has not been a care activity for that patient recorded in the reporting month. Our position is therefore affected by the issue with the Lorenzo MSDS where Dedalus does not map the BMI to the required SMOMED

codes, and by the fact that the MSDS submissions for May and June were created by the process to merge and dedupe the Lorenzo and BadgerNet MSDS files, which we know creates a number of data quality issues.
NHSD have confirmed that they will take into account the alternative 'BMIRec' measure which is only looking at BMI records for those patients booked in July 22, and this would be an accepted exemption. Our performance for that measure is 97.9%, meeting the expectation of >=90%.

CQIMDQ37 - Number of women who delivered in the month who had no previous births.
The CNST report indicates that we have not uploaded any data for previous live births, still births or c-sections for the deliveries in July. This is because the data was not part of the migration file at go-live, and there will now need to be a manual exercise to enter that information into BadgerNet for all the records that were imported.
The Digital Analytics team are working on extracting the required information from Lorenzo to provide a list of the updates required to the Maternity project team. The priority for updates on BadgerNet will be deliveries in July, followed by the remaining records.

Once the updates for July are complete, another MSDS file will be generated and uploaded, following which we will request another indicative CNST report. If the manual updates are successful in addressing this issue, the final submission for July will be made before the 30th of September. The maternity team have access to a number of data quality and data completeness reports within BadgerNet, which will allow them to track the quality of the data being captured well in advance of any future submissions to NHS Digital.

AMG requested a briefing to take to the exec meeting this week. Further missing fields were discussed, however these do not affect the CNST and it is possible further fields may be identified. However the BadgerNet system has its own Data Quality report centred around the MSDS submission and requirements for CNST which will be monitored by the Maternity team.

TP confirmed that the reporting went live during the go-live month of May where some mixed economy data would have been part of the submission – this is due to end approx. October once the cohort of patients should be entirely recorded on Badgernet

ACTION: Digital Analytics team to provide a briefing on MSDS and CNST reporting for AMG/PF to take to Exec team meeting

WHHFT/DSG/11 - Any Other Business

AMG requested that the Terms of Reference will need to be approved by FSC – this request is to be made clear.

Action: TP will explain in the FSC report, that the pack of ToR will come to October DSG and then be signed off by October FSC.

WHHFT/DSG/12- Items for escalation to Finance and Sustainability Committee

- MSDS reporting
- LiON Portal
- PACS Antivirus install scheduled to take place in September
- Pausing of PatientAide programme

Date and Time of Next Meeting: Monday 10th October 2022 13:30-15:30

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/09/132**	
SUBJECT:	**Health & Safety Annual Report 2021/22**	
DATE OF MEETING:	28th September 2022	
AUTHOR(S):	Layla Alani, Director of Governance & Quality, Interim Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive Officer	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Health and Safety Annual Report describes the structures and responsibilities of the Trust in ensuring a health and safe environment for staff, patients and the public. The information provided within this report relates to the financial year 2021/22. The report provides assurance of the monitoring of incidents in order to ensure that efforts for improvement are focused. The report has triangulated incident reporting and its findings alongside other reporting mechanism namely clinical governance with themes mirrored, including an increase in incident reporting (evidencing a positive reporting culture) and specific increases such as the number of incidents that relate to challenging behaviour which have been seen as a result of system pressures and an increase in the number of vulnerable patients attending the acute Trust. These incidents have more commonly been reported in the Emergency Department, the Stroke Unit and the Forget me Not Unit. The management of sharps has shown good compliance overall. Where improvement is required this has been identified with action	

<table>
<tr><td></td><td colspan="4">plans in place and is supported by a planned quarterly audit programme for 2022/23.

The report details previous Covid -19 measures that have remained in place during the reporting period for continued assurance.

Assurance statement –
There is an established pro-active safety management system within the Trust with clear processes and procedures to ensure compliance with all relevant Health and Safety regulations.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note
x</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to receive and note the Health & Safety Annual Report 2021/22</td></tr>
<tr><td rowspan="7">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Health & Safety Sub Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="3"></td></tr>
<tr><td>Date of meeting</td><td colspan="3">21.07.22</td></tr>
<tr><td>Summary of Outcome</td><td colspan="3">Approval and submit to Quality Assurance Committee</td></tr>
<tr><td>Committee</td><td colspan="3">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="3">QAC/22/08/202</td></tr>
<tr><td>Date of meeting</td><td colspan="3">02.08.22</td></tr>
<tr><td>Summary of Outcome</td><td colspan="3">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">Section 22 – information intended for future publication</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT		AGENDA REF:	

1. BACKGROUND/CONTEXT

2. KEY ELEMENTS

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

4. IMPACT ON QPS?

5. MEASUREMENTS/EVALUATIONS

6. TRAJECTORIES/OBJECTIVES AGREED

7. MONITORING/REPORTING ROUTES

8. TIMELINES

9. ASSURANCE COMMITTEE

10. RECOMMENDATIONS

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Health and Safety Annual Report July 2022

1. Executive Summary

All Health Care Organisations are regulated by the Health and Safety Executive (HSE). The Trust Board accepts the statutory obligations under the Health and Safety at Work Act 1974 which, along with subordinate and other legislative requirements are recognised as the minimum standards to be achieved.

The Trust is committed to continually providing best practice standards in the delivery of a positive Health and Safety culture and considers this a fundamental component in providing a safe and healthy environment for staff, patients and the public.

The Trust's mission is to be 'outstanding for our patients, our communities and each other', with a vision that 'we will be a great place to receive healthcare, work and learn'. The embedding of Health and Safety practices across the organisation are fundamental in achieving this.

2. Introduction

This report provides the Health and Safety Sub Committee and Quality Assurance Committee with a summary of Health and Safety activity during the financial year 2021/22. This includes analysis of standards that relate directly to the management of Health and Safety.

The Health and Safety at Work Act (1974) provides a legislative framework to promote and encourage excellent Health and Safety standards at work with delegated responsibility from the Chief Executive Officer to the Chief Nurse. The standards as noted below are supported by policies, Standard Operating Procedures and risk assessments to ensure that all WHH staff are aware of how to optimise safety at work for themselves, our patients and the public. The Health and Safety at Work Act (1974) in particular requires the Trust to provide and maintain:

- A Health and Safety Policy.
- Safe systems of work to control risks in connection with the use, handling, storage and transportation of articles and substances.
- A safe and secure working environment, including provision and maintenance of access and egress to premises.
- Safe and suitable plant and work equipment.
- Information, instruction, training and supervision as necessary.

There are Health and Safety mechanisms in place to provide assurance of compliance with proactive monitoring and triangulation through existing governance mechanisms.

3. WHH Health and Safety Management Structure

The law places an 'absolute duty' on employers to carry out risk assessments, which must include:

- Identified hazards arising from or in connection with the work.
- Who will be affected by the hazards.
- The control measures in place or proposed control measures.
- Evaluation of the risk.
- Review date.

WHH adopts a structured approach to the completion of risk assessments to ensure consistency across the organisation. Risk assessments are completed on the Trust's risk assessment form and are reviewed as follows:

- Whenever there is a significant change e.g. staff, environment or equipment.
- After an accident or 'near miss".
- After noncompliance identified through audits and inspection programmes.
- At least annually.

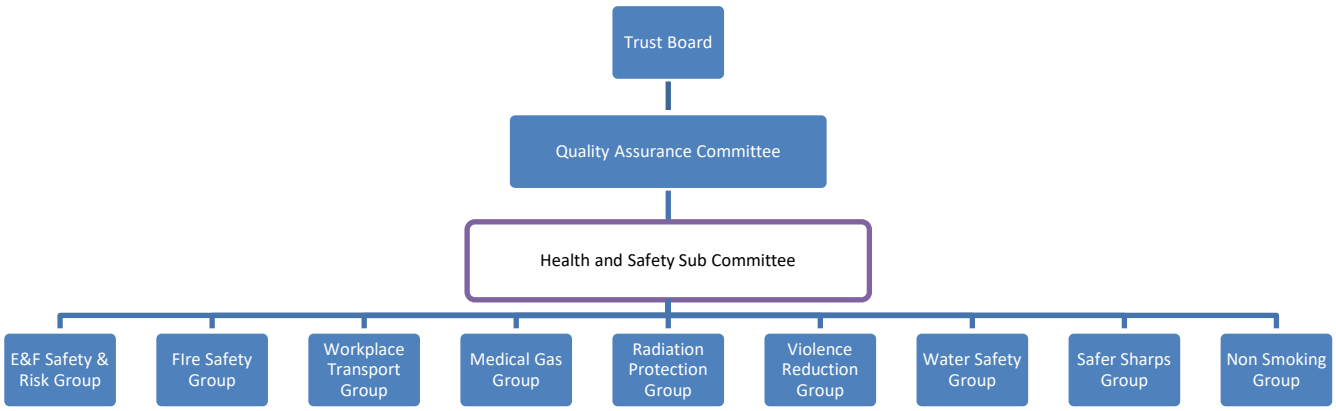
All Wards and Departments have in place a number of risk assessments as part of the Risk Management Framework, with escalation to the appropriate risk register if required. Specific items are escalated to the Health and Safety Sub Committee (as required) for additional scrutiny, oversight and assurance.

3.1 Health and Safety Committee Structure

The Health & Safety Sub-committee is responsible for monitoring the development, implementation, audit and delivery of Health and Safety organisational management throughout the Trust. The Health & Safety Sub-committee receives reports and has responsibility for the ratification of policies approved at sub-group level. It is in this way that compliance with external organisational requirements such as the Health and Safety Executive , Care Quality Commission and NHS Resolution are managed.

The Director of Governance & Quality is the Chair of the Health & Safety Sub-committee which is accountable to the Quality Assurance Committee (QAC) ahead of Trust Board.

The Health & Safety supporting committees are structured as follows, the Ventilation Group also now reports to the Health and Safety Sub Committee:



4.0 Health & Safety Policy

Warrington and Halton Teaching Hospitals NHS Foundation Trust follow the approved Health and Safety Executive guidance for the management of Health and Safety known as HSG65. This document provides clarification and direction in relation to:

- Effective Health and Safety policies.
- Organisation of Health and Safety.
- Planning and implementation of requirements.
- Measuring and auditing performance.

The diagram above describes the essential requirements of successful Health and Safety management (HSG 65):

By using this model, the Trust ensure that the requirements noted below are met with evidence collated:

- Legal and statutory obligations under the Health and Safety at Work e Act (1974) and subsequent regulations are met.
- Health and Safety management is understood and effectively managed.
- Health and Safety compliance is evidenced providing assurance to the Trust Board.
- Health and Safety is an integral part of WHH culture and its daily operating systems.
- To protect staff, patients, public, services, reputation and finances, through the process of early identification of risks relating to Health and Safety. Where risks are identified sufficient assessments, controls and mitigation are in place.
- Safe systems of work are in place and adhered to.
- Provide a safe working environment without risks to health.
- Adequate provision of welfare facilities.
- Provision of sufficient training, instruction and information to enable all employees to contribute positively to their own safety and health at work.
- There are safe arrangements for the use, handling and storage and transport of articles, materials and substances.
- There is safe access and egress.
- Staff understand the need to comply with Health and Safety policies and procedures.
- There is a top-down commitment to Health and Safety.
- Workplace risks are assessed, and safe systems of work are in place.
- A supportive culture to learning from incidents is evidenced.

5. Underpinning Legislation

The following regulations underpin the Trust's approach to safety management enabling a safe and secure environment to be maintained *(the list is not exhaustive).* These are referenced within and supported by the Health and Safety at Work Act (1974) which has four main objectives:

1. Provide training and information on how to carry out work processes safely.
2. Provide a safe place to work and working environment.
3. Develop a Health and Safety policy.
4. Undertake risk assessments.

Health and Safety at Work Act (1974, *forms the basis of specific areas of focus detailed within table*)	Construction, Design & Management Regulations (2015)
Workplace (Health, Safety and Welfare) Regulations (1992)	Management at Work Regulations (1999)
Control of Substances Hazardous to Health Electricity at Work Regulations (sub section 1974)	Noise at Work Regulations (2021) Personal Protective Equipment Regulations (2022)
Consultation with Employees Regulations (subsection 1974)	Work Equipment Regulations (1998)
Display Screen Equipment Regulations (1992)	RIDDOR Regulations (sub section, 1974)
Confined Spaces Regulations (sub section, 1974)	Manual Handling Regulations (1992)

Control of Asbestos Regulations (2012)	Work at Height Regulations (2005)

6. Coronavirus (COVID19)

6.1 Risk Management of Coronovirus

The Covid -19 pandemic continued to be a focus for Health and Safety in 2021/22 with a number of existing risks and controls in place such as social distancing, visiting and access egress. Throughout the pandemic WHH has taken necessary steps to ensure compliance with the requirement stipulated by the HSE, to ensure a Covid secure workplace:

6.1.2 Assurance:

- ✓ All offices and rest rooms risk assessed.
- ✓ Social distancing controls in place including assessment of equipment.
- ✓ Infection prevention measures in place including 2metre bed space where possible. Trust fully risk assessed.
- ✓ Full access to appropriate Personal Protective Equipment (PPE).
- ✓ Fit testing was undertaken only by appropriately trained staff and accredited Fit2Fit company. In total there were 3838 people tested, this figure included Trust staff, agency staff and patient relatives where in exceptional circumstances visiting was permitted ie for vulnerable patients or those approaching end of life.
- ✓ Access egress ensuring limited access and secure entry to corridors, stair wells and rest rooms. There is an inspection programme in place.
- ✓ Implementation of agile working policy, reducing risk of transmission.
- ✓ Covid 19 risk register continues to be reported to the monthly Risk Review Group.
- ✓ Legal Report shared with Trust Board in 2019/20 mapping actions taken during the pandemic, many of these measures have remained in place in 2021/22. Risk registers continually updated.
- ✓ Continuation of robust governance structure formulated by a number of cells including; medical, nursing, procurement, HR, governance and legal, operational, pharmacy and infection prevention management.
- ✓ Health and Safety observational walkrounds, Senior Nurse Walkrounds and Care Quality Commission mock inspections.
- ✓ A large number of risk assessments have also been developed and continue to be developed to ensure the safety and welfare of all staff and patients as required. This is further supported through the introduction of Standard Operating Procedures examples include:
- ✓

Covid Quick Reference Guide
PPE and COVID Pathways
Maternity Covid Testing

At the time of writing this report social distancing measures have been stood down and patient visiting reintroduced in accordance with national guidance. This position will continue to be reviewed as necessary, locally and nationally. The Covid-19 governance structure remains in place but with a reduced meeting frequency. This will flex accordingly.

7. Incident Reporting 2021/22

In 2021/22 Health and Safety incident reporting increased by 36%. In the previous year 1259 incidents were reported in comparison to 1716 (2020/21). The increased reporting of

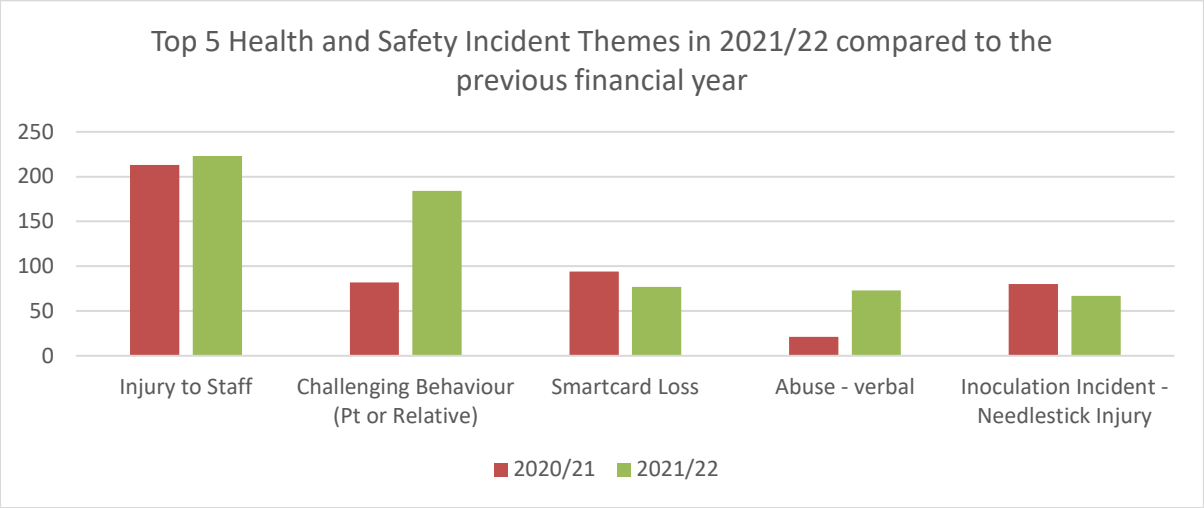
incidents during the financial year has also been mirrored through clinical governance incident reporting, thus is reflective of the current climate indicating a positive culture of reporting and ultimately learning for improvement.

Graph 1 details the top 5 themes of incidents for 2021/22 with comparison to the previous financial year. Injury to staff has remained the most common theme with a marginal increase in the number of incidents when compared to the previous year (n=10). This predominantly relates to slips, trips and falls, hit by an object e.g hitting head, fingers caught in door and burns and staff assault (verbal and non verbal). There has been a marked increase of 124% in the number of incidents associated with challenging behaviour. This is a likely consequence of operational pressures, increased wait times and an increased number of vulnerable patients attending the Trust, particularly the Emergency Department, also referenced through clinical governance mechanisms. This increase has also been noted on B12 (forget me not) and B14 (stroke ward). Staff are supported through de-escalation and conflict resolution training and the role of the Local Security Management Specialist (LMNS) who is notified of all incidents of this nature. The increase noted in verbal incidents is also reflective of this with a reported increase of 28%.

7.1 Needlestick injury incidents

Graph 1 displays that in 2021/22 there was a reduction of 83% in needlestick injury incidents when compared to 2020/21. The Trust has in place a clear process for the prevention of exposure to blood borne viruses through the management of safer sharps. The last audit undertaken noted 63% of the Trust achieved 100% compliance with the management of sharps. 16% achieved 90% compliance and 21% achieved 80% compliance, action plans are in place as required supported by Quarterly Sharps Management audit Programme.

Graph 1



8. Employers Liability Claims 2021/22

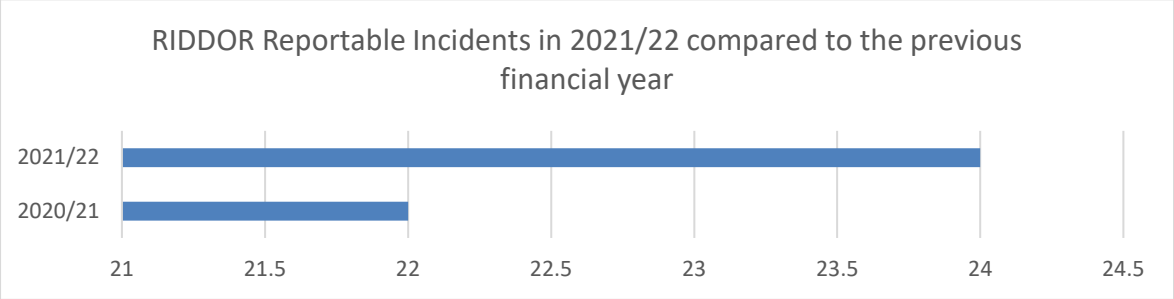
In 2021/22 there 3 claims registered and investigated with payment agreed:

- 282.80 fixing a crown following fall, equating to 8,493.80
- Monitor fell on staff member 2,583
- Assault on staff member 5,628

9. RIDDOR Reporting

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013), states that certain workplace accidents, incidents, ill health and certain near miss events must be recorded.

Depending on the severity and nature of the injury, and indeed the party affected, the Trust has a legal duty to report this data to the Health and Safety Executive (HSE). This reporting process is undertaken by the Health and Safety Advisors and overseen by the Senior Safety and Risk Manager and Head of Health, Safety and Risk. 24 RIDDOR reportable incidents occurred within the Trust in 2021/22 compared to 22 in the previous financial year (n=2).



RIDDOR reporting remained static during the course of the previous financial year. These incidents were apportioned as follows (further detail provided in **appendix 1)**:

- 21 incidents affected staff (increase of 1 when compared to 2020/21)
- 2 incidents affected a visitor/contractor (increase of 1 when compared to 2020/21)
- 1 incident affected a patient

Graph 2 provides detail on the reporting of RIDDOR by sub category. The highest number (n=9) relates to slips, trips and falls alongside moving and handling (e.g poor technique, unexpected considerable force, weight distribution) and challenging behaviour. This is mirrored within the top 5 themes of incident reporting with narrative as detailed above.

Graph 2: RIDDOR by type and subcategory

10. Control of Substances Hazardous to Health

To ensure compliance with the Control of Substances Hazardous to Health Regulations, the Trust records the following information on a system called "SYPOL":

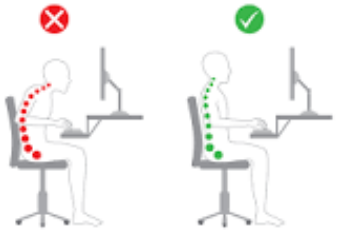
- COSHH Risk Assessments
- COSH Control Sheets
- COSHH Safety Data Sheets

To-date, there are 1,233 completed COSHH assessments available with new assessments being added accordingly. There are 1,096 different materials used within the Trust.

10.1 Assurance:

- The majority of products and their activities fall within the category of low risk.
- All new COSHH risk assessments are created, approved and returned to the appropriate Departments to be shared with staff.
- Bi-monthly reports are produced and circulated throughout the Trust to ensure Wards and Departments are notified of any updated risk assessments.
- Any substance rated as 'high' is managed with a robust Standard Operating Procedure, following advice from the safety data sheet and/or manufacturer.

11. Display Screen Equipment (DSE) Assessments



Health and Safety provide formal individual DSE workstation assessments for members of staff following a referral process undertaken by their manager or recommendation from Workplace Health and Wellbeing. The assessments generally take place when a member of staff is suffering pain and discomfort at their workstation, or they have a pre-existing medical condition.

During the period April 2021 to March 2022, the department carried out 46 workstation assessments for staff.

6 referrals were due to previous car accidents and falling down the stairs which had left staff with chronic neck and back pain.

The main reason for other referral was existing health issues such as disc degeneration, sciatica, shoulder impingement, pain and discomfort during and after pregnancy, arthritis/osteoarthritis, carpal tunnel syndrome, Cobalamin deficiency (Vitamin B12), migraines, previous hip replacement and general aches and pains in the lumbar region.

11.1 Assurance.

The assessments are to support staff within the workplace to prevent harm or any exacerbation of existing conditions. This is carried out by making reasonable adjustments to workstations. Additional support and advice is offered to staff in relation to the setting up of workstations, the use of 2 or 3 screens, positioning of the mouse and keyboard, regular breaks from a static position and eye care. Due to the increase in home working/agile working, additional information and advice has also been provided during the assessment regarding the setting up of workstations within the home to prevent poor posture.

12.Health and Safety Training.

The following Health and Safety training is in place. A large number of the training sessions available are mandatory and this is recorded on the Trust central system – ESR. Monthly compliance reports are sent out via the Organisational Development Team.

Topic	Training Requirements
Health and Safety Training for Senior Managers	Booklet to be read and signed 3 yearly
Health and Safety Training	E-learning to be completed 3 yearly
Non-Clinical Manual Handling	Classroom or e-learning to be completed 3 yearly
Clinical Manual Handling	Classroom training to be repeated every 2 years
Working at Height	Departmental based annually

The programme consists of:

- Health and Safety Awareness Training for all Staff – This is a general awareness of Health and Safety law and how it is managed throughout the Trust. The training can be accessed via e-learning or a Health and Safety Awareness Booklet
- Health and Safety Awareness for Senior Managers and Doctors – This is a training booklet which provides up to date information on current legislation and corporate manslaughter

12.1 Trust Mandatory Training Compliance relating to Health and Safety

The table below shows the most recent compliance with Health and Safety related training:

Course/Compliance	April-22
Conflict resolution	88.52%
Corporate induction	96.41%
Falls Awareness	96.81%
Health Safety and Welfare	89.24%
Local induction	92.23%
Moving and handling Level 1	86.90%

13. Estates and Facilities Health, Safety and Risk Safety Group

13.1 Specific requirements:

- Promote and monitor the effective management of Health and Safety risks within the Estates, Facilities and Medical Engineering Departments
- Continually review new and existing Health and Safety legislation, to ensure that the Estates, Facilities and Medical Engineering Department are compliant
- To ensure that there are effective systems in place for the identification, control, monitoring and reviewing of risk, ensuring that they are evaluated using the Trust Framework for Grading Risk, and that the appropriate level of management action is decided and implemented accordingly.
- Ensure that effective arrangements are in place for planning, organizing, controlling, monitoring and reviewing preventative and protective measures.
- Ensure that all department staff are provided with comprehensive information on the risks within their areas and the mitigations in place to reduce those risks

- Review of all incidents and investigation of incidents involving Estates, Facilities and Medical Engineering Department or contracting staff, identifying trends and ensure that appropriate action is taken
- Ensure that the Department of Health Estates & Facilities procedure for reporting defects and failures relating to non-medical equipment, engineering plant, installed services and building fabric is complied with (latest guidance DH (2008)01).

13.1.2 Asbestos

The Trust continue to make consistent progress on asbestos management including the appointment of an Authorising Engineer for asbestos safety. The Trust carries out annual re-inspections in accordance with its new Ratified asbestos policy and asbestos management plan to meet its statutory requirements as set out within the Control of Asbestos Regulations 2012 (CAR2012).
A responsible Person dedicated to asbestos management has been formally appointed as well as named Authorised Persons who are responsible for ensuring the requirements of CAR2012 are complied with for all projects and works were asbestos may be liable to be disturbed. The asbestos group has also implemented a training regime for all staff from basic asbestos awareness training up to detailed training on Regulation4 CAR2012 the Duty to Manage Asbestos.

Assurance: The Trust is fully compliant with the duties placed upon it by the Control of Asbestos Regulations 2012.

13.1.3 Fire Safety Group

The Fire Safety Group meets monthly and is responsible for the review of all fire safety matters within the Trust. There are no noted incidents in relation to fire incidents in 2021/22.

13.1.4 Remedial Fire Works and Upgrades

- Ongoing in-house preventative maintenance continues, and a tender process is underway for an external certified and third party approved contractor to manage all fire door maintenance.
- Work, upgrades to the Fire Alarm system in Wards and Departments have been completed with the new systems commissioned. The new fire panels have been installed in all buildings and are interconnected with the communication centre main panel.
- The total number of fire alarm activations for the 12-month period was 59. Warrington had 48 unwanted fire alarm signals. The installation of the new PROTEC 6500 intelligent digital fire alarm system on the Warrington site will significantly reduce unwanted fire signals.

14. Violence Reduction Group

There is a Violence Reduction Group in place to oversee and monitor the Violence Reduction Standards and subsequent training, for which there is a robust action plan led by the Associate Director of Estates and Facilities. A Violence and Reduction Standards Strategy is pending ratification at the time of writing this report.

15. RECOMMENDATIONS

The Quality Assurance Committee are asked to note the contents of the Health and Safety Annual Report.

16. Appendix 1: RIDDIR Incidents

Incidents affecting visitors:

- Fall in the car park of the Hospital
- Visitor found on the floor between Wards B12 and B14

Incident affecting patient:

- A cyclist crashed into the patient on a pedestrian crossing.

Incidents affecting staff:

- Nine incidents were due to slip, trip or fall.
- Six incidents were in relation to injuries from moving and handling.
- Five incidents were in relation to injuries sustained whilst managing patients with clinically challenging behaviours.
- One incident was due to fingers being trapped in a door

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/09/133**
SUBJECT:	**Violence Reduction Strategy 2022-2025**
DATE OF MEETING:	28th September 2022
AUTHOR(S):	Ian Wright, Associate Director Estates & Facilities
	Layla Alani, Director of Governance & Quality, Interim Deputy Chief Nurse
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamies, Chief Nurse & Deputy Chief Executive Officer
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Violence, Prevention and Reduction Strategy is a guide for all colleagues to ensure that measures are put in place to better protect staff against deliberate violence and aggression from patients, their families and the public, and to prosecute offenders more easily. Our primary aim of this strategy is to create a culture in which our staff feel supported, safe and secure at work. Strategic aims are to: • Identify and respond to incidents better, so that staff feel that reporting is worthwhile. • Ensure victims are central to the process and ensure adequate support for those engaging with the criminal justice system. • Gain Trust Board level support and oversight for violence prevention and reduction.

	• Raise the public's awareness of the issues, along with the action that will be taken. • Review policies, procedures and resources with the Strategy in mind. • Ensure each and every member of staff has fit for purpose training. • Ensure effective communication within the Trust, including the identification of Single Points of Contact (SPoC) to simplify communication routes. Ensure effective communication with partners such as the Police Service and Public Prosecution Services.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the Violence Reduction Strategy 2022-2025			
PREVIOUSLY CONSIDERED BY:	**Committee**	Health & Safety Sub Committee		
	Agenda Ref.			
	Date of meeting	21.07.22		
	Summary of Outcome	Approved for submission to Quality Assurance Committee		
	Committee	Quality Assurance Committee		
	Agenda Ref.	QAC/22/08/203		
	Date of meeting	02.08.22		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

REPORT TO BOARD OF DIRECTORS

SUBJECT		AGENDA REF:	

1. BACKGROUND/CONTEXT

2. KEY ELEMENTS

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

4. IMPACT ON QPS?

5. MEASUREMENTS/EVALUATIONS

6. TRAJECTORIES/OBJECTIVES AGREED

7. MONITORING/REPORTING ROUTES

8. TIMELINES

9. ASSURANCE COMMITTEE

10. RECOMMENDATIONS

We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Violence Prevention and Reduction Strategy 2022-25

Foreword

I am delighted to welcome you to this Violence, Prevention and Reduction Strategy. This strategy outlines a framework that supports a safe and secure working environment for our *NHS* staff, safeguarding them against abuse.

Violence and aggression come in many forms including physical and verbal assaults. Incidents leave people with physical and psychological injuries, leading to time off, isolation from the workplace, loss of confidence, people quitting their jobs, post-traumatic stress disorder and other significant long-term psychiatric conditions.

The World Health Organisation defines violence as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, developmental impact, or deprivation.'

We are committed to supporting the promise from the NHS England NHS People Plan, launched in July 2020 for leaders to prevent and control violence so that *"staff should never be fearful or apprehensive about coming to work"*.

This strategy has been developed in close consultation with you, including a survey to discuss key priorities with individual ward managers, CBU managers and teams. Through the feedback that we have received we have identified areas that you are doing well in and also some key challenges that you face now and anticipate for the future.

We are very proud to launch our new three-year Strategy 2022-2025. We will build upon the commitment to support all staff in our aspiration to embed a culture where our staff feel supported, safe and secure at work.

We recognise that our staff should be protected, and assault should never be considered part of the job. Therefore, the aim of this strategy is to create a culture where staff feel confident to raise their concerns and sets out the important steps that we will take to reduce the risk of work-related violence in healthcare and as far as reasonably possible, reduce the occurrence of violence towards staff.

We look forward to working with you to support the implementation of this Strategy which will be monitored by our Board of Directors, Quality Assurance Committee. Health and Safety Sub Committee and by our public and partners through the reporting of measurable success detailed within our Trust Annual Report.

Thank you all for your continued hard work.

Dan Moore
Chief Operating Officer

Introduction

The Violence, Prevention and Reduction Strategy for 2022–2025 outlines how Warrington and Halton Teaching Hospitals NHS Foundation Trust will address the significant and ever-increasing risk to staff from violence and aggression and will ensure that measures are put in place to better protect staff against deliberate violence and aggression from patients, their families and the public, and to prosecute offenders more easily.

This Strategy has been created with recognition and alignment of National Plans and Strategies. WHH is committed to supporting the promise from the NHS England NHS People Plan, launched in July 2020 for leaders to prevent and control violence so that *"staff should never be fearful or apprehensive about coming to work"*. In addition, in January 2021, NHS England launched the Violence Prevention and Reduction Standard which complements existing health and safety legislation NHSE.uk/violence-prevention-and-reduction-standard.

The Violence Prevention and Reduction Standard provides a risk-based framework which supports our staff to work in a safe and secure environment and safeguards against abuse, aggression and violence.

NHS Trusts have a statutory duty of care to prevent and control violence in the workplace. In order to achieve full compliance with the standards and support our staff to work in a safe and secure environment the Trust have undertaken a comprehensive risk assessment and considered the associated factors of violence within the organisation. This has led to the Violence, Prevention and Reduction Strategy being developed, with agreed objectives based on the findings of the risk assessment, demonstrating that WHH is committed to the health, safety and wellbeing of all employees and those who access its services.

Furthermore, all staff have the right to feel safe from the threat of violence and aggression. The Health and Safety Executive (HSE) says violence at work is "any incident in which an employee is abused, threatened or assaulted in circumstances relating to their work." This can include verbal abuse or threats as well as physical attacks. Violence can impact people in different ways. It can result in lack of confidence, anxiety to not turning up to work, increased use of alcohol and post-traumatic stress disorder (PTSD).

WHH recognises that the majority of service users and patients are not violent and should not be perceived as such. The causes of violence and aggression within healthcare settings are often complex and can be attributed to many factors. However, it is recognised that there may be many instances when staff and patients may be faced with potentially violent or aggressive incidents.

We are WHH & We are PROUD to make a difference

Mission, Vision, Aims, Purpose

Our Violence, Prevention and Reduction Mission and Vision

This Violence, Prevention and Reduction Strategy is a guide for all colleagues to ensure that measures are put in place to better protect staff against deliberate violence and aggression from patients, their families and the public, and to prosecute offenders more easily.

Mission

With regard to violence prevention and reduction, it is the Mission of WHH to prevent and reduce incidents of violence and aggression towards our staff, by raising awareness and improving corporate arrangements, because violence and aggression is not part of the job.

Vision

With regards to violence prevention and reduction, it is the Vision of WHH to prevent and reduce violence wherever possible.

Roles and Responsibilities

The Board of Directors is responsible for ensuring that this strategy is implemented and tracking progress of its delivery. All staff are responsible for following the associated policies, procedures and risk management arrangements developed or governed by this strategy.

Strategic Aims and Purpose

Our primary aim of this strategy is to create a culture in which our staff feel supported, safe and secure at work.

Our Strategic aims are to:

- Identify and respond to incidents better, so that staff feel that reporting is worthwhile.
- Ensure victims are central to the process and ensure adequate support for those engaging with the criminal justice system.
- Gain Trust Board level support and oversight for violence prevention and reduction.
- Raise the public's awareness of the issues, along with the action that will be taken.
- Review policies, procedures and resources with the Strategy in mind.
- Ensure each and every member of staff has fit for purpose training.
- Ensure effective communication within the Trust, including the identification of Single Points of Contact (SPoC) to simplify communication routes.
- Ensure effective communication with partners such as the Police Service and Public Prosecution Services, including the identification of a SPoC to simplify communication routes.

The aim of this Violence Prevention and Reduction Strategy is to set out a plan for WHH to address this significant and ever-increasing risk to staff from violence and aggression. This will support staff to work in a safer and more secure environment, which safeguards against abuse, aggression and violence and. The purpose of this Strategy is to:

1. Define and set out the requirements of NHS England's Violence Prevention and Reduction Standards
2. Set out the Trust's commitment and approach to providing a safe and secure environment for staff patients and visitors
3. Create a culture where staff feel confident to raise their concerns. Where inequalities or disparities are found this is collaboratively addressed.
4. So far as reasonably possible, reduce the occurrence of violence and aggression towards staff
5. Set out our ambition to continuously improve the management of risk relating to violence and aggression.
6. Have competent trained staff to manage violent and aggressive behaviours in a culture that promotes preventive practice and de-escalation where necessary. Training will include ED&I related situations.
7. Identify a series of violence reduction objectives
8. Outline the approach to implementation and monitoring
9. Describe the relevant compliance and assurance arrangements regarding risk management within the Trust

HSE guidance sets out the steps employers should take to reduce the risk of work-related violence in healthcare. To ensure we achieve this, the Strategy will use the following measures of success:

- ✓ We will put in place a violence reduction policy and share this with all staff and provide relevant training.
- ✓ We will make sure there are enough staff.
- ✓ We will do risk assessments (of the workplace and staff) and consider other factors (for example, protected characteristics) of violence. This will inform any prevention plans and solutions put in place. Consider space, layout and staff security.
- ✓ We will make work a place where staff don't have to put up with violence or see it as 'part of the job'.
- ✓ We will teach staff how to react to or calm down those who are being abusive.
- ✓ We will design the work environment to reduce the risk of violence.
- ✓ We will talk with trade unions and patients about making violence reduction strategies and processes.
- ✓ We will encourage staff to report all violence incidents and know how to do this.
- ✓ After an incident, we will bring staff together for debriefing to discuss what happened.
- ✓ We will ensure staff are supported when reporting an incident.
- ✓ We will ensure staff have access to physical and mental health support
- ✓ We will report physical attacks or serious cases of threatening or verbal abuse to the police, including any details about when it happened and who.
- ✓ We will have handover briefings for recording and exchanging information about patients.
- ✓ We will collect and monitor data on violent incidents.
- ✓ We will be the best place to work and have safe systems of work in place

Violence, Prevention and Reduction Standards

This Violence, Prevention and Reduction Strategy has been developed using the 'Plan, Do, Check, Act, Approach (PDCA). PDCA is an iterative four-step management method recommended by the Health and Safety Executive as a model for achieving a balance between the systems and behavioural aspects of Health and Safety Management (HSE Management). The model is used extensively across multiple industries and more recently in healthcare.

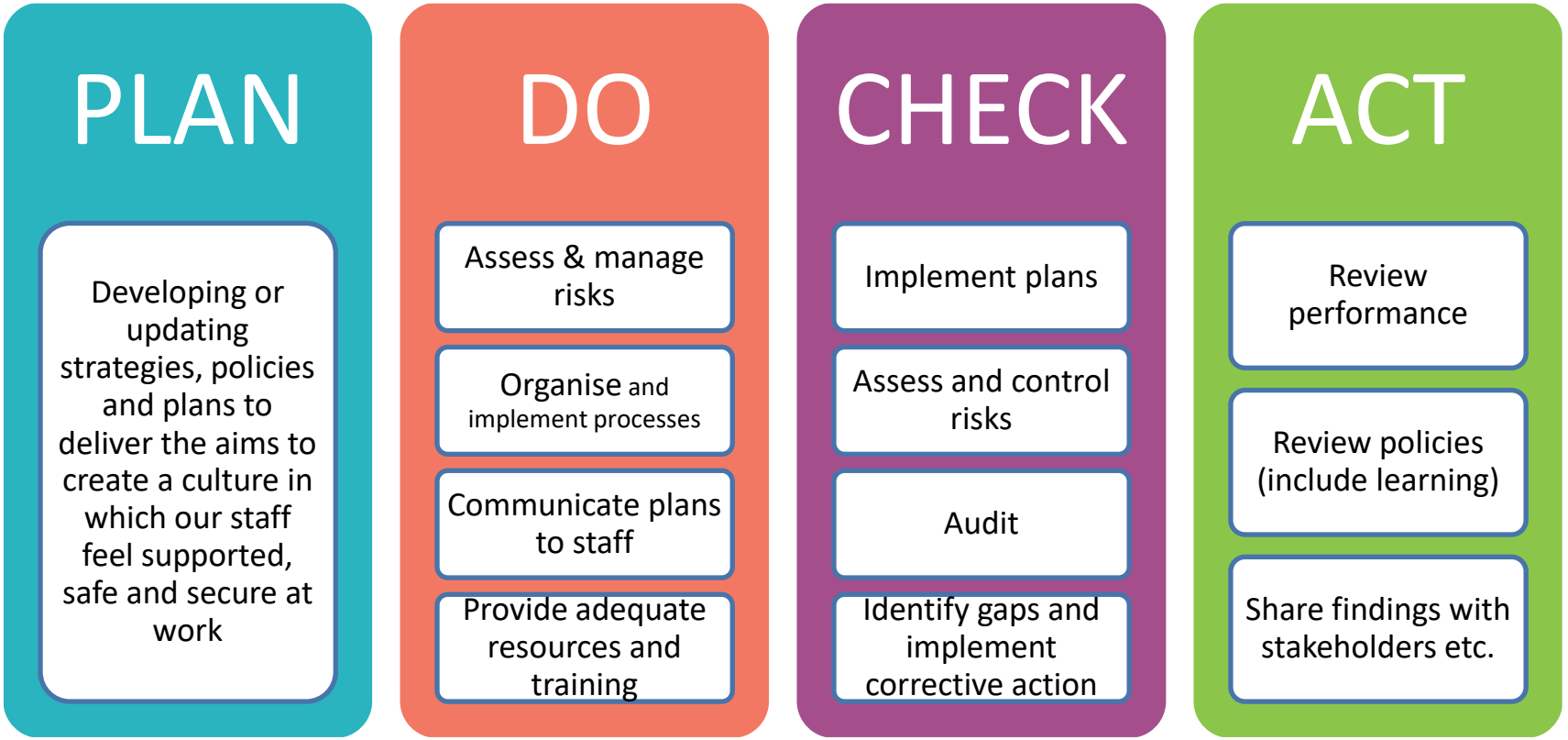
Furthermore, the Violence Prevention and Reduction Standard (NHS England 2021) is based on the Plan, Do, Check, Act model outlined below as an iterative four-step management method to validate, control and achieve continuous improvement of processes. This is outlined below in the 'Plan on A Page' followed by a detailed overview of the PDCA four-step management method.

By adopting this Plan, Do, Check, Act model, the Trust will aim to:

- Protect patients, staff and visitors within the Trust from incidents of violence and aggression and to prevent, minimise and reduce the risks of such incidents occurring
- Ensure that the Trust has in place adequate arrangements to monitor the implementation and effectiveness of controls required to reduce and prevent the risk of violence and aggression to staff
- Identify causes and assess the likelihood of violence and aggression
- Ensure that suitable and sufficient support is provided for staff who are exposed to incidents of violence and aggression
- Demonstrate compliance against the Violence Prevention and Reduction Standard (NHSE 2021).

This Violence, Prevention and Reduction Strategy will ensure WHH has the 'Plan, Do, Check, Act, approach in place.

Plan, Do, Check, Act, Approach - Plan on a Page



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Plan, Do, Check, Act, Approach

PLAN

- A suitable corporate framework for the prevention and reduction of violence and aggression (including violence prevention and reduction strategies, security strategy, policies and projects).
- Suitable violence prevention and reduction procedures to ensure that all line managers take an active role in violence prevention and reduction (including strengthened response to incidents and improved investigations).
- Clear goals and objectives with regards to improvement, along with agreed arrangements for monitoring and performance.
- Enhanced incident reporting arrangements to encourage reporting.
- Improved support mechanisms for staff by ensuring suitable strategic links with Health and Wellbeing and Peer Support.
- Plan to improve understanding of, and support for, staff engaging with in judicial processes.
- Review of the Organisational structure and governance arrangements.

CHECK

- Senior Management Team to have oversight of the performance of this strategy and the associated policy and procedures. Inputs to include incident data, risk assessments, risk registers, governance reports, lessons learned, staff intelligence, HR intelligence and stakeholder engagement.
- Adequate governance and assurance structures including arrangements for inspection and audit.
- Processes for ensuring gaps are addressed and corrective action taken.
- Deep dives into high impact aggression incidents.

DO

- Fully implement policies and procedures to support continuous improvement to reduce the likelihood and severity of incidents on staff health and wellbeing and service delivery.
- Develop, implement and maintain a suite of risk assessments relating to all aspects of violence and aggression including clearly documented action plans and associated projects (awareness projects).
- Consult, communicate and engage with management, Trade Unions, and staff Trust-wide
- Improve use of data to aid decision making and understanding.
- Provide adequate resources and competence to deliver this strategy, manage risk, investigate incidents, act as single points of contact and provide management and staff with support.
- Document a training needs analysis to ensure fit for purpose preventative training is delivered by qualified and experienced Training Officers, to enhance staff and management knowledge and empower staff to move away from a culture of acceptance, predict high-risk events and withdraw with confidence.
- Improve partnership working with external agencies
- Heighten public awareness using various communication channels.
- Media informed of all prosecutions and sentencing.

ACT

- Enable the Senior Management Team to review performance and direct change in response to data collected and lessons learned.
- Clear process to review risk management plans, policies and risk assessments.
- Arrangements to ensure key findings are shared with stakeholders

We are committed to ensuring this strategy meets the individual needs of all of our patients, workforce and communities. In doing so, this strategy will be delivered in conjunction with our Patient, Service User and Carers Diversity, Inclusion and Belonging Strategy 2022-2025 and our Workforce Equality, Diversity and Inclusion Strategy 2022-2025.

This strategy will ensure that it meets the individual needs of all, taking into account the protected characteristics outlined in the Equality Act 2010: age, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. As well as this, we will also explore how wider socioeconomic factors impact on specific groups of people.

This strategy will ensure equity in access to our hospitals and the experience of all our workforce is reviewed whilst we create a culture of belonging in which everyone feels supported, safe and secure.

1. In **year one** of this strategy, WHH will undertake a review of what information we record, how we utilise data related to equality, diversity and inclusion and our internal systems and processes.
2. In **year two**, we will focus on ensuring that inequality and disparity in the experience of staff groups with protected characteristics is addressed and monitored through systems and processes. We will work with our subject matter experts to ensure that our objectives and work plans apply due regard and meet our regulations under the Public Sector Equality Duty.
3. In **year three**, WHH will focus on working with our staff networks and patient groups to embed learnings, principles and findings from years one and two to ensure they are fully embedded in business-as-usual organisational procedures.

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Local Violence Prevention and Reduction Indicators

In year one of this Strategy 2021-22, WHH will undertake a self-assessment on compliance with the Violence Prevention and Reduction Standard using the Plan, Do, Check, Act model.

In addition, within the safety priority, there are nine new local safety indicators, with new stretched local safety indicators to be identified commencing in year two and becoming fully embedded in year three.

Year one 2022/2023 local staff safety indicators shown in the 'Plan on A Page'

Improve Staff Safety

- Undertake a self-assessment on compliance with the Violence Prevention and Reduction Standard using the Plan, Do, Check, Act model.
- Ward/Department Risk Assessments undertaken in 2021-22- 100% compliance.
- Reduction in the number of incidents reported and the level of harm regarding violence and aggression.
- Strengthen the monitoring of incidents reported regarding violence, identifying any trends and escalating to the Corporate Risk Register if required.
- Provision and delivery of appropriate training in Conflict Resolution Training and De-escalation Training commensurate to roles and risks posed following a training needs analysis (TNA) - 85% compliance.

Improve Staff Experience

- Ensure all individuals who have been affected by or exposed to violence and aggression will be offered appropriate individualised support.
- Raise awareness and communicate the 'Staff Support violence aggression support protocol'.
- Communicate poster campaign and security newsletter to prevent violence and aggression and respect our staff.
- Annual Security Awareness month to be held in November 2022.

Safety -23 SAFETY PRIORITIES: PLAN ON A PAGE

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2022-23 Safety Priorities

IMPROVE STAFF SAFETY 	1. Violence Prevention and Reduction Standard self- assessment. 2. Ward/Department Risk Assessments to continue to be undertaken in 2022-23 3. Reduction in the number and level of harm of incidents reported. 4. Strengthen the monitoring of incidents, identify trends and escalate to appropriate Risk Register. 5. Provision and delivery of appropriate training following a TNA.	A culture where our staff feel supported, safe and secure at work.
IMPROVE STAFF EXPERIENCE 	6. All individuals affected or exposed to violence will be offered support. 7. Raise awareness for the 'Staff Support violence aggression support protocol'. 8. Communicate poster campaign & security newsletter to prevent violence and aggression and respect our staff. 9. Annual Security Awareness month to be held in November 2022.	Stronger protection and safeguarding staff from violence

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Objectives and Governance

Objective Setting

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

The six objectives are:

1. Empowering Leadership.
2. Identifying themes and trends to enhance learning and reduce the severity of incidents reported. This analysis will include equality data and will be triangulated with EDI metrics.
3. Developing security risk reduction tools.
4. Competent people providing training for all groups of staff.
5. Providing support mechanisms to our staff.
6. Year on year improvement in the reduction and prevention of violence and aggressive incidents.

The six objectives are set out on the following pages.

Outstanding Governance

Seeking assurance in the right forum is key to strong delivery. The Board of Directors is responsible for ensuring appropriate arrangements are in place to safeguard the health and safety of those who may be affected by the Trust's activities.
The Trust's health and safety reporting mechanism is determined and overseen by the Health and Safety Sub Committee. Its main responsibilities are detailed within the Terms of Reference.

The Health and Safety Sub Committee will monitor the development of this strategy before recommending approval by the Quality and Assurance Committee.
Mechanisms have been established for consultation and co-operation between management and staff side on all relevant health and safety issues, via the Health and Safety Sub Committee.

All violence and aggression related incidents will be reported to the Health and Safety Team and any themes or issues will be monitored and actioned as necessary.
The Trust will declare to the Board of Directors twice a year that they have met the Violence, Prevention and Reduction Standard in accordance with the NHS Standard Contract.
In addition, We will seek assurance through the implementation of this Strategy which will be monitored by our Board of Directors, Quality Assurance Committee. Health and Safety Sub Committee and by our public and partners through the reporting of measurable success detailed within our Trust Annual Report.

Objective one – Empowering Leadership

What we'll do

- Empower staff at all levels to challenge unacceptable behaviour and feel supported in doing so.
- Escalating episodes of violence and aggression to optimise learning and ensure safety for patients, staff and the wider public. This will be achieved through functions including the Safety Huddle and the Incident Reporting System with necessary reviews undertaken.
- Regular communication briefing to staff about learning from incidents, skills of de-escalation and our commitment to ensure safety for both staff and patients.
- Observational walk arounds will be undertaken by the Senior Nursing Team, the Health and Safety Team and the Local Security Management Specialist (LSMS).
- A working group is in place that focuses upon violence prevention and reduction.

How we'll achieve this

- ✓ Provide de-escalation and specialist training to patient facing staff members.
- ✓ Visibility of the Local Security Management Specialist (LSMS) to discuss and highlight episodes of violence and aggression and subsequent learning. To support with and provide assurance of appropriate risk assessments.
- ✓ LSMS will produce a security newsletter, which will feature incident data, training data, how to report violence and aggressive incidents and good news stories.

Objective two – Identifying themes and trends and occurrences to reduce the severity of incidents reported

What we'll do

- Gather intelligent data to establish a baseline in order to be able to identify areas to reduce levels of harm i.e. From risk assessments and incidents.
- We will further develop the process for gaining feedback from those responsible for managing risk to ensure that lessons are fed back to those involved in adverse events.

How we'll achieve this

- ✓ This will be achieved by daily review of DATIX incidents and Risk Assessment reviews.
- ✓ The LSMS will feedback to the staff member involved in adverse incidents and will notify the staff member of what further actions are being taken relating to adverse events.

Objectives

Objective three – Developing Security risk reduction tools

What we'll do

- Ensure all services/ departments have in place security risk assessments.
- Ensure all risk assessments have suitable and sufficient controls in place.
- Ensure all risk assessments are communicated with the relevant staff.

How we'll achieve this

- ✓ An annual Security Risk Assessment Audit will take place.
- ✓ An audit tool is being developed to ensure that all wards and departments have up to date risk assessments and that suitable control measures are in place and they are communicated to staff

Objective four – Competent people - providing suitable and sufficient training for all groups of staff

What we'll do

- Provision of a robust training plan for all staff groups within the Trust.
- Ensuring staff attend regular update training.
- Evaluate the effectiveness of current training provision

How we'll achieve this

- ✓ Training Needs Analysis (TNA) has been developed based on incident data from high risk areas.
- ✓ Training requirements and incident data has now been added to ESR/ Business Intelligence (BI) Workforce and will be monitored monthly and presented at the Violence and Reduction Group.
- ✓ Evaluating the effectiveness of training delivered will be carried out by course evaluation questionnaires.
- ✓ The de-escalation Trainer will be invited to the Violence and Reduction Group Bi-monthly to highlight any issues

Objective five – Providing support mechanisms to our staff across all services

What we'll do

- Include debriefing guidance for managers in the new Line Managers Competency Framework.
- Raise staff awareness regarding the referral process for:
- Employee Health and Wellbeing.
- Mental Wellbeing hub.

How we'll achieve this

- ✓ LSMS will work with our Health and Safety team to develop debrief guidance.
- ✓ Raising awareness will be published in the Security newsletter, working alongside WHH Health and Wellbeing Department.
- ✓ Raising awareness with a poster campaign, for example: 'My Mother Works Here…please respect her'.

Objective six – Year on year improvement in the reduction and prevention of violence and aggressive incidents

What we'll do

- Bi-annual violence and aggression assurance report to be presented to the Board of Directors.
- Bi-monthly assurance report to be presented at the Health and Safety Sub-Committee with the inclusion of compliance data relating to completed risk assessments across the Trust.
- The Violence and Reduction Group will undertake compliance assessments twice a year as a minimum or quarterly if significant concerns are identified

How we'll achieve this

- ✓ Support provided by the Associate Director of Estates and Facilities for the delivery of this strategy and plan
- ✓ The LSMS will Present a bi-monthly report to the Health and Safety Sub-Committee and will present compliance data from security risk assessment audits being facilitated.
- ✓ The LSMS will present a monthly report to the Violence and Aggression Sub Group and will present compliance data from security risk assessment audits being facilitated.
- ✓ This will feedback to the Violence and Reduction Group

Consultation Process

Consultation Process

Thank you to the following contributors and partners for supporting the development of this Violence Prevention and Reduction Strategy.

This Strategy has been developed by the Head of Security and Car Parking/Local Security Management Specialist in consultation with the Health and Safety Sub Committee which includes Trade Unions and Management (Terms of Reference available).

- WHH Violence and Reduction Group
- WHH Health and Safety Sub Committee
- WHH Quality and Assurance Committee
- Clinical Business Unit Managers
- Ward Managers
- Sisters and Charge Nurses
- Staff Nurses
- Health Care Assistants
- Allied Health Professionals
- Specialist Nurses Associate
- Assistant Practitioners
- Nursing Associates
- Advanced Clinical Practitioners
- Consultant Nurses
- Security and Health and Safety Management
- Social Partnership Forum and its subgroups
- Medical Staff
- Therapy Staff
- Health and Wellbeing

Associated Documents

This Strategy is supported by the following policies and documentation:

- Violence and Aggression Policy (2019)
- Health and Safety Policy (2019)
- Incident Reporting and Investigation Policy (Including Serious Incidents Framework and Duty of Candour) (29 January 2021)
- Security Policy (Including Lone Worker Procedures (2022)
- Risk Management Strategy (2019)
- Security Service Policy (2022)
- Dignity at Work Policy (2019)
- Safeguarding Adult Policy (2019)
- Safeguarding Unborn Children and Young Persons Policy (2022)
- Trust Procedural Document Control Policy (2019)
- Patient, Service User and Carers Diversity, Inclusion and Belonging Strategy (2022-2025)
- Workforce Equality, Diversity and Inclusion Strategy (2022-2025)

This strategy will be communicated to all staff throughout the Trust and can be accessed via the Trust intranet site.

References

NHS England (July 2020, modified March 2021) We are the NHS: The People Plan for 2020-21. https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

NHS England (December 2020, modified January 2021). Violence Prevention and Reduction Standard https://www.england.nhs.uk/publication/violence-prevention-and-reduction-standard/

Legislation and Guidance

Employers (including NHS employers) have a general duty of care to protect staff from threats and violence at work. The following Health and Safety legislation covers violence at work:

- Health and Safety at Work Act 1974 (HASAWA) Health and Safety at Work etc Act 1974 – legislation explained (hse.gov.uk)
- Management of Health and Safety at Work Regulations 1999 The Management of Health and Safety at Work Regulations 1999 (legislation.gov.uk)
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) Reporting of Injuries, Diseases & Dangerous Occurrences RIDDOR (hse.gov.uk)
- Safety Representatives and Safety Committees Regulations 1977 Consulting workers on health and safety. Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended). Approved Codes of Practice and guidance L146 (hse.gov.uk)
- Health and Safety (Consultation with Employees) Regulations 1996. Consulting workers on health and safety (hse.gov.uk)

The following Associated legislation covers violence at work:

- The Corporate Manslaughter and Corporate Homicide Act 2007 HSE: Corporate manslaughter
- Protection from Harassment Act 1997 – Legislation.gov.uk Protection from Harassment Act 1997 (legislation.gov.uk)
- Assaults on Emergency Workers (Offences) Act 2018 Assaults on Emergency Workers (Offences) Act 2018 (legislation.gov.uk)
- Equality Act 2010 - Legislation.gov.uk Equality Act 2010 (legislation.gov.uk)
- Offences against the person legislation Offences against the Person, incorporating the Charging Standard | The Crown Prosecution Service (cps.gov.uk)
- Section 39 Criminal Justice Act 198 Criminal Justice Act 1988 (legislation.gov.uk)

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact the Communications Team on 01925 662710.

Polish:	Niniejsza publikacja jest dostępna w alternatywnych językach lub formatach na życzenie
Punjabi:	ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਬੇਨਤੀ 'ਤੇ ਵਿਕਲਪਕ ਭਾਸ਼ਾਵਾਂ ਜਾਂ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਉਪਲਬਧ ਹੈ
Urdu:	یہ اشاعت درخواست پر متبادل زبانوں یا وضعوں میں دستیاب ہے
Bengali:	এই প্রকাশনাটি অনুরোধের ভিত্তিতে বিকল্প ভাষা বা বিন্যাসে উপলব্ধ
Gujurati:	આ પ્રકાશન વિનંતી પર વૈકલ્પિક ભાષાઓ અથવા ફોર્મેટમાં ઉપલબ્ધ છે
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Engagement and Involvement Team
Warrington and Halton Teaching Hospitals
www.nhs.uk email: whh. engagement@nhs.net

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Trust Overview

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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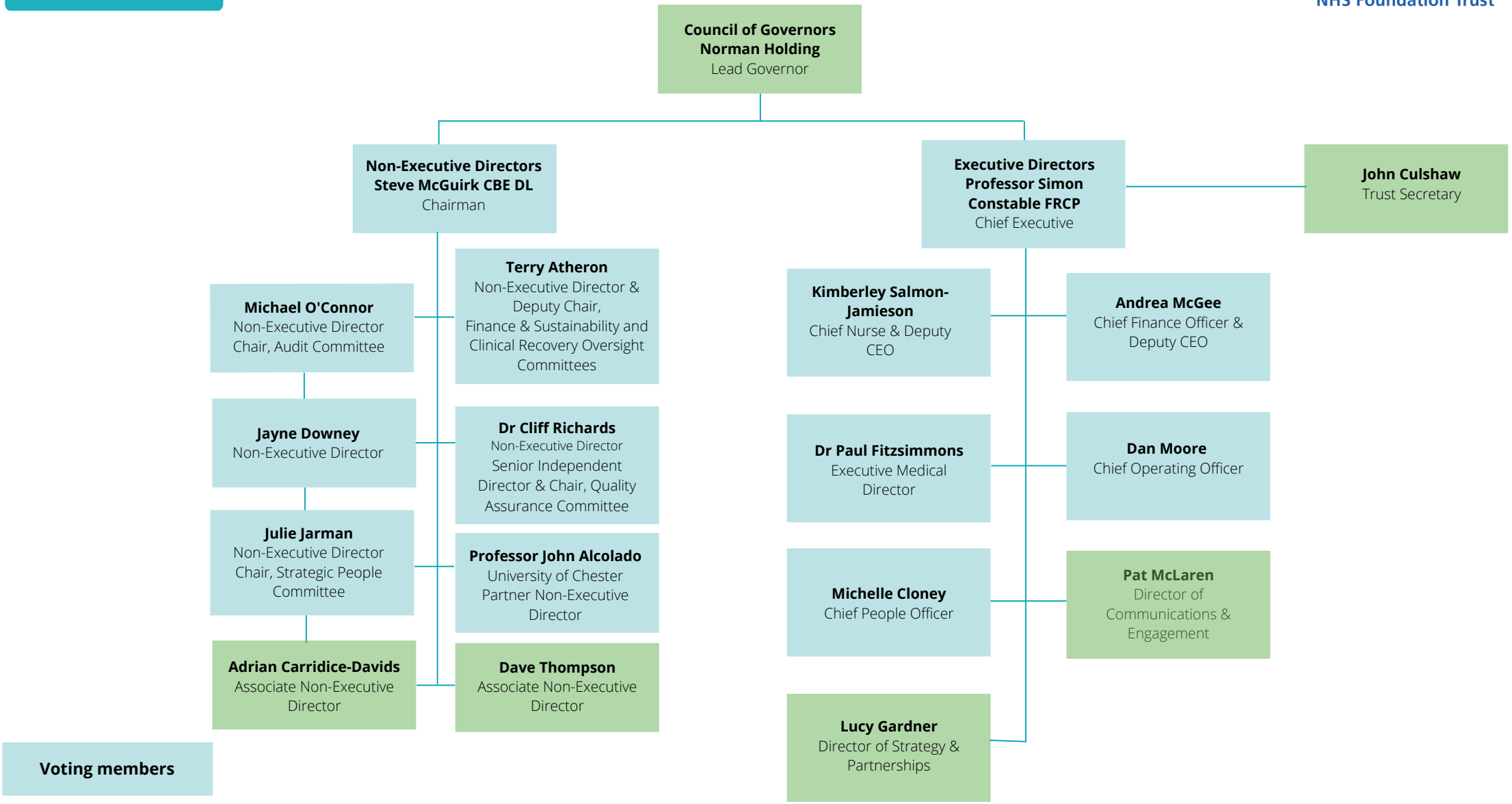
Trust Board

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Voting members

Non-voting members

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Executive Team

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NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Professor Simon Constable FRCP
Chief Executive

John Culshaw
Trust Secretary

Andrea McGee
Chief Finance Officer & Deputy CEO

PORTFOLIO

Management Accounts
Financial Services
Financial Planning
Contracts, performance & commercial development
Clinical coding & service development
Supplies & Procurement
Informatics & Business Intelligence

Kimberley Salmon-Jamieson
Chief Nurse & Deputy CEO

PORTFOLIO

Professional leadership for nurses, midwives & AHPs
Clinical governance
Risk management
Regulatory compliance
Infection prevention & control
Patient safety
Patient experience
Quality Academy
Clinical Education
Clinical Research
Safeguarding
Maternity & Children's Safety Champion
Palliative Care

Dan Moore
Chief Operating Officer

PORTFOLIO

Planned Care
Unplanned Care
Integrated Care
Clinical Support Services
Estates and Facilities

Dr Paul Fitzsimmons
Executive Medical Director

PORTFOLIO

Professional leadership for doctors, dentists & physician associates
Clinical effectiveness & productivity
Learning from deaths
Medicines management
Appraisal & Revalidation
Medical Education
Clinical Research
Digital Services

Michelle Cloney
Chief People Officer

PORTFOLIO

Human Resources
Recruitment
Payroll
Pensions
Workforce intelligence
Occupational health & wellbeing
Staff engagement
Organisational development
Learning & development

Lucy Gardner
Director of Strategy & Partnerships

PORTFOLIO

Strategy development & delivery
New hospitals
Town Deals - community health hubs
ICS and Place developments
Local Health and wellbeing strategy delivery
Anchor programme, including green plan
Partnerships & collaboration
COVID-19 vaccination

Pat McLaren
Director of Communications & Engagement

PORTFOLIO

Internal and external communications
Media relations
Community and stakeholder engagement
Freedom of Information
WHH Charity Fundraising

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Trust Operations

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Dan Moore
Chief Operating Officer

Zoë Harris
Director of Operations & Performance

Val Doyle
Associate Director
Planned Care Group

Digestive Diseases
Glenna Smith
Clinical Business Manager

Surgical Specialities
Vera Cebral
Clinical Business Manager

Women's and Children's
Abby Jones
Clinical Business Manager

CLINICAL SERVICES

Digestive Diseases

Surgical Specialities

Women's & Children's Health

Sharon Kilkenny
Associate Director
Unplanned Care Group

Integrated Medicine & Community
Chris Barlow
Clinical Business Manager

Medical Care
Sharon Martlow
Clinical Business Manager

Urgent & Emergency Care
Sheila Fields- Delaney
Clinical Business Manager

CLINICAL SERVICES

Urgent & Emergency Care

Medical Care

Integrated Medicine & Community

Hilary Stennings
Associate Director
Clinical Support Services

Paul Mooney
Chief Pharmacist

Lesley McKay
Associate Director Infection Prevention & Control (IPC)

Mark Jones
Radiology Services Manager

Michelle Smith
Therapies Manager

Neil Gaskell
Pathology Services Manager

Jenni Delea
Outpatients Services Manager

Chris Barrow
Vaccination Programme Lead & Long COVID Service

CLINICAL SERVICES
Haematology
Microbiology
Clinical Chemistry
Histopathology
Imaging
Radiology
Breast Screening
Infection Prevention & Control
Outpatients
Pharmacy
Therapies

Caroline Williams
Associate Director of Integrated Care

Danielle Whittaker
Service Manager

Integrated Hospital Discharge Team

CLINICAL SERVICES

Hospital Discharge

Ian Wright
Associate Director, Estates & Facilities Management

Dan Boyd
Head of Estates Maintenance, Compliance & Risk

Lee Bushell
Head of Capital Projects

Julie McGreal
Head of Facilities

Phil Sloan
Head of Security & Car Parking (LSMS)

Alan Vaughan
Head of Medical Engineering

COPORATE SERVICES

Estates Maintenance & Compliance
Capital Projects
Catering
Facilities Management
Security
Car Parking
Medical Engineering

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Care Groups and Clinical Business Units

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Dan Moore
Chief Operating Officer

Zoë Harris
Director of Operations & Performance

Planned Care Group

Mr Mark Tighe
Associate Medical Director

Val Doyle
Associate Director

Natalie Crosby
Associate Chief Nurse

Digestive Diseases

Mr Pranesh Nagarajan
Clinical Director
Glenna Smith
Clinical Business Manager
Lucy Parry
Lead Nurse

CLINICAL SERVICES
Gastroenterology
General Surgery
Upper Gastro-intestinal Surgery
Colorectal Surgery
Endoscopy
Breast Surgery
Anaesthetics
Liaison Pain Management
Pre-operative Assessment
Ward A4
Ward A5 Gastro
Ward A5 Elective
Ward B4
Planned Investigations Unit
Theatres
Post- Anaesthesia Care Unit
CT Room

Surgical Specialities

Dr Paul Scott
Clinical Director
Vera Cabral
Clinical Business Manager
Cheryl Finney
Lead Nurse

CLINICAL SERVICES
Trauma & Orthopaedics
Ophthalmology
Urology
Ear Nose & Throat Surgery
Audiology
Maxillofacial Surgery
Orthodontics
Ward A6
Ward B3
Captain Sir Tom Moore Ward

Women's and Children's Health

Dr Satish Hulikere
Clinical Director
Abby Jones
Clinical Business Manager
Catherine Owens
Director Midwifery & Associate Chief Nurse

CLINICAL SERVICES
Midwifery
Obstetrics
Gynaecology
Colposcopy
Paediatrics
Neonatology
Antenatal Day Unit
Antenatal Clinic
The Nest
Birth Suite C23
Gynaecology
Assessment Unit
Ward C20
Neonatal Intensive Care Unit
Wards B10 & B11
Children's Outpatients

Unplanned Care Group

Dr Mark Forrest
Associate Medical Director

Sharon Kilkenny
Associate Director

Emma Painter
Associate Chief of Nursing

Medical Care

Dr Laura Langton
Clinical Director
Sharon Martlow
Clinical Business Manager
Claudine Reynolds
Allen Hornby
Lead Nurses

CLINICAL SERVICES
Critical Care Medicine
Cardiology
Respiratory Medicine
Cardio-Respiratory Investigation
Diabetes & Endocrinology
Nephrology
Rheumatology
Neurology
Dermatology
Acute Care Team
Intensive Care Unit
Acute Cardiac Care Unit A3
Acute Respiratory Unit B18
Ward C21

Urgent & Emergency Care

Dr James Wallace
Clinical Director
Sheila Fields- Delaney
Clinical Business Manager
Ali Crawford
Lead Nurse

CLINICAL SERVICES
Emergency Medicine
Acute Medicine
Emergency Department
Same Day Emergency Care Unit
Runcorn Urgent Treatment Centre
Acute Medical Unit A1
Ward A2
Patient Flow Team

Integrated Medicine & Community

VACANT
Clinical Director
Chris Barlow
Clinical Business Manager
Janet Pye
Lead Nurse

CLINICAL SERVICES
General Medicine
Care of the Elderly
Palliative Care
Frailty Assessment Unit
Ward A7
Ward A8
Ward A9
Forget me Not Unit B12
Stroke Unit B14
Ward B19
Ward K25
Discharge Suite
Integrated Discharge Team

Clinical Support Services

Dr Alison Davis
Clinical Director

Hilary Stennings
Associate Director

Nicola Milkins
Acting Matron

Paul Mooney
Chief Pharmacist

Michelle Smith
AHP Lead

Mark Jones
Radiology Services Manager

Neil Gaskell
Pathology Services Manager

CLINICAL SERVICES
Haematology
Microbiology
Clinical Chemistry
Histopathology
Imaging
Radiology
Breast Screening
Infection Prevention & Control
Outpatients
Pharmacy
Therapies

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Nursing and Governance

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Kimberley Salmon Jamieson
Chief Nurse & Deputy Chief Executive

Layla Alani
Director of Integrated Governance & Quality & Interim Deputy Chief Nurse

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Clinical Governance
CQC Compliance
Health & Safety
Risk Management
Audit
Legal Services
Quality Academy

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Sharon Wright
Patient Safety Nurse

Heather Aston
Tissue Viability

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Patient Safety
Ward Accreditation
Ward Metrics
Clinical Education
Medical Devices
Medicines
Improvement
Nurse staffing & workforce

Nicola Milkins
Acting Matron Clinical Support Services

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Vanessa Wallace
Patient Safety Nurse

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Interim Digital Lead Nurse

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Unplanned Care Group

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Urgent & Emergency Care
Lead Nurse

Claudia Reynolds
Medical Care
Lead Nurse

Allen Hornby
Critical Care
Lead Nurse

Janet Pye
Integrated Medicine
Interim Lead Nurse

Natalie Crosby
Associate Chief Nurse
Planned Care Group

Cheryl Finney
Surgical Specialties
Lead Nurse

Lucy Parry
Digestive Diseases
Lead Nurse

Catherine Owens
Director of Midwifery & Associate Chief Nurse

Wendy Turner
Katie Clarke
Lead Nurses Safeguarding Adults/Children

Jen McCartney
Head of Patient Experience & Inclusion

PORTFOLIO

Operational Support
Palliative Care
Safeguarding
Mental Health
Learning Disability
Patient Experience
Volunteers
Chaplaincy
Military Veterans
Equality, Diversity & Inclusion (Patients)
Infection Control Support
Bereavement Services

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Medical Cabinet

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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Executive Medical Director
& Chief Clinical Information Officer

Dr Paula Chattington
Director of Medical Education

Kate Davidson
Medical Education Manager

Dr Anne Robinson
Deputy Medical Director &
Responsible Officer

Debbie Mallett
Medical Cabinet Business Manager

Dr Mark Forrest
Associate Medical Director
Unplanned Care Group

Dr Laura Langton
Clinical Director
Medical Care

Dr James Wallace
Clinical Director
Urgent & Emergency Care

VACANT
Clinical Director
Integration Medicine & Community

Dr Alison Davis
Clinical Director
Clinical Support Services

Mark Tighe
Associate Medical Director
Planned Care Group

Dr Paul Scott
Clinical Director
Surgical Specialities

Mr Pranesh Nagarajan
Clinical Director
Digestive Diseases

Dr Satish Hulikere
Clinical Director
Women's & Children's

Portfolio Associate Medical Directors

Dr Eshita Hasan
Associate Medical Director for Patient Safety

PORTFOLIO

VTE
Medicines Governance
Infection Control/Sepsis/UTI
CQUINS
Discharge
Communication
Diagnostic Testing Policy
Incident Investigation
CQUIN
Patient Safety Specialist
Mortality, Learning from Deaths
Serious Incidents

Mr Mark Halliwell
Associate Medical Director for Clinical Effectiveness

Dr Anna Vondy
Deputy AMD for CE - Research

Dr Mithun Murthy
Deputy AMD for CE - Cancer

PORTFOLIO

Clinical Audit
NICE
LocSSIPs
Consent
Clinical Ethics Committee
Research
7 Day Services
Trust Wide Trauma Group Chair
Cancer

VACANT (New Post)
Associate Medical Director
Clinical Productivity & Strategy

PORTFOLIO

Clinical Productivity
Getting It Right First Time (GIRFT)
Strategy

Dr Janice Fazackerley
Associate Medical Director – Medical Appraisal & Revalidation

Dr Hilary Furniss
Deputy AMD Appraisal & Revalidation

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Medical Appraisal Standards
Responsible Officer (RO)
Documentation and Reporting
Support for Doctors Revalidation
Support & Professional Development for Doctors

Dr Rita Arya
Associate Chief Clinical Information Officer – Women's & Children's Health

Dr Damian Stansfield
Associate Chief Clinical Information Officer – Medical Specialties

Dr Phyu Wai
Associate Chief Clinical Information Officer – Medical Specialties

Mr Gareth Stables
Associate Chief Clinical Information Officer – Surgical Specialties

Miss Virag Varga
Associate Chief Clinical Information Officer - Surgical Specialties

PORTFOLIO
Clinical Information

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Finance

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Andrea McGee
Chief Finance Officer & Deputy Chief Executive

Jane Hurst
Deputy Chief Finance Officer

Alison Jordan
Associate Director of Information

Janet Parker
Associate Director of Finance - Strategy

Alice Forkgen
Associate Director of Finance - Operations

Alison Parker
Associate Director of Procurement

Greg King
Head of Financial Planning

Marie Garnett
Head of Contracts, Performance & Commercial Development

Paula Brereton
Head of Clinical Coding & Service Development

Lynn Simpson
Head of Management Accounts

Karen Spencer
Head of Financial Services

Claire Leather
Head of Finance (GIRFT)

PORTFOLIO

Business Intelligence
Statutory Reporting
Governance of Data Quality
Digital Analytics
Data Warehouse
Enterprise Solutions

PORTFOLIO

Financial Planning
Clinical Income
PLICS/Benchmarking
Service Line Reporting
Overseas Patients
Private Patients
Charitable Funds
Strategic Business Cases
GIRFT
Reference Costs

PORTFOLIO

Business Cases, Bids & Tenders
Benefits Realisation
Business Planning
Commercial Development
Contracts & SLAs
Performance Assurance Framework
Use of Resources

PORTFOLIO

Clinical Coding
Service Development
Internal/External Training
Internal/External Audit
Clinical Engagement
Quality Improvement

PORTFOLIO

Care Groups Function
Corporate Function
Budget Setting
Budget Management
Forecasting
Costings & Financial Information CIP
Corporate Benchmarking
Service Improvement
Internal Monthly Reporting
Finance Systems

PORTFOLIO

Financial Accounting
External Financial Reporting
Financial Controls
Treasury Management
Cash Flow
Cash Office
Internal & External Audit
Accounts Payable/Accounts Receivable
Counter-Fraud
Capital Accounting

PORTFOLIO

Tendering and Commercial Contracts
Order Processing
Stores Receipt & Distribution
Materials Management
Workflow
Procurement Services to Bridgewater Community

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People

NHS
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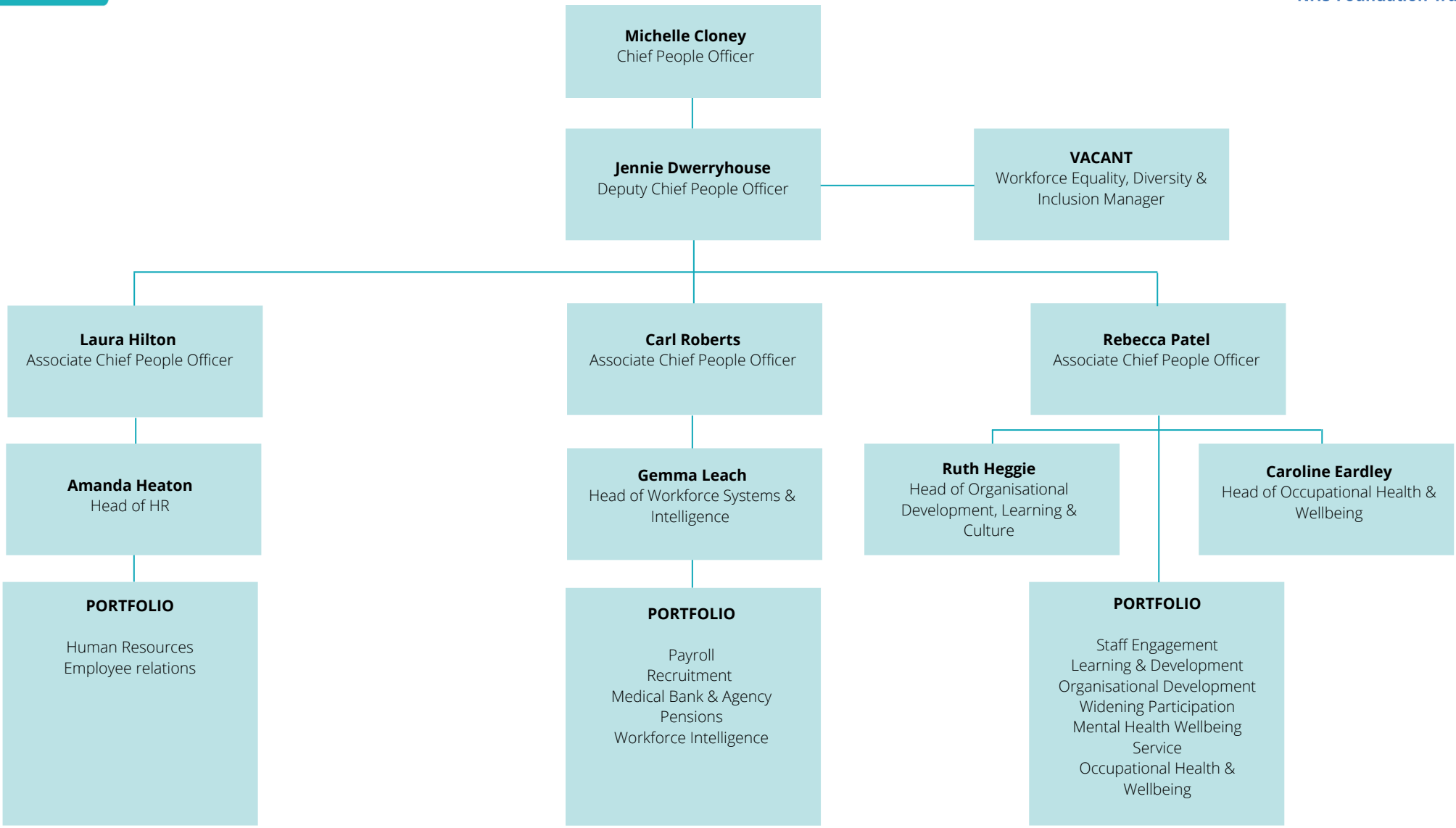
NHS Foundation Trust



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Digital Services

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Dr Paul Fitzsimmons
Executive Medical Director &
Chief Clinical Information Officer

Dr Tom Poulter
Chief Information Officer

Sue Caisley
Deputy Chief Information Officer

Stephen Deacon
Head of Digital Compliance

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Information Governance

Cyber Security

Digital Compliance

Emma O'Brien
Head of ePR & Programme Management

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EPR Project Managers/Support

Training Team/Administrator

RA (Smartcards)

Optimisation

Release Management

Tracie Waterfield
Head of IT Services

PORTFOLIO

Server

Network

IT Deployment

IT Support

Service Desk

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Strategy and Partnerships

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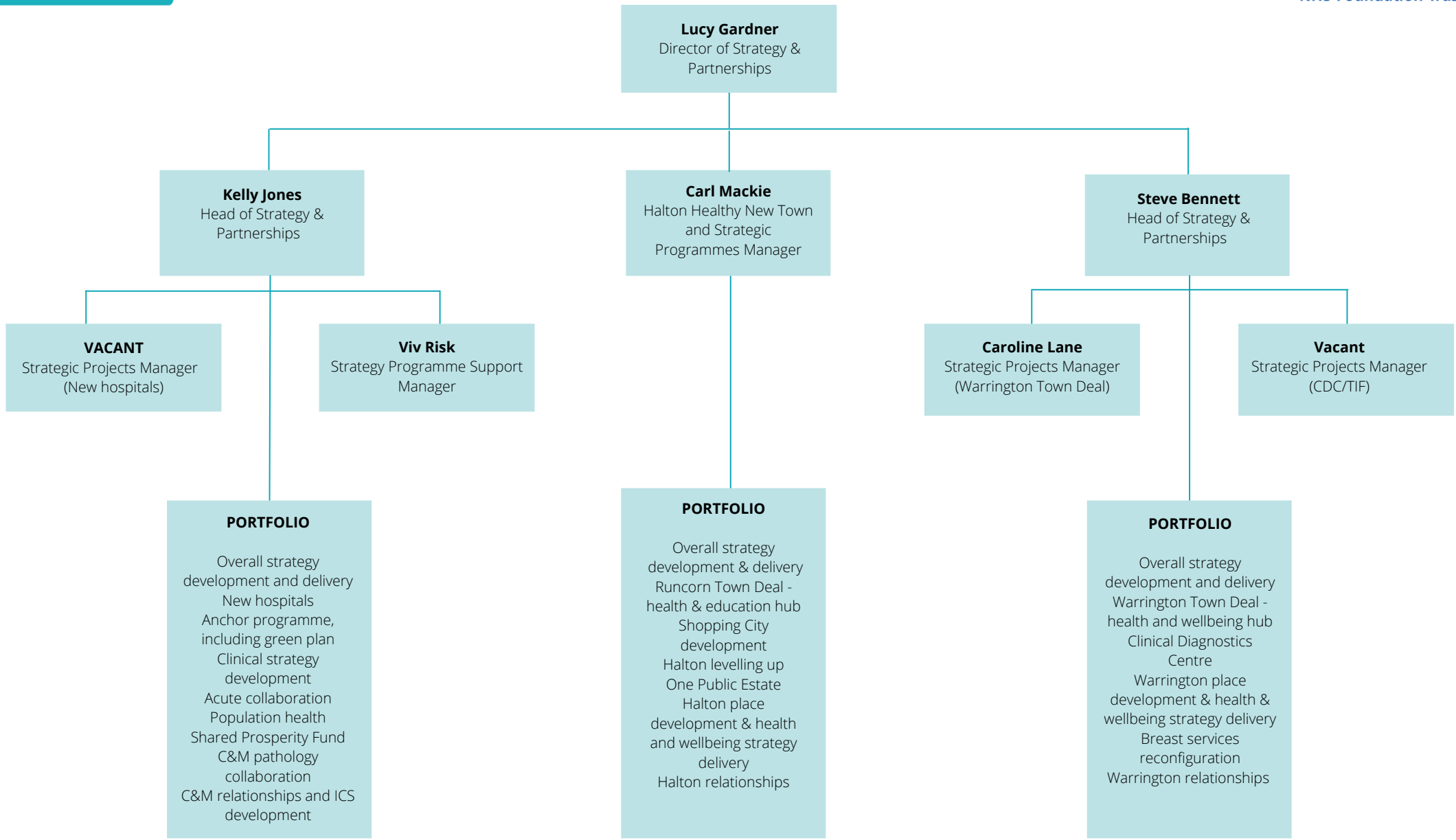

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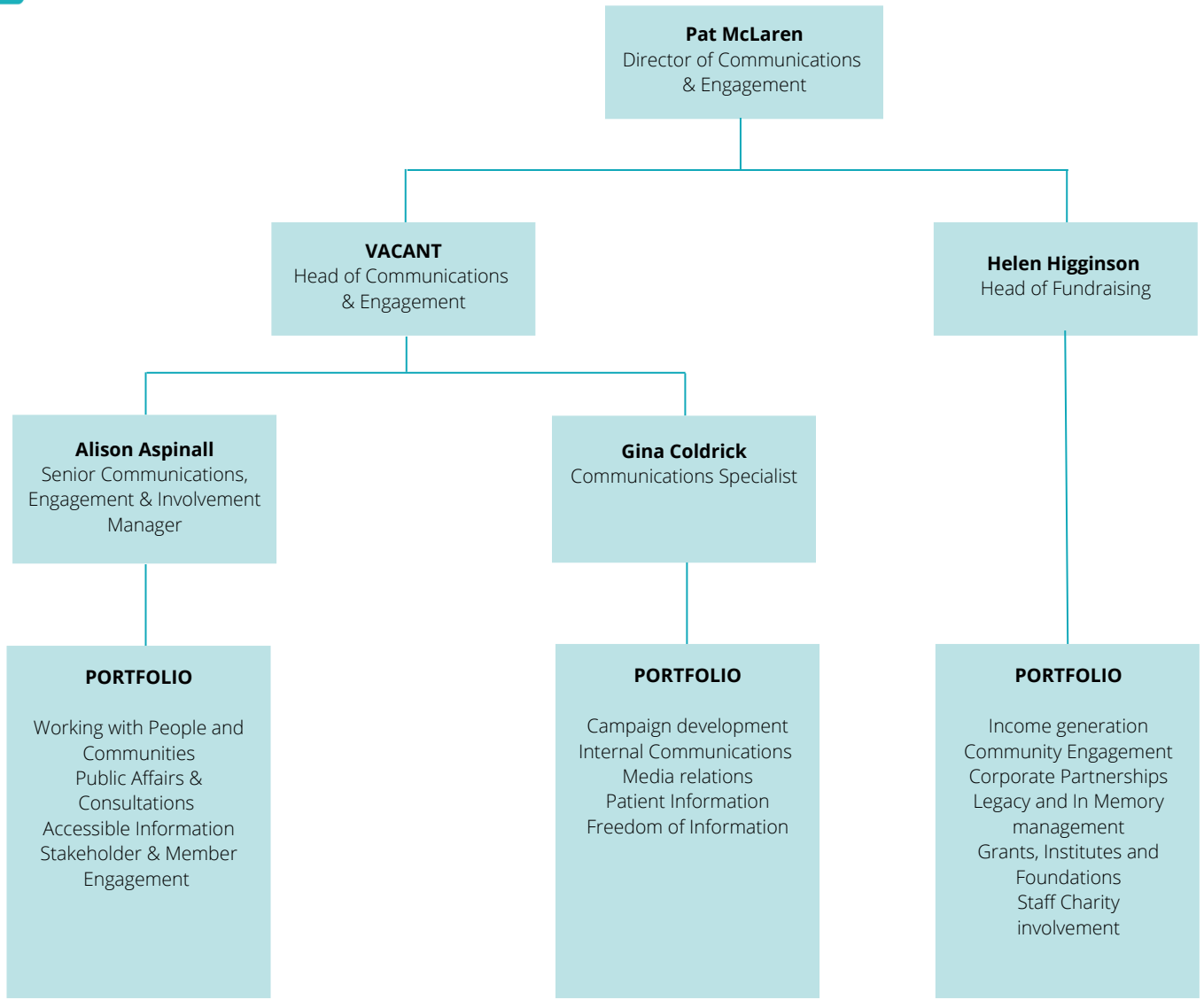
Communications and Engagement

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Version: 15/09/2022

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/09/135**	
SUBJECT:	**Safe Staffing Report; 6 Month Acuity Review, June 2022.**	
DATE OF MEETING:	28th September 2022	
AUTHOR(S):	Ali Kennah, Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper details the June 2022 review of nurse staffing in line with the commitment requested by the National Quality Board (NQB) in 2016 and more recently in the Improvement Resource for Adult Inpatient Wards in Acute Hospitals January 2018. A 3-month pause in the completion of this paper is noted because of the requirement from NHSE/I for clinical staff to complete training in preparation for the acuity data collection, due to the introduction of the Emergency Department SNCT and an NHSE/I review of the existing tool in place. The report provides an overview of the current nursing/midwifery staffing workforce data, which shows latest (June) vacancy data in whole time equivalent (WTE) for the following: • HCSW: 63 **reduced 16%** from 75 in May 2022 • RN: 79 **increased 8%** from 72 in May 2022 • Midwife: 30 **increased 3%** from 29 in May 2022 • Theatres: 17 **reduced 5%** from 18 in May 2022 Overall vacancy for the above staff groups: 197, a positive **reduction of 3%** from 203 in May 2022 WHH are no longer monitored in relation to HCSW vacancy numbers as part of the Cheshire and Mersey Recruitment Programme, this is positive for the Trust and demonstrates the ongoing work in relation to recruitment. The successful recruitment of 30 International Nurses has supported our reduction in nursing vacancies, takes our total number of International nursing recruits to 124. The report details the range of recruitment and retention schemes at WHH	

	The results from the Safer Nursing Care Tool (SNCT) data collection in June 2022 demonstrate: • A deficit of 132.62 whole time equivalent (WTE), our current vacancy data for band 5 nurses and band 2 HCSW's shows 142 WTE, the results are comparable with our own data, however SNCT does not differentiate between qualified and unqualified groups of staff and as such it requires a very good understanding of patient groups and nursing requirements, hence the requirement to overlay the SNCT data with professional judgement. • A7, A8, A9 have seen an increase in the number of enhanced care patients and those with no right to reside, the dependency of these patients has impacted on the delivery of safe care and is reflected within the SNCT indicative data, a further professional judgment review is being undertaken looking at the enhanced care requirements for patients on these wards as part of a safe staffing review for those areas. Turnover has **increased** month on month for the last 12 months from 11.65% in July 2021 to 14.95% in June 2022 which is above the national average. The ICB have recently appointed a Retention Lead who will support WHH in retention planning. This report was discussed at Quality Assurance Committee (QAC) 2nd August 2022, the discussion related to the difficulty in maintaining expected staffing numbers with current gaps in staffing, increased sickness levels and extra beds opened for escalation and the mitigation in place to provide safe levels of care. The report is presented to Trust Board as per the National Quality Board (NQB) guidance 2016, 2018. The guidance states that Trust Boards should have oversight of the workforce plans in place for sufficient and sustainable staffing capacity and the capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. This report provides assurance of safe staffing levels and the mitigation plans in place to maintain this and is for noting as a requirement of the above.

PURPOSE: ***(please select as appropriate)***	Information *	Approval	To note *	Decision
RECOMMENDATION:	The Trust Board is asked to recieve and note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.			
	Date of meeting	2nd August 2022		
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Safe Staffing Report; 6 Month Acuity Review June 2022**	**AGENDA REF:**	**QAC/22/07/91 a**

1. INTRODUCTION

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

1.2. Nursing and midwifery workforce supply continues to be a significant challenge nationally with the shortfall in registered nurses well-documented across all NHS organisations. According to NHS workforce statistics, the current shortage of staff across the NHS in England is nearly 94,000, with 39,000 within the registered nursing workforce (NHSE). In September 2021, the National University and Colleges Admission Services (UCAS) received unprecedent interest in healthcare programmes commencing in September 2021. This has translated into an increase in students commencing on Nursing, Midwifery and AHP programmes over the last 12 months.

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

- Twice-yearly review of nursing establishments using an evidence-based decision matrix, the Safer Nursing Care Tool (SNCT)
- Daily analysis of Safe Care results
- Annual Chief Nurse led evaluation of staffing establishments
- Monthly analysis of Care Hours per patient Day (CHPPD) in line with the Carter Report (2015)
- Daily monitoring of staffing capacity versus demand with a review of harm data and the relationship to staffing

As per the NQB guidance, this bi-annual report will provide the results from the first of the twice yearly SNCT data collection for 2022, completed in June 2022 with analysis and next steps following review of the data. The report also includes the current Trust nursing and midwifery workforce position with figures demonstrating the trend from July 2021 to June 2022, and actions being taken to mitigate and reduce vacancy specifically within the registered nurse and health care support worker (HCSW) workforce. A summary workforce position for the Care Groups and Allied Health Professions (AHP) workforce is also detailed.

2. NATIONAL/LOCAL CONTEXT

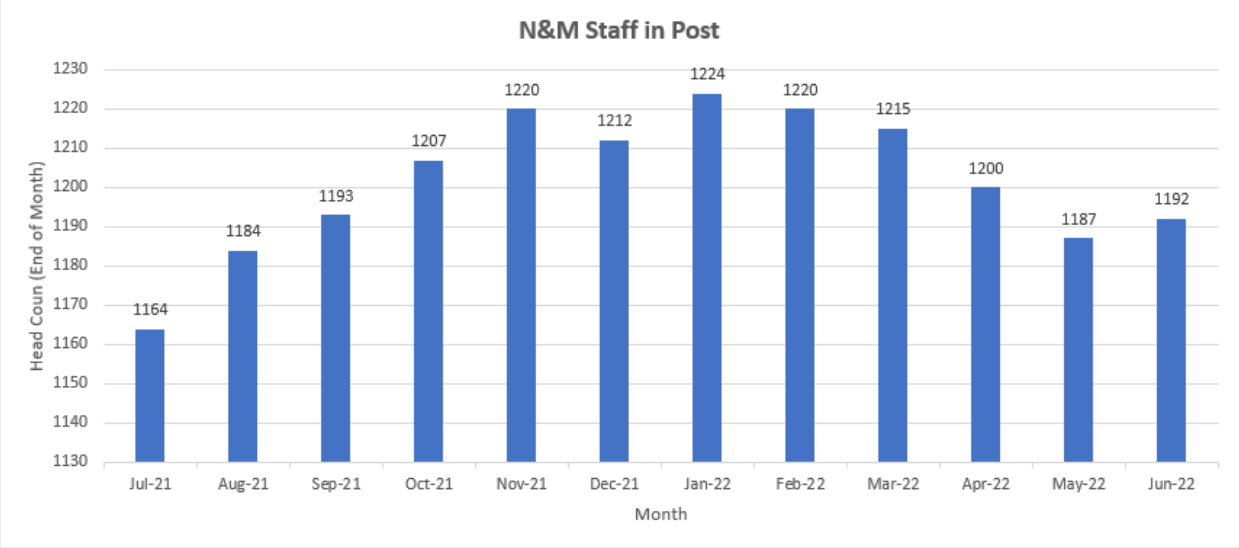
2.1. The COVID- 19 Pandemic has resulted in the nursing, midwifery and AHP workforce working in new ways and unfamiliar settings. These changes have often happened rapidly to meet increased demand which has

in turn increased the number of leavers across the nursing professions for the first time in 4 years (NMC May 2022). The demand on services continues as higher levels of patient acuity and dependency are experienced across all the clinical areas at WHH, which mirrors the national picture, as published in NHS providers report, NHS Reality Check; The financial and performance ask for Trusts on 2022/2023. Furthermore, the Care Quality Commission (CQC) State of Care report (May 2022) suggests a higher dependence amongst older people as a result of the pandemic which is reflected in the WHH increasing super stranded figures, as highlighted in a report presented to The Quality Assurance Committee in May 2022 (Appendix 1) and the impact this has on staffing.

There is clear evidence which shows that nurse staffing levels make a very significant and positive difference to patient outcomes (mortality and adverse events) patient experience, quality of care and the efficiency of care delivery. Short staffing compromises care and recurrent short staffing results in increased stress and reduced staff wellbeing, leading to higher sickness and a higher turnover rate.

3. TRUST WORKFORCE POSITION

Fig. 1 Nursing and Midwifery Staff in Post July 2021-June 2022



3.1. The table above demonstrates a familiar yearly pattern of increased staff in post in Q3/4 due to students who qualify in September and gain registration across October and November. There is then a natural trend of rising vacancies across Q1 which is due to turnover rates currently sitting at 14.86% for WHH, which is above the national turnover rate of 13.6% and the Trust target of 13%. However, national turnover rates are higher at present and in 2021 there was an increase of 13% of nurses who left the NMC register compared to the previous year (nurses.co.uk June 2022). WHH have a turnover rate of 21.35% for HCSW's which is mirrored nationally and across the Cheshire and Merseyside footprint and the trigger for the NHSE/I National Programme to reduce HCSW vacancies to as close zero by April 2022.

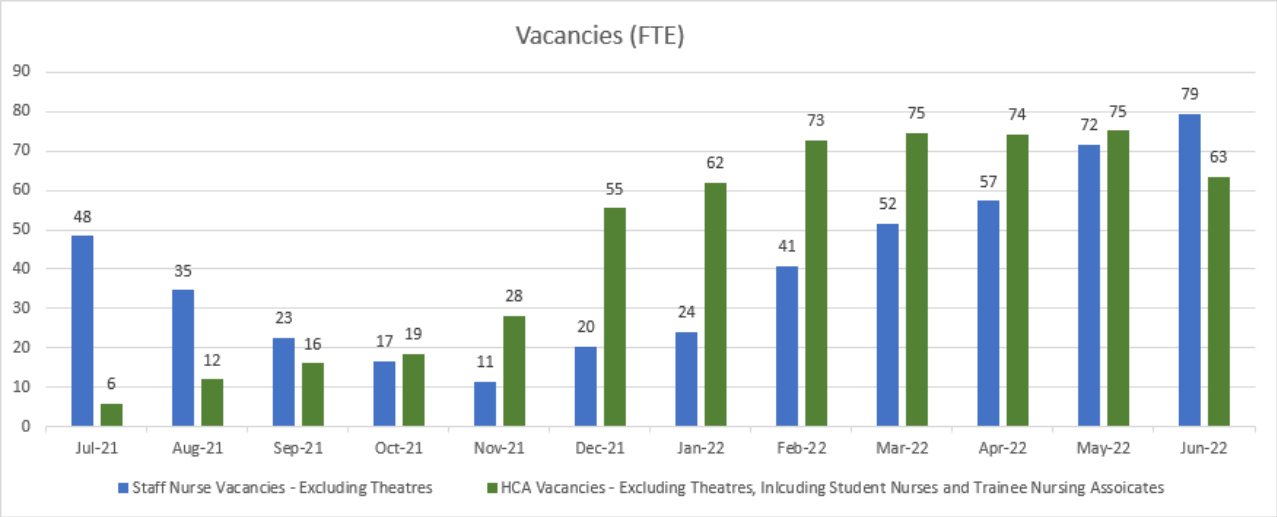
3.2. Vacancy Position

3.2.1. To provide clarity with the vacancy data presented, WHH externally report Provider Workforce Return (PWR) data each month to NHS Digital- this data is driven by number of staff paid in month

so whilst the PWR data shows whole time equivalent (WTE) vacancies, many of these have already been assigned and therefore are not open posts. The latter data is held for the Trust by the Trust Workforce Lead and monitored via the Trust Workforce Review Group. Monthly meetings are held between the Finance Department, HR and Trust Workforce Lead to compare data and ensure correct reporting. A narrative explaining the number of staff within the recruitment pipeline accompanies the tables below.

3.2.2. The chart below identifies the number of band 5 Registered Nurse (RN) and band 2 Health Care Support Worker (HCSW) vacancies up to the end of June 2022, this is based on the funded establishments, against the number of staff in post

Fig. 2 Registered Nurse band 5 and Health Care Support Worker Vacancies (excluding theatres)

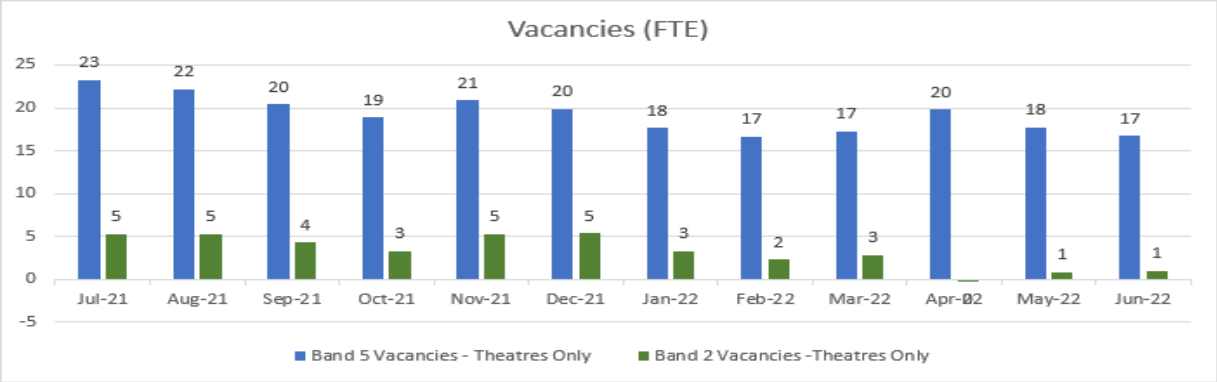


N.B. Theatre staff are excluded due to the job titles of their staff in post- they are demonstrated separately below in Fig 2

3.2.3. Despite ongoing successful recruitment, a recent increase in HCSW vacancies is noted across Q4 2021 and into Q1 2022, this is due to business case approval for K25, B18 and C21 and the transfer of international nurses from HCSW roles into registered nurses. More recently we have seen a reduction in the trend, which has continued into July with staff successfully onboarding due to the work underway to reduce HCSW vacancies.

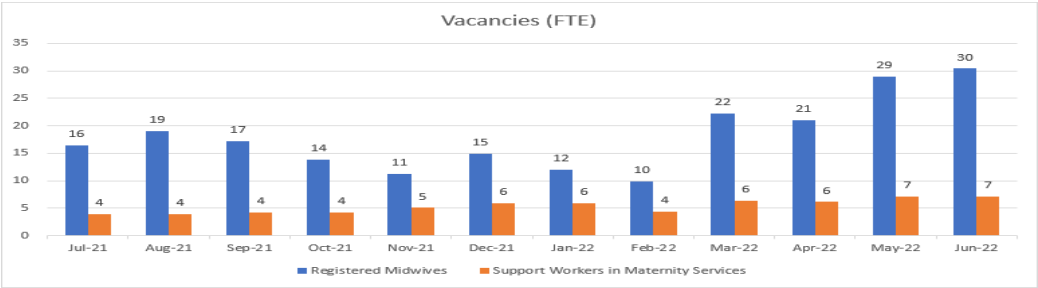
3.2.4. Approved business cases as noted and increased turnover of registered nurses means the reduction of transferring international nurses from HCSW's to registered nurses has not been seen within the registered nurse vacancy data.

Fig. 3 Theatres Band 5 and Band 2 Vacancies



3.2.5. Within the vacancy figures, inclusive of theatres, 80 RN's and 54 HCSW's have already been allocated to and are in the recruitment pipeline following successful recruitment. Those in the recruitment pipeline are due to be in post over the next 3 months (October 2022), with the 30 International Nurses due in HCSW posts by December 2022. Theatre band 5 vacancies are planned to reduce by over 50% by November, with the rest on trajectory for December/January.

Fig.4 Midwives and Maternity Support Workers vacancies



3.2.6. Of the vacancies demonstrated in the above figure, 24.37 WTE staff are currently at various stages of the recruitment pipeline, with plans in place for the remaining vacancies.

3.2.7. The ambition for WHH is to reduce vacancies down to zero for RN/Midwifery and HCSW staff, however the aforementioned turnover rates must be acknowledged. Therefore, a focus on retention coupled with recruitment plans, as highlighted below will support the reduction in vacancies across the next 3 months.

3.3. WHH Recruitment and Retention plans for Registered Nurses and HCSW's:

3.3.1 **Rolling recruitment programme:** Regular advertising for both RN and HCSW with bi-weekly shortlisting and ongoing interviews. The senior nursing teams are part of the interview process and ward managers, overseen by matrons, complete a monthly vacancy report which allows the workforce leads to support each area with recruitment. WHH is a member of the NHSEI programme to achieve zero HCSW vacancy, particularly to those without previous care experience. The funding associated to this national programme has supported the recruitment of an additional member of staff within the recruitment team to assist in reducing time to post. Which has proven successful in reducing vacancies. This post has been extended until the end of September 2022.

3.3.2. **Transfer Window reintroduced in March 2022 (suspended due to Covid):** This supports new registered nurses to move to a different ward/ area without going through the formal interview process. This is subject to the clinical requirement and WTE vacancy on the receiving ward and requires senior nurse approval. Since the reintroduction, 3 members of staff have utilised this process.

3.3.3. **Increased Trust Induction Sessions:** Overall Trust Induction sessions were increased by 253% as 46 HCSW's went through induction in Q1 22/23 against 13 in Q4 21/22. No delays have been experienced in staff commencing in post as a result. This is overseen by Head of Clinical Education, Workforce Improvement Lead for HCSW's and the post in HR funded from the National Programme.

3.3.4. **Staff Stories:** These are examples of staff who have developed their careers through pathways available in the Trust, e.g. Those who have completed apprenticeships, Trainee Nurse Associates (TNA's) and more recently a HCSW who works within the Clinical Education Team to buddy other new HCSW's**.**

3.3.5. **International Recruitment:** 30 more nurses from overseas will be in HCSW posts by December 2022 which will take our total cohort of international nurses to 122. WHH continue to work with C&M Recruitment Teams to ensure overseas nursing supply. We have a designated practice educator, supported by the Trust Temporary Workforce Lead. Support remains in place to ensure that at the end of their contracts, those nurses make WHHH their choice of employer.

3.3.6. **Over recruitment to ensure supply of HCSW's:** When WHH have reached a 10% vacancy rate, a plan will be worked up through the Care Groups and supported by the Finance Department to maintain a supply of HCSW's by over recruiting to address the deficit, this is due to the high turnover rate which equates to approximately 7/8 HCSW's leaving monthly.

3.3.7. **HCSW development with NHSP:** A continuous programme is in place to recruit HCSW's through the nurse bank NHS Professionals (NHSP), they work for 6 months on the bank during which time they complete the Care Certificate, they are allocated to an area and stay there until their 6-month programme has finished. Of the 18 candidates that have or are currently going through the training since December 2021, 12 are interested in a post or have secured a post, returning a 66% success rate.

3.3.8. **Recruitment of 3rd Year Students:** This process is in place, and 3 offers have been made to 3rd year students posts to commence in September 2022. A plan to make offers to students earlier in their training is underway and an associated campaign named the 'The Golden Ticket' will be developed for the next cohort of students (in their 2nd year) starting at the Trust in October 2022. This programme supports students being offered (subject to interview and associated recruitment requirements) a substantive post earlier on in their training pathway.

3.3.9. **Buddy programme for newly qualified Registered nurses (pilot):** It is proposed to implement a buddy scheme, potentially to be referred to as a CHUMs scheme to personalise it to the Cheshire and Merseyside region (Appendix 2). WHH will pilot this scheme in Autumn 2022.

3.3.10. **Close working with CH&M Higher Education Institutions (HEI's):** Increase student capacity to benefit from the recent significant surge in interest in nursing training courses, as part of the expansion plan, we have increased our student placement capacity by 17.5% with a plan in place to increase further working closely with CH& M HEI's

3.3.11. **Nursing Associates: A recurrent process of supporting 8 HCSW staff to develop their skills into Nursing Associates is in place annually:** The next Registered Nursing Associate apprenticeship programme is due to commence in March 2023. WHH will be starting information sessions for staff in August 2022, with the recruitment process due to commenced in September 2022 for the 8 places that the Trust will be advertising for. To date 34 have commenced their Nursing Associate Programme at WHH.

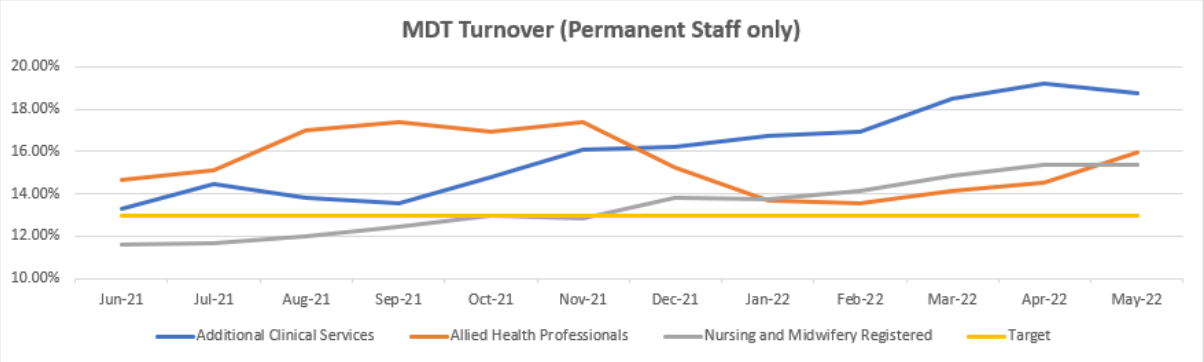
3.3.12. **Professional Nurse Advocates PNA:** The PNA model focussed on supporting the wellbeing of nurses through restorative supervision and psychological support to improve their capacity to cope, especially in managing difficult and stressful situation. WHH are supporting 16 staff who have either completed their PNA training or are in the programme. The aspiration is to have 1 PNA per 20 nurses as outlined by CNO Ruth May in Spring 2021.

3.3.13. **Specialist Areas Recruitment:** Theatres, Maternity, ED and Therapy Teams regularly hold recruitment events for their departments, supported by the Trust Workforce Lead as part of recruitment planning programme. The Maternity Senior Team held an offer holder's day on 6th July where all prospective new starters, mainly student midwives starting in September/October 2022 were welcomed to meet the team. The team are also pursuing international recruitment with a trajectory to fill posts by the Autumn. The Senior Theatre Team utilise apprenticeship roles to support their recruitment, in addition to the more traditional appointments to fill like for like.

3.3.14. **Strategy Documents:** The Cheshire and Mersey Nursing, Midwifery and AHP Strategy outlines the framework for quality care delivery across Cheshire and Mersey with a continuous thread of supportive measures for staff. The WHH Nursing Midwifery Strategy 2022-2025 mirrors this and workstreams are underway to achieve the objectives keeping in mind the development and supportive opportunities for staff at the Trust. A HCSW Strategy is in development recognising the need to demonstrate the opportunities at WHH for that staff group for career progression, a draft of the Strategy will be complete in September 2022. A Trust Workforce Plan is being developed through engagement with the Care Group Leads and Heads of Service, this will build on our existing plans in place to produce a responsive recruitment and retention strategy for WHH. The plan will be completed by October 2022.

3.4. Staff Turnover:

Fig 5. Registered Nurse and Midwifery, Health Care Support Workers and AHP Turnover.



3.4.1. The table above illustrates an increase in nursing and midwifery turnover from 12.23% in November 2021 to 14.74% in May 2022 and 14.95% in June 2022, against a national average of 13.6%, and Trust target of 13%. The additional clinical services data includes HCSW's as one of a group of staff captured this way, which when analysed as a single group shows a turnover rate of 21.35%.

3.4.2. The main reasons staff cite for leaving the Trust is captured as an overall reason within the Trust Workforce Dashboard. The dashboard will be including, from July 2022, the exit interview data which will provide richer information to support our retention planning, the main headings from highest number to lowest for leaving over the last 12 months available now are:

- Voluntary resignation (unknown), this reason is cited for the greatest number of leavers
- Voluntary resignation (work life balance)

- Retirement age
- Flexible retirement

3.4.3. Monthly progress updates on care group workforce positions including leaver data are now provided to the Trust Workforce Revie Group chaired by the Deputy Chief Nurse. Work is underway to gain more insight into the 'unknown' reasons on the workforce dashboard. The high-level briefing papers will pull out the exit interview trends so we can both locally and Trust wide address any emerging themes.

3.4.4. The HCA specific leaver data is monitored and reported to NHSEI on a weekly basis. The themes for leaver reasons from this data are:

- Flexible retirement
- Work/Life balance

3.4.5. The recruitment and retention work highlighted in section 3.3 has targeted areas to reduce attrition of HCSW's. In addition, WHH offer felxible working, fixed shift patterns and annualised hours where possible to support the work life balance of staff.

Fig.6 Sickness Absence

Month	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
N&M Registered	7.87%	7.89%	9.06%	10.61%	7.98%	8.56%	9.08%	7.38%	7.88%
Band 2 HCA	12.93%	13.71%	14.10%	12.56%	9.93%	11.58%	12.36%	9.39%	8.52%

3.4.6. Sickness absence levels for registered nurses and HCSW's has been consistently above the Trust target of 4.2% throughout the last 9 months as demonstrated above, which impacts on the overall staffing available in the Trust.

3.4.7. The increase in overall sickness has been related to increased community covid cases with chest and respiratory sickness issues accounting for 26.43% of the overall sickness reasons over the last 6 months. The Trust supporting attendance policy is being utilised to provide guidance in managing staff absence with a focus on wellbeing.

3.4.8. Any shortfalls in staffing are reviewed and managed twice daily at the operational staffing meetings chaired by a Lead Nurse to ensure all wards and departments have sufficient staff to meet the acuity and activity needs of the wards. The estimated cost of sickness absence for nurses is reported bi-monthly in the Safe Staffing Board Report.

4. SAFER NURSING CARE TOOL DATA COLLECTION

4.1. The Safer Nursing Care Tool (SNCT):

4.1.1 In line with NQB recommendations, the Safer Nursing Care Tool (SNCT) was developed to ensure the right staff, with the right skills are in place to support safe patient care. Originally developed by The Shelford Group and utilised for adult inpatient wards, it has recently been adapted nationally for the assessment of patients in the Emergency Department (ED). Recommended to be undertaken twice yearly, the first of these data collections was completed in June 2022 for both ED and adult inpatient areas.

4.1.2 Prior to the commencement of the data collection, 5 senior nurses from the Emergency Department Team completed the associated training to enable them to use the ED tool and 24 senior nurses from across several specialities, to use the adult inpatient tool.

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

4.1.4 All wards have completed a 20-day data collection during June 2022. ED data collection was over a 12-day period, twice daily moving the time each day forward by one hour to ensure a 24-hour data collection was incorporated within the 12-day audit.

4.1.5 The twice daily data collection is then entered into to the SNCT calculator which indicates the number of staff required for patient care based on acuity and dependency. This process will be repeated in November 2022, and the two sets of data will then support workforce plans and review of establishments to ensure they meet patient and service needs.

4.1.6 The table below demonstrates the staff required calculated from the June 2022 SNCT data collection against those already within the budgeted establishment.

Fig.7 SafeCare Required WTE Nurses vs Nurses in Post

SafeCare Required WTE Nurses vs Nurses in Post*					
Ward	**SafeCare Required WTE**	**Budgeted Nursing Staff WTE**	**+/- Budget**	**Nursing Staff in Post WTE**	**+/- in-post**
AMU	42.5	59.66	17.16	49.02	6.52
A2	41.7	38.17	-3.53	33.65	-8.05
A4	47.9	40.89	-7.01	36.49	-11.41
A5 G	27.9	29.16	1.26	28.43	0.53
A5 E	18.5	22.29	3.79	20.08	1.58
A6	52	49.77	-2.23	39.67	-12.33
A7	48.6	43.46	-5.14	32.62	-15.98
A8	51.6	43.46	-8.14	41.54	-10.06
A9	56.2	43.46	-12.74	43.18	-13.02
B3	52.9	0	-52.9	17.22*	-35.68
B12 FMN	35.6	48.12	12.52	39.85	4.25
B14	40.4	36.48	-3.92	30.71	-9.69
B18	41.9	56.78	14.88	41.79	-0.11
B19	33.2	38.14	4.94	25.72	-7.48
C20	16.8	18.15	1.35	16.06	-0.74
ACCU	40.6	48.71	8.11	44.61	4.01
C21	42.1	38.31	-3.79	30.81	-11.29
K25	29.3	27.5	-1.8	15.63	-13.67
Total	**719.7**	**682.51**	**-37.19**	**587.08**	**-132.62**

**These are staff that are working on B3 but not within a funded establishment.*

4.1.7 The above data does not include ITU who align to the Guidelines for the Provision of Intensive Care Services (GPICS) staffing recommendations, and ED, who for the first time this year are included in the census with a data collection tool designed specifically for Emergency departments, see fig 8. The table also does not include CSTM who were unable to complete the data collection within the timeframe, due to tight timeframes and planned ward closures. The CSTM team have planned a data collection to start in August 2022, this will be calculated and added to the table above.

4.2. Analysis and Next Steps

4.2.1 There are some areas above with significant differences between SNCT indicative data and funded establishment. A professional judgement review of their establishment will be undertaken and presented to the Trust Workforce Review Group meeting and reported into the bi-monthly Trust Board Staffing Paper.

4.2.2 A7, A8, A9 have seen an increase in the number of enhanced care patients and those with no right to reside, the dependency of these patients has impacted on the delivery of safe care and is reflected within the SNCT indicative data, a further professional judgment review is being undertaken looking at the enhanced care requirements for patients on these wards as part of a safe staffing review for those areas.

4.2.3 The budgeted nursing staff for A1 shows a positive position however throughout the day responsive staffing planning is in line with NICE guidance and 1:8 staffing ratios, this area has a high turnover of patients which SNCT data collection may not capture through the twice daily census, acute patients are moved through the ward quickly due to the nature of assessment areas.

4.2.4 A piece of work is underway on A6 looking at the dependency of their patients, who in many cases align to patients on B12 and their associated needs however have an added complexity of surgery. This will be reported through the Trust Workforce Review Group and bi- monthly Trust Board Staffing Paper.

4.2.5 Ward B3 shows the largest variance which is to be expected of an unfunded ward.

4.2.6 The results of the census show a deficit of 132.62, our current vacancy data for band 5 nurses and band 2 HCSW's shows 142 WTE, the results are comparable with our own data, however SNCT does not differentiate between qualified and unqualified groups of staff and as such it requires a very good understanding of patient groups and nursing requirements, hence the requirement to overlay the SNCT data with professional judgement.

Fig.8 Safer Nursing Care Tool (SNCT) Data for the Emergency Department (ED)

Existing Funded WTE	108.03
Actual Staff in Post	91.75
Super Nummary Staff WTE	29.68
SNCT Indicative WTE	80.61
Results	-3.64

4.3. Analysis and Next Steps

4.3.1 The SNCT data collection tool calculates how many staff are required to look after the number of patients in the department looking at their acuity and dependency levels. One of the limits of this data collection is that ED have 29.68 staff in post and within the department that do not directly look after patients due to their role. For example, the navigator, the co-ordinator, and the ambulance handover nurse are 3 of those roles were the WTE nursing equivalent are not for inclusion within the review. The figures for these are demonstrated above and the results align with the numbers of staff currently within the department. Another limiting factor of SNCT calculations is the impact the department layout has on the number of staff required. The indicative numbers calculated using the data tool are

raw numbers needed for the patients recorded at that time without the complexities of layout and the number of staff required to safely staff several areas within one space taken into consideration.

4.3.2 Professional judgement should also be applied to the results of SNCT, this is fundamental to the ED figures, therefore the data tool whilst a supportive tool to predict staffing requirements across the 24hr period in ED, should not be considered an exact science.

4.3.3 A full review of staffing in ED will be undertaken following the deep dive work undertaken by the Deputy Chief Nurse and presented to QAC in May 2022 which showed delays in care and an increase in harms as a result within the ED. Significant increases in attendances, Increased acuity, dependency, and time spent in the department are all contributory factors This will commence in Autumn 2022. The results will be reported through the bi-monthly Trust Board Staffing Paper

5. EVIDENCE BASED STRATEGIC PLANNING

5.1. SafeCare

5.1.1 The Trust operationally utilises the SafeCare function within the Allocate E-Rostering system to collect acuity and dependency data twice daily for all wards. SafeCare uses the same dependency scoring as the Safer Nursing Care Tool (SNCT). The data is inputted twice daily.

5.1.2 The senior nursing team review the data twice daily to ensure appropriate escalation plans are in place to support staffing decisions to meet the needs of the operational demands so that high quality care can be provided on inpatient wards. Any potential care issues associated with staffing are also recorded here using the Red Flag system. Red flags remain open until resolved during the staffing meetings and reports are sent to Lead Nurses and Matrons on a weekly basis to allow them to review their trends and themes.

5.1.3 A monthly report is also shared with the senior nurses that triangulates staffing incidents, staffing red status, red flags and patient harms. In relation to red flags the table below demonstrates the gradual increase across the last 12 months demonstrating increased potential harms to patients. (Included in appendix 1 report)

Fig. 9: Staff Red Flags Data for 2021/22 – 2022/23

Time Period	Q2 2021/22	Q3 21/22	Q4 21/22	Q1 22/23
No. Red Flags opened	377	810	857	976

5.1.4 The above table demonstrates 158% increase in Red Flags opened by senior nursing teams related to staffing capacity versus demand. This continues to be monitored daily with staff moved across departments to support areas of greater need. Staffing numbers also form part of our serious incident reporting to ensure triangulation of harm in relation to staffing has continued oversight and actions to address.

5.2 Care Hours Per Patient Day (CHHP)

5.2.1 Care Hours per Patient Day (CHPPD) was developed following Lord Carter's review in February 2016, it has been tested and adopted to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatients wards. CHPPD monitoring and tracking can be facilitated alongside E-Rostering systems and supports the daily assessment of

operational staffing requirements. CHPPD are monitored monthly via the Trust IPR and reported via the bi-monthly Trust Board Staffing Paper.

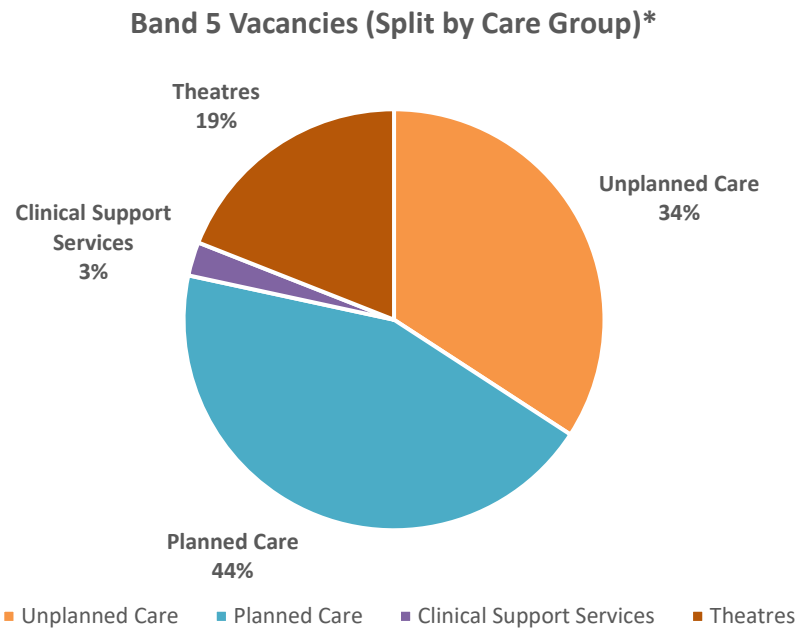
6. MONTHLY STAFFING RETURN

6.1 Nursing and Midwifery staffing data is published daily at entrances to WHH wards along with submission of data on a monthly basis through the Unify system to NHSE, in addition to publication on the Trusts website and reporting to the Board of Directors. A review of the 'ward staffing boards' has been undertaken to ensure that staffing levels are displayed on all ward entrances and to support patient understanding of ward staffing.

6.2 The Trust is required to submit a monthly staffing return as part of the Strategic Data Collection Service (SDCS) detailing planned v's actual staffing fill rates. In line with recommendations from the NQB (2016) the staffing data return is presented to the Board of Directors on a bimonthly basis highlighting areas where fill rates fall below 90%. Although the 90% standard has not been constantly achieved during the daytime there have been mitigating actions taken with senior nurse escalation, and an increase in HCA fill rates to support the ward teams. Matrons and lead nurses support the ward managers with ward risk assessments and staffing plans to ensure safety is maintained.

7.CARE GROUP AND SERVICE WORKFORCE UPDATE POSITION

Fig. 10: Band 5 Vacancies – split by Care Group



*There is a discrepency of 6.62 WTE difference in data due to the variation between PWR data and internally held, as detailed in section 3.2.1

7.1 Unplanned Care Group

7.1.1 The Unplanned Care Group is made up of 3 Clinical Business Units:

- Urgent and Emergency Care (UEC)

- Intergrated Medicine and Community (IM&T)
- Medical Care

7.1.2 Latest data from the Unplanned Care Group at the end of May 2022 show there are a total of 50.72 WTE vacancies across bands 2-5. Across bands 6 and 7 there are 17.28 WTE. UEC have the highest number of vacancies with 9.23 band 5 vacancies, with A9 and B18 having 4.53 WTE and 4.26 WTE band 5 vacancies respectively.

7.1.3 Approval of business cases for wards K25 and C21 has impacted on the amount of registered nurse and HCSW vacancies within the care group over the last 8 months with an increase of 41.87 in total as a result, recruitment has been closely monitored with only 1.95 WTE posts to fill. The recent approval of B19 will add 11.64 WTE to the vacancies moving forward.

7.1.4 Pre-COVID there was a capital bid for the Enhanced Care Unit on AMU, consisting of 3 'pods' (bed areas) which would allow AMU to support patients of higher acuity. The capital funding was approved, without a revenue request, therefore a review of staffing establishment is underway, this is reflected in the SNCT data, the nurse requirement to safely manage patients in the pods is currently unfunded.

7.1.5 ED hold separate recruitment events which have proven sucessful and they have new starters in the recruitment pipeline who will join the department between July 2022 and September.

7.1.6 In the month of May, the Unplanned Care Group had: 8.64 WTE leavers and 2.61 WTE starters. The main reason for leaving was cited to be work/life balance, although there was a high % of reason 'unknown'. Further work to be considered with CBUs to improve data collection. Permanent staff turnover of 15.19%, an increase from April which was 14.82%.

7.2. Planned Care Group

7.2.1 Planned Care Group is made up of 3 Clincal Business Units:

- Digestive Diseases
- Surgical Specialities
- Womens and Childrens

7.2.2 Total band 5 vacancies at the end of June in the Planned Care Group is 39.51. The majority of vacancies within Planned Care Group are within theatres, as highlighted in **fig. 3** with 17 band 5 and 1 WTE band 2 vacancies. The total WTE vacancies for band 2 is 12.19 with 11.19 of those in ward A6.

7.2.3 A focussed piece of work to understand the reasons for such high levels of turnover on that ward The team participate in the International Recruitment Programme and are working with the Trust Workforce Lead to develop retention strategies. Interviews are taking place in month and the team are working on succession planning for the Band 7 leadership team.

7.2.4 The Neonatal Unit are working to recruit into their Band 6 & 7 vacancies (2.0 WTE each). Difficulties in recruitment for this level of NNU nurse are experienced across the network. There is a wider piece of work being carried out, with Director of Midwifery oversight, following a meeting with the North West Neonatal Operational Delivery Network in June 2022. Successful recruitment has been completed in month for 3WTE Band 5 posts with start dates September to November 2022.

7.2.5 As part of the work WHH are doing with NHSE/I to improve Alcohol Services at WHH, we have successfully secured funding to recruit 2 WTE band 6 nurses to the Alcohol Liaison Service. Their posts will be in place for 3 years.

7.2.6 Ward B3 escalation has caused significant staffing pressure for the Care Group in the last 6 months, with heavy reliance on temporary staffing and internal staff moves, particularly across other areas on the Halton site. Ward B4 was escalated as an extension of B3 for medically optimised inpatients from January – May 2022 which caused additional staffing pressure across the Care Group with an increased use of temporary staffing and associated costs demonstrated below in Fig. 11 and 12.

7.2.7 The cost of staffing B3 from October 2021 to June 2022 for 33 escalation beds opened during this time and an additional 12 beds on B4 between the period January – May 2022.

Fig.11: Ward B3 Staffing Costs

Staffing Costs	Grand Total
Unqualified Nurses	**146,931**
Qualified Nurses	**336,577**
Grand Total	**483,508**

Fig. 12: Ward B3 Temporary Staffing Costs

Temporary Staffing	Grand Total
Agency Nursing Qualified	90,906
Bank Nurse: Qualified	212,210
Bank Nurse: Unqualified	208,820
Grand Total	**511,936**

7.2.8 In May 2022 there were 9.88 WTE leavers and 4.71 WTE starters within Planned Care Group, like Unplanned Care and a theme across the Trust, 'unknown' is cited for most leavers, with work life balance as the next reason recorded. The turnover for Planned Care was 15.5% in May 2022.

7.3 Maternity Services

7.3.1 The recommended ratio of midwives to women in a maternity service nationally is one midwife per every 28 women (Safer Childbirth, RCOG 2007) and notes that this number should flex dependant on acuity.

7.3.2 A full maternity workforce planning review using the nationally recognised Birth-rate Plus® workforce planning tool was completed in March 2022. This full review follows the desktop review and audit submission undertaken as part of the Ockenden work programme. Birth-rate Plus considers clinical complexity, the number of births, the location of birth and the number of women cared for by Warrington and Halton Teaching Hospitals staff as well as those women who receive care from other providers but who choose to give birth at Warrington and Halton Teaching Hospitals. An additional percentage is added for specialist roles and managers within the service.

7.3.3 Based on 2020/21 activity, a 23% uplift the clinical total recommended for Warrington & Halton Teaching Hospitals NHS Foundation Trust is 106.09 WTE, of this 95.48 WTE could be Registered Midwives bands 5 -7 and 10.61 WTE MSWs providing postnatal care (on the ward/community) if a 90/10% skill mix is applied. The calculated total workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust is 116.70 WTE, which includes an additional 10% for non-clinical roles. The comparative current funded establishment is 122.22 WTE which means that whilst there is a positive variance of 5.52 WTE registered midwives this will help to sustain the high achievement of the current rostered model for Continuity of Carer.

7.3.4 The overall ratio for Warrington & Halton Teaching Hospitals NHS Foundation Trust of 24.6 births to WTE in line with NICE guidelines.

7.3.5 Sickness rates for Maternity Services were 10.27% for May 2022.

7.4 Clinical Support Services Update

7.4.1 Across Clinical Support Services Care Group there are 9.92 WTE vacancies across all bands, of these 5.4 WTE are currently at various stages of the recruitment pipeline, with plans for the remaining posts to be filled by October 2022. The Care Group supply a high-level briefing paper into the Trust Workforce Review Group to provide assurance of recruitment planning and share learning. A focus for improvement has been highlighted in relation to retention, exit interview data shows work life balance as the main reason for leaving, closely followed by retirement and flexible retirement for this team as highlighted across the Trust.

7.4.2 Sickness recorded for OPD nurses is 14.94% for June 2022, turnover is 23.41%. This is a small team therefore the percentages are bigger; however, the impact is great and improvements with turnover rates are an objective for the Care Group, monitored through the Trust Workforce Review Group.

7.5 Allied Health Professional (AHP) Update

7.5.1 Therapies workforce consists of 5 allied health professions, nurses, and clinical support workers. The data presents the 5 qualified professions and clinical support workers.

7.5.2 There is a WTE vacancy of 30.65, the biggest number in the occupational therapist and physiotherapist staff groups 15.03 and 12.62 WTE, respectively. A turnover rate of 15.61% is noted for May 2022 with 10.74 leavers and 4.01 starters to the Trust. Recruiting into band 6 vacancies remains a challenge for both physiotherapy and occupational therapy (OT). Therapies continue to embed a grow your own approach as apprenticeships develop for physiotherapists, OTs, speech and language therapists and dietitians.

7.5.3 Therapy leads link in with the Trust Workforce Lead to ensure joint working across recruitment is in place, focussed recruitment and retention planning for Therapy Services for both occupational and physiotherapists, forms part of their Strategy and recent successful approval of a business case has supported the Teams to recruit from oversees to address some staffing gaps.

7.5.4 A review of the leavers data shows most leavers and starters were amongst the qualified staff group. Exit interviews have been introduced to capture themes to support the retention of staff. Band 5 support forums for all professions have been reintroduced, this is addition to the preceptorship programme. Therapy students continue to be given the opportunity to join the therapy bank as potential WHH staff when HCPC registered.

7.5.5 Therapy sickness has reduced at 4.38% which is an improving picture.

8. WORKFORCE DEVELOPMENT

8.1. Health Care Support Worker Buddy Programme

8.1.1 Utilising NHSE/I funding, WHH has piloted a HCSW Buddy Programme to support newly recruited health care support workers commencing posts in the Trust from May 2022. The HCSW buddy role has been supported by staff seconded to the Clinical Education Team for a fixed term period and HCSW's from the nurse bank who offered 1-2 shifts per week.

8.1.2 A role descriptor was provided for each HCSW buddy, and a training day provided. The HCA buddies were allocated to work with some of the Trust's new HCSW's during their first two weeks in post. The buddies have:

- Promoted the importance of supporting new HCSW's in post with all members of the ward team.

- Advocated on behalf of new starters, empowering them to raise their queries and concerns in a timely way.
- Supported new HCSW's to complete competency documents.
- Engaged new starters in career conversations about next steps in nursing career e.g., Level 3 apprenticeships and TNA programme.
- Feedback in relation to the role is positive, quantitative data to support this is currently being collated.

8.2. CPD Funding 2022/23

8.2.1. On the 21 June 2022, WHH received confirmation from Health Education England (HEE) of this year's Continuing Professional Development Funding for nursing associates, nurses, midwives, and allied health professionals (AHPs).

8.2.2. The CPD allocation for 22/23 is: £470,666. This is the third year of the three-year period (2020/21 – 2022/23) and allocations are calculated on workforce headcount data (Dec 2020). This funding aims to support the NHS, and support building skills and expertise of our workforce vital to services and communities. In line with the policy that employees have access to the £1,000 funding over three years, organisations will be required to ensure in their practical and financial planning that access to the funding is equitable for all eligible staff.

8.2.3. The training needs analysis, which will contribute to the submission of the Trust's 22/23 CPD investment plans, has been finalised and will be submitted to HEE by 31st July 2022.

8.2.4. The funding is an investment solely for CPD and cannot be used for funding backfill, mandatory training or to support apprenticeship/advancing practice programmes.

8.3. Non-Medical Prescribing Funding

8.3.1. WHH submitted a request to HEE for £19, 330 to support the development of new non-medical prescribers. Our 2022/23 allocated funding is £18930 to support 12 places.

8.4. Advancing Clinical Practice

8.4.1. WHH submitted a request to HEE for salary replacement support for 22 trainee advanced practitioners. All places have been approved by HEE. The following areas have submitted requests:

- Frailty (Rapid Response Therapy Team) x1
- Respiratory Physiotherapy x1
- Therapy orthopaedics x1
- MSK (Clinical Assessment and Triage Service) x1
- Therapy Orthopaedic inpatient and out-patient orthopaedic service x1
- Medical Care x17 (across cardiology, acute medicine, geriatrics, respiratory, diabetes & endocrinology)

8.4.2. The onboarding and monitoring of these trainee staff is overseen by the Deputy Chief Nurse and monitored through the Trust Workforce Review Group

9. OVERALL SUMMARY

9.1 As highlighted at the beginning of this report, the current demands on the system and the post COVID-19 effect have impacted on staff groups both nationally and locally. Despite this ongoing issue, WHH has more staff in post than 12 months ago, however an increasing trend of registered nurse vacancies is seen across Q4 2021/22 and Q3 22/23, noted to be normal variation from a workforce perspective, a continued focus on recruitment and retention is in place. The report demonstrates that our budgeted nurse staffing WTE is comparable to the safe care census data requirements although showing a minus 132.62 WTE, this result will be used as a comparison against the next data collection in November 2022. We have successful involvement in Cheshire and Merseyside workstreams for both HCSW's and International Nurse recruitment. The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing.

10. RECOMMENDATIONS

10.1 It is recommended that the Trust Board members recieve and note the progress to date and the contents of the report.

APPENDIX 1: Safe Staffing and Review of the Harm Profile 2021-2022

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Staffing levels and the Impact on Harm 2021-2022

An increase in falls with harm, pressure ulcers and serious incidents reported in the Emergency Department has triggered a review of staffing levels and their relationship to harm for 2021-2022

Over 2021-22:

- **Falls with harm increased by 75% (14 in 2021-2022, 8 recorded 2020-2021)**
- **10 # NOF**
- **Pressure ulcers increased by 10.8% (92 in 2021-2022, 83 recorded in 2020-2021)**
- **135% Increase in moderate harm in Emergency Department (33 reported in 2021-22, 14 reported in 2020-2021)**
- **Between 35-53 escalation beds opened at any one time**
- **Increased 12 hour breached in ED**
- **Increased patients with no right to reside**

Staffing levels and the Impact on Harm 2021-2022

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- RED Flag system to escalate concerns
- RAG status in place to record level of staffing
- In accordance with the Safer Nursing Care Tool (SNCT) a twice daily acuity and dependency review is completed on each in patient area, a red flag is raised when staffing levels are not met in line with the needs of the patients. The red flags may be closed down or remain open and monitored by senior nursing teams depending on whether the issue can be fully resolved.
- RAG status is recorded on the Staffing Gold Command daily with plans made to mitigate any red status reported

Red flags, red RAG status for staffing levels and total absence per quarter 2021-2022

Quarter	Q1			Q2			Q3			Q4		
Red Flags opened	203			377			810			857		
Red Flags unresolved	106			175			513			547		
Red RAG status	874			741			1093			1290		
Sickness/absence total with COVID-19 isolation	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
RN/Midwife	6.62%	6.54%	6.03%	7.75%	6.55%	7.24%	7.81%	7.83%	8.98%	10.50%	7.78%	8.36%
HCA	9.5%	10.18%	10.50%	10.91%	10.50%	10.06%	12.72%	13.58%	13.79%	12.56%	9.76%	11.38%

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Staffing levels and the Impact on Harm 2021-2022

- Moderate and severe harm and total falls and all pressure ulcers per quarter 2021-202
- *10 of the recorded falls have resulted in hip fractures 2 reported on A7 a ward that has the second highest number of red RAG status reports for 21-22
- The highest reporter of falls is ward A1 who recorded 163 occasions of red RAG staffing status, positioned at 11th highest reporter out of 35 for red RAG status, in addition, A1 regularly send staff to support the Emergency Department
- C21 are a high reporter of falls- staffing establishment on this ward has been reviewed and business case passed with recruitment ongoing
- Highest reporting category for falls 2021-2022 is found on floor which means no witness to the fall, lower staff ratios will contribute to this reporting category

Quarter	Q1	Q2	Q3	Q4
Falls with harm*	3	2	4	8
Total falls	125	147	144	175
Pressure Ulcers	16	21	23	27

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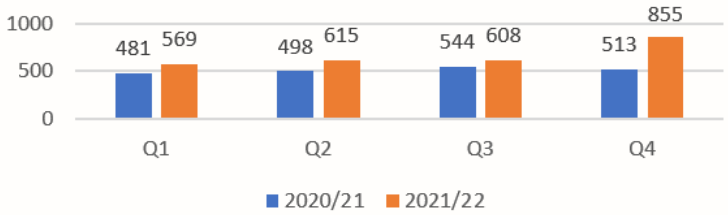
Staffing levels and the Impact on Harm 2021-2022

- Emergency Department Datix reporting has increased by 30% in 2021-2022



	Q1	Q2	Q3	Q4
2021-22	5	8	4	16
2020-21	0	5	3	6

Moderate harms and above have increased by 135% in 2021-22

Themes highlighted are:

- Delays in treatment
- Lack of assessment for sepsis
- NEWS2 policy not followed
- Communication
- Training

Rag status for ED checked against all serious incidents some ambers reported and 1 red, (Q4) number of occasions demonstrate NHSP staff from the pool to provide baseline staffing numbers

Staffing levels and the Impact on Harm 2021-2022

The graphs demonstrate the increasing demand on the Trust in relation to the timely flow of patients through the system. This has an overcrowding impact on the Emergency Department which in turn increases risk to patient safety. The nurse staffing numbers in ED do not account for the significant increase in numbers in the department for lengthy periods therefore the request for extra staff is consistent.

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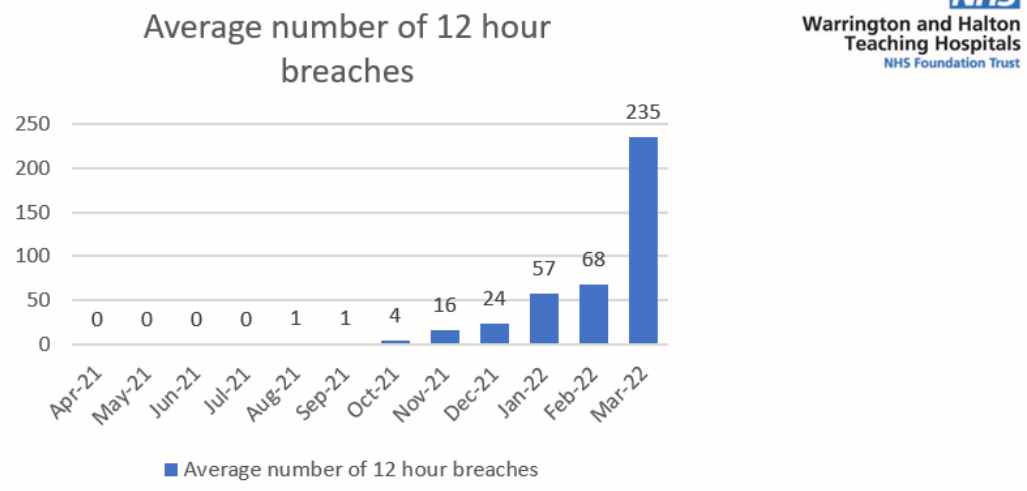

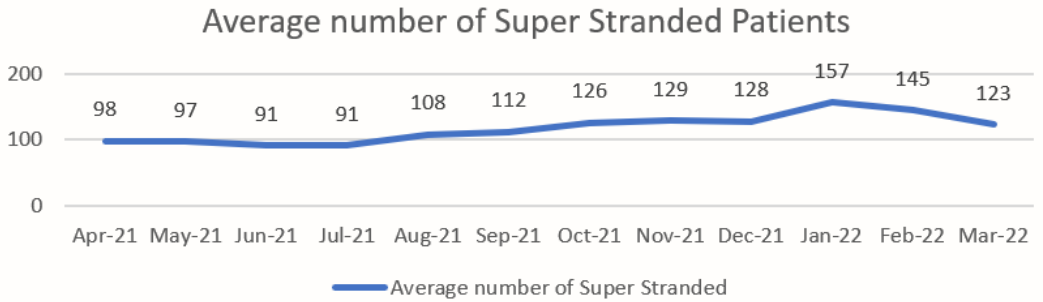

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Staffing levels and the Impact on Harm 2021-2022

Analysis

- Unresolved red flags increased across the reporting period with 63% of red flags unresolved in Q3 and Q4- which is when the highest concentration of harms have occurred
- B4 recorded the 3rd highest red RAG status – during the reporting period they have changed their function from planned elective to escalated area, staff on B4 support B3 (unfunded ward with no staffing establishment)
- ITU have the highest incidence of pressure ulcers for 21-22 (12) with their highest concentration between May 2021 and February 2022, with 75% (8) of the pressure ulcers occurring during the months ITU recorded their highest number of red RAG status
- A7 reported the second highest incidence of hospital acquired pressure ulcers across the year (11), a review of staffing rag status demonstrates A7 reported red RAG status for staffing on 378 occasions being the second highest reporter of red RAG status for 21-22
- Ward A6 are the 3rd highest reporter of hospital acquired category 2 pressure ulcers have also had a category 3 pressure ulcer SI. There was no ward manager on A6 for 5 months, due to sickness and eventual retirement, which impacted on staffing levels and leadership. Matron provided support during this time

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Staffing levels and the Impact on Harm 2021-2022

Contributory factors:

- The opening of escalation beds has an impact on the ability to safely staff clinical areas. During 21-22 between 35-53 extra beds have been opened across both sites at any one time.
- Significant absence due to Omicron COVID-19 variant in Q3/4
- Staff tiredness therefore lack of pick up of extra shifts
- B3 is an unfunded ward with no staffing establishment, take staff from established areas leaving gaps
- Increased attendances into the Emergency Department
- Rising numbers of patients with no right to reside

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Staffing levels and the Impact on Harm 2021-2022

Mitigation

- Senior nurse oversight at staffing meetings twice daily with messaging communication throughout the day to monitor staffing levels
- Out of hours matron rota in place to provide senior presence on site
- Minimum staffing levels set during COVID-19 extremis in line with CH&M
- Incentive schemes to ensure fill during seasonal holidays
- Utilise non ward based nurses and AHP's in response to Emergency Department overcrowding
- Recruitment and retention programme in place for both domestic and overseas staff with close monitoring of progress through recruitment pipeline
- Part of CH&M Health Care Assistant recruitment programme
- Strong links with HEI's with plans to increase student capacity further
- Close working with NHSP with robust processes for requesting and following up DNA's
- Trainee Nurse Associate programme in place
- Development opportunities for all bands

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WHH utilise a red flag system to escalate concerns with staffing levels and record the staffing RAG status on the Gold Command template which is used to inform the day's staffing plans

This presentation will detail the red RAG status, red flags raised and staffing absences and analyse the correlation to harm for 2021-2022. Other contributory factors, mitigation and next steps are included

APPENDIX 2: Cheshire and Merseyside Nursing, Midwifery and AHP Workforce Development (CHUMs)

Cheshire and Merseyside Nursing, Midwifery and AHP Workforce Development

A position paper and plan to introduce a Cheshire and Merseyside Nursing, Midwifery and Allied Health Professional Buddy Scheme ("CHUMs" Scheme) to support both newly qualified and early career (1 to 5 years) nurses, midwives and AHPs in both the transition into work and to improve retention.

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May 2022

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1.

What is known

It is well-recognised that newly qualified healthcare practitioners experience a reality shock[1-6] or transition shock[7] during the first post-qualification year, a phenomenon that is not limited to the UK. Transition shock commonly occurs in newly graduated nurses[8] and some allied health professionals, particularly occupational therapy[4,9] and radiography[3,6] as they move from the academic to the real-world environment. [10] Individual factors including age, gender, work experience[10] and self-efficacy and work patterns[11, 12] have been identified as key factors to explain transition shock. The area of practice and the work environment correlate significantly with the experiences of transition shock[1, 10] with reports of practitioners having to "hit the floor running" [13] at the start of their careers and acknowledging that it can take six months to one year to feel part of a team. [14] Transition shock creates feelings of negativity, affecting the practitioner both personally and professionally.[15] Such feelings have profound effects on retaining newly qualified graduates in the workforce.

Many studies, representing a global picture, [10, 16, 17] estimate that up to 60% of newly graduated nurses intend to leave their job within the first year. In the UK alone, there are 50,000 nursing (including midwifery) vacancies[18] up from 41,000 in 2018[19] and workforce vacancy figures indicate that 28% of new nurses, are leaving within the first three years[20] , a situation which poses a significant risk to healthcare delivery and patient safety. [10] According to the Royal College of Nursing,[21] over the past year alone (2021-2022), there was a 13 percent increase in nurses leaving the profession, representing the first increase for four years of a decline. Workforce figures show that 1 in 10 (10.3%) of nursing posts in England are lying empty, and more specifically, 8.4% in the northwest.[22] Such figures are a stark reality of one of the biggest workforce challenges confronting healthcare nationally[18] and globally. [23] Figures for the allied health professionals (AHPs) are somewhat more difficult to come by. However, it is recognised that the attrition rate of the radiographers, particularly therapy radiographers, is higher than many other health professions with an estimate of 28% over the five years.[24] More specifically, AHP leaver and turnover rates are increasing at 5.9% and 11.7% respectively as at November 2021[25] suggesting that AHPs are more likely to leave the NHS completely than in previous years. What is particularly disconcerting, is that 17.7% of AHP leavers (i.e. those leaving the NHS completely) leave their first year of employment and 56% between one and five years, with the typical leaver being under 30 years of age.[25] It is anticipated that the COVID-19 pandemic will take its toll on staff retention in the NHS and globally. [26, 27] As at October 2021, the Royal College of Nursing [27] reported that 57% of nurses were considering or planning to leave their job, up from 36% the previous year. The attrition and respective high turnover of staff comes with additional financial burdens associated with recruitment[28], another much unneeded and unwanted consequence.

2.

Findings from a systematic review[18] confirmed that the factors influencing recruitment and retention within nursing are diverse, ranging from professional issues; nursing leadership and management; organisational factors to education and career advancement opportunities. The most frequently cited reasons related to professional issues, in particular work-related stress and low job satisfaction due to burnout, high workloads, pressures, job demands/perceived difficulties and emotional exhaustion. Whilst there is a paucity of literature on retention of allied health professionals, there is some overlap with therapeutic and diagnostic radiographers' decisions to stay or leave the NHS.[29] Poor leadership and management have also been highlighted as detrimental in the retention of nursing staff [18] and in promoting a positive workplace culture[14,30] but within radiography, both the role of managers in moderating burnout and improving retention and addressing mental health are viewed as significant in addressing retention[31 cited by 29], and potential transfer from the NHS to independent providers. A further factor which influences retention of radiographers is that of the provision of continuing professional development and carer progression[32, 29] which is also considered significant by physiotherapists to maintain motivation and commitment to the profession in lower bands.[33]

Appropriate strategies to address the transition of newly qualified practitioners are pivotal to reduce stress, attrition and turnover and, thus improve retention. Improving resilience has been identified as a potential solution for those transitioning from student to newly qualified to enable them to make sense of their experiences of transition and manage stress.[34] Whilst, there is no universal definition of resilience, it stems from the Latin to "spring back" [35] and is defined as the ability to recover quickly from difficulties[36] or to cope well with the changed and adversity in the workplace.[37] An even better outcome from becoming resilient is thriving where individuals emerge from these changes stronger than before.[38] Resilience levels vary between individuals and, as a characteristic, is innate but individuals have the capacity to learn and build resilience skills to increase their resilience capacity and, as such, should be taught. [39] It is recognised that limiting resilience to individuals is not sufficient and that resilience should be rethought to address environmental and organisational culture. [40] There is though, resistance due to the need for corporate co-operation and responsibility[41 cited by 40] and subsequently, the individual will continue to be accountable for succumbing to burnout.

3

What is being done to improve retention?

With this in mind, it is important to find solutions to support the newly qualified practitioners' transition and those in early career (one to five years) and to facilitate their working lives such that they want to stay in their post and in the NHS. Whilst, preceptorship programmes have been implemented widely across the UK and are recognised as being fundamental to the development of a newly qualified healthcare practitioners' journey to become competent and confident[42], there has been a distinct absence of pastoral support.[2] However, the recently published North West Multi-Professional Preceptorship Framework (2021)[43], includes a standard which recognises that time for pastoral support, either as one to one or a group, through guided reflection, clinical supervision or coaching is pivotal in assisting with transition.

On a national basis, NHS England introduced a Generational Programme for 2021 through to March 2022 whose remit was to find solutions to better support healthcare professionals in the early and late stages of their career[44] and the "We are the NHS: People Plan 2020/21" and the "Our People Promise"[45] have a focus to improve the NHS as an organisation by supporting its people. More specifically, the creation of a staff retention guide[46] offers a number of initiatives to promote a culture where people feel valued and supported in their new roles, including encouraging pastoral support.

Local and organisational initiatives to provide support are emerging such as buddy schemes where new recruits are provided with an informal mentor and have been a common feature of the recruitment and induction [47] for many organisations, or personal professional mentor roles in the format of a new pastoral support initiative.[2] The concept of buddy schemes within the NHS is not new [48,49] but there is a paucity of literature (academic and policy) which underpin the concepts of buddying. Typically, buddying schemes provide new starters with practical advice, guidance and experiential knowledge which supports them in their new role. Within a paediatric setting, the introduction of a personal professional mentor (PPM) and the provision of active pastoral support [2] for newly qualified nurses revealed that they benefitted from the support. The PPM acted as an experienced confidant, independent from the newly qualified nurses' practice area and was able to counteract feelings of transition isolation. As such, the PPM role mirrored the role of the personal tutor with pastoral responsibilities within academic environments[50] and could see the added value.

4

What is being proposed for Cheshire and Merseyside?

It is proposed to implement a buddy scheme, potentially to be referred to as a CHUMs scheme to personalise it to the Cheshire and Merseyside region. If Cheshire and Merseyside are to introduce a CHUMY scheme, organisations will need to consider how they can best support and retain experience staff in the CHUMY role.

Having scrutinised buddy schemes already embedded within NHS Trusts, the proposed scheme would need to consider the following:

For whom?	Healthcare practitioners **new to post and to the organisation,** irrespective of profession, role or experience but which might include: ▪ Newly qualified healthcare practitioners and align with commencement of the preceptorship programme. ▪ Early years (1 to 5 years) including those who have joined with some experience.
What is the CHUM scheme?	▪ An established and experienced member of staff is paired with another staff member who may be **new to post** (irrespective of grade or experience) within the Trust or a staff member **who feels isolated** to provide **informal support.** ▪ An opportunity to help a new staff member to understand the **culture of the organisation** and **ask any questions without being judged**. ▪ An opportunity to grab an occasional coffee with someone with whom they can confide. ▪ An opportunity to provide **independent and moral support** away from the individual's workplace environment. ▪ Key aim is to **provide pastoral support** and is an addition to the preceptorship programme. ▪ Has the potential to be **mutually beneficial** for staff members. ▪ A mechanism to foster a friendly happy workplace and help **improve staff retention** and **motivation**.

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	▪ A scheme and relationship that will continue after the completion of the preceptorship programme
Who can be a CHUM?	▪ An established and experienced member of staff who is both cognisant of and loyal to the organisation. ▪ Someone from the same or different professional background from the starter. ▪ Someone who is prepared to **make time** and **has the time** to be a CHUM.
What it is NOT	**Not mandatory.** ▪ Not a replacement for preceptorship. ▪ Not limited to new qualified staff. ▪ Not a replacement for line manager nor a replacement of an appraisal. ▪ Not a replacement for formal or clinical supervision. ▪ Will not interfere with or conflict with any work commitments. ▪ Not for career conversations and coaching. ▪ Structured and inflexible. ▪ Not a contract.
What is expected from organisations?	Acknowledge that this is **a voluntary role** for which renumeration is not available. Identify staff within the organisation who exemplify good practice and loyalty to the organisation. Determine whether governance is needed. **Prepare the CHUMY for their role through the provision of a clear role descriptor which outlines:** ▪ CHUMY's responsibilities; ▪ Attributes needed (ability to listen; openness and commitment; good time management skills; honest and considerate approach; strong communication and encouraging attitude); ▪ Recognition that pairings can be within the same profession or can cross professional boundaries to encourage an inter-professional approach;

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	▪ Provision of a workshop to prepare the CHUMYs for the role, clearly articulating the supporting process and the CHUMY process; ▪ Provision of links to useful resources for CHUMYs including well-being resources; ▪ Identify a central point of contact for day-to-day support with queries; ▪ Clarity regarding whether written notes of the CHUMY meetings should be kept; ▪ Develop a peer support group or restorative supervision for those staff (new starters and others), frequency to be determined; ▪ Provide clear guidance relating to confidentiality within the relationship; ▪ Provide clear guidance on how to escalate issues where there are serious concerns regarding possible malpractice, safeguarding issues, issues affecting the safety of others, or lack of competence which may be identified in CHUMY meetings.
What are the ground rules to be addressed at the start of the relationship?	Whilst the CHUMY scheme and relationship is informal, a number of ground rules should be set including: ▪ Ensure organisational values and behaviours are maintained. ▪ Manage expectations: making it clear of the purpose of the CHUMY scheme and relationship within; ▪ Provide a safe space and non-discriminatory and non-judgemental relationship to ensure that the relationship facilitates a comfortable engagement; ▪ Confirm that confidentiality will be respected but if an issue is raised that causes concern (such as safeguarding or unsafe practice), make it clear that the matter will be escalated.
Establish boundaries	Both parties within the CHUMY relationship should:

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	Agree and feel comfortable with how they will communicate moving forward: for example, whether they want: ▪ Frequency of meetings and length of meetings, for example, four times per year or more, depending on need for support; ▪ Regular and planned meetings or ad hoc; ▪ Meet on Trust premises or off-site or online (such as FaceTime) or just on the telephone; ▪ Recognise that this will depend on work and personal commitments; ▪ Recognise that the relationship may change over time.
Create a positive environment	Ensure that the CHUMY meetings are: ▪ Enjoyable; ▪ Supportive; ▪ Flexible.

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