We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

WHH Board of Directors 25th September 2019 Meeting Part 1

Supplementary Binder & Matters for Approval

Supplementary Information

Matters for Approval

We are WHH

And together we

make a difference

Learning From Experience Q1 Report

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Director of Integrated Governance & Quality

July 2019

Overview

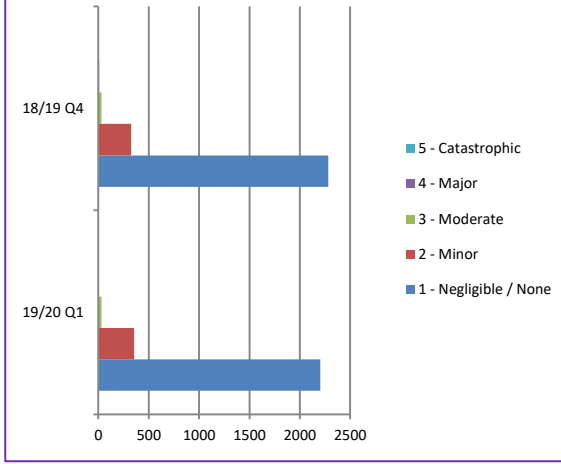
The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 1, 2019/12. They should be viewed in conjunction with the High Level Briefing Report.

Incident Headlines

Warrington and Halton Hospitals NHS
NHS Foundation Trust

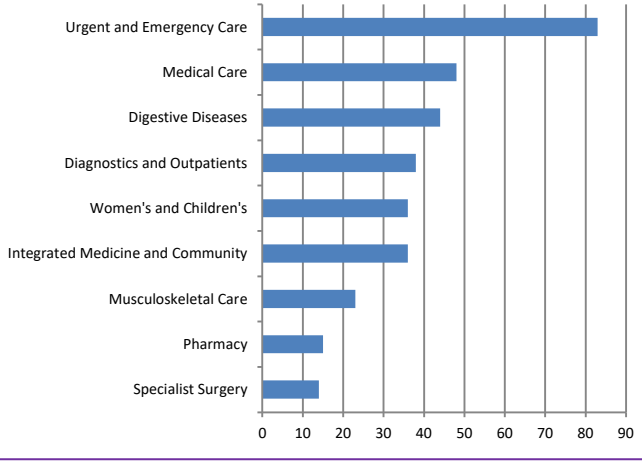
How many staff are raising incidents Q4 vs Q1?

- There was a slight **decrease** in incident reporting within the Trust in Q1 (2651 in Q4 vs 2594 in Q1).
- There was a **decrease** in incidents causing Moderate to Catastrophic harm in Q1 (42 in Q4 vs 36 in Q1).
- The number of minor harm incidents increased slightly in Q1.



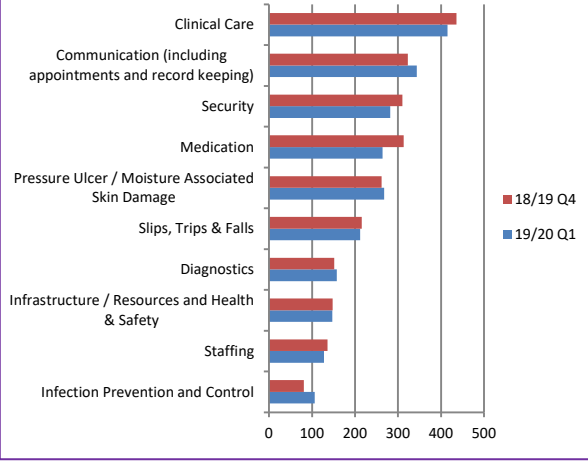
How many incidents are open Q4 vs Q1?

- The Trust reported 216 incidents open in CBUs in the Q4 LFE. To date that has increased to 337. The graph below shows 9 CBUs with open incidents.
- Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that performance improves.
- Work continues in the Trust to monitor open incidents closely and ensure incident reviews are completed efficiently across the organisation.



What type of incidents are we reporting Q4 vs Q1?

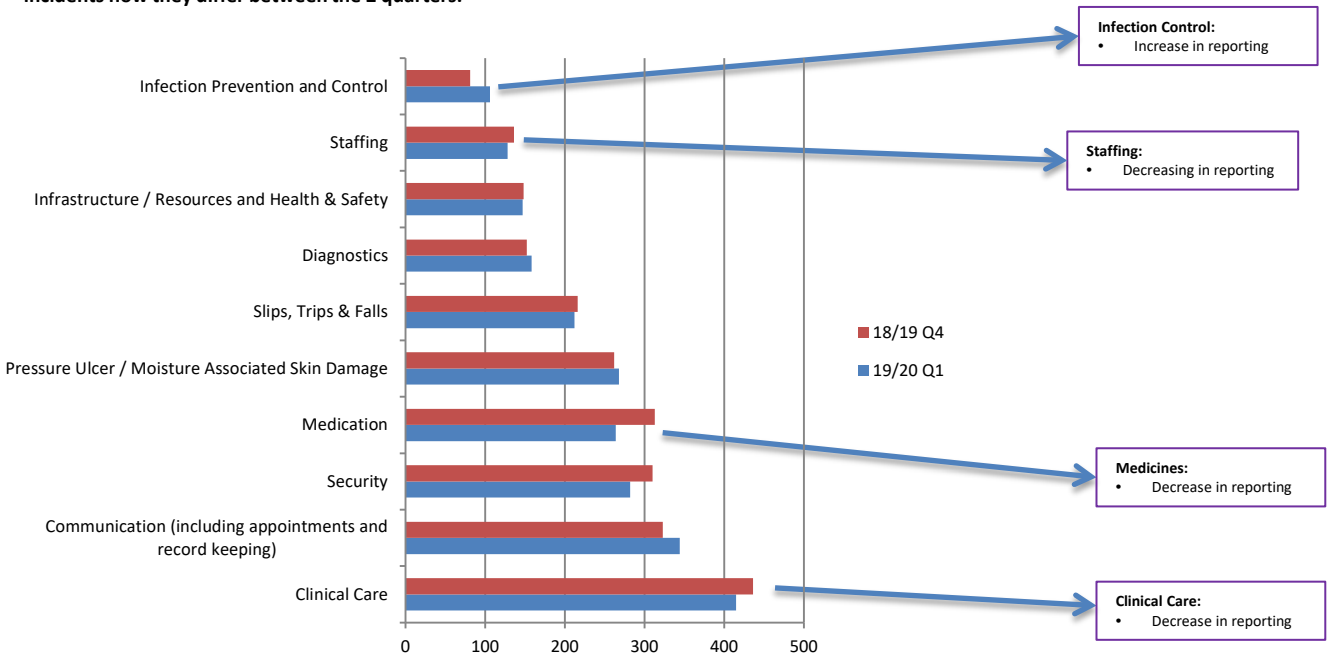
- As stated there was a decrease in the amount of indents reported. Incidents relating to clinical care, medication, falls and staffing decreased in Q4; however, issues relating to pressure ulcers, infection control and diagnostics increased.



Incident Category Analysis Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

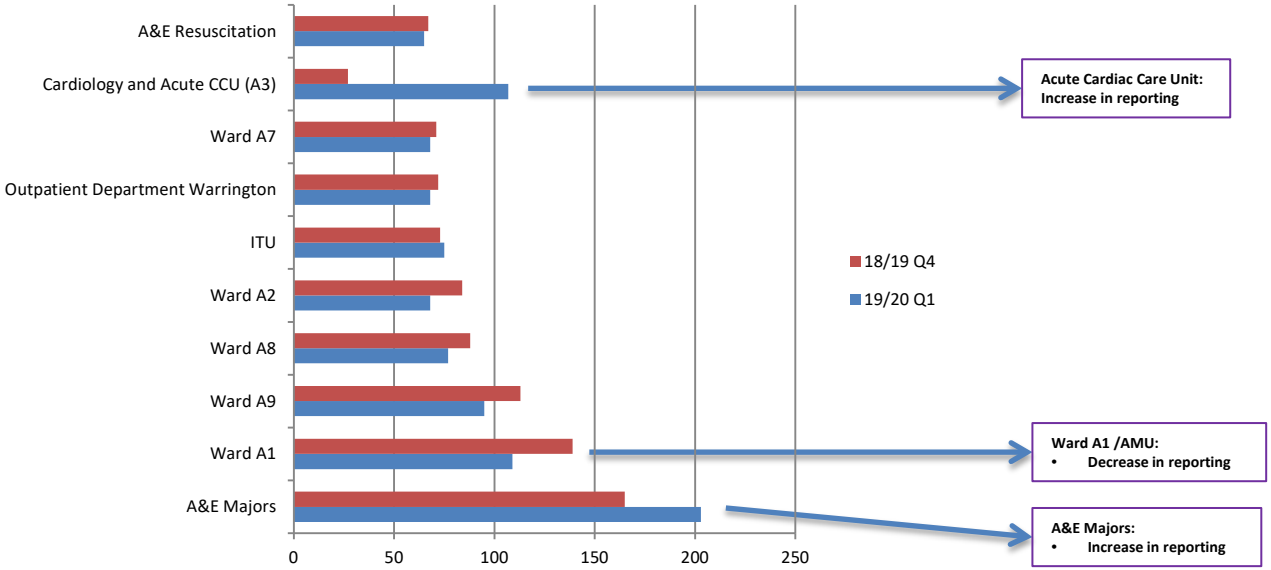
The information shows the top categories reported incidents how they differ between the 2 quarters.



Incident Location Analysis Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

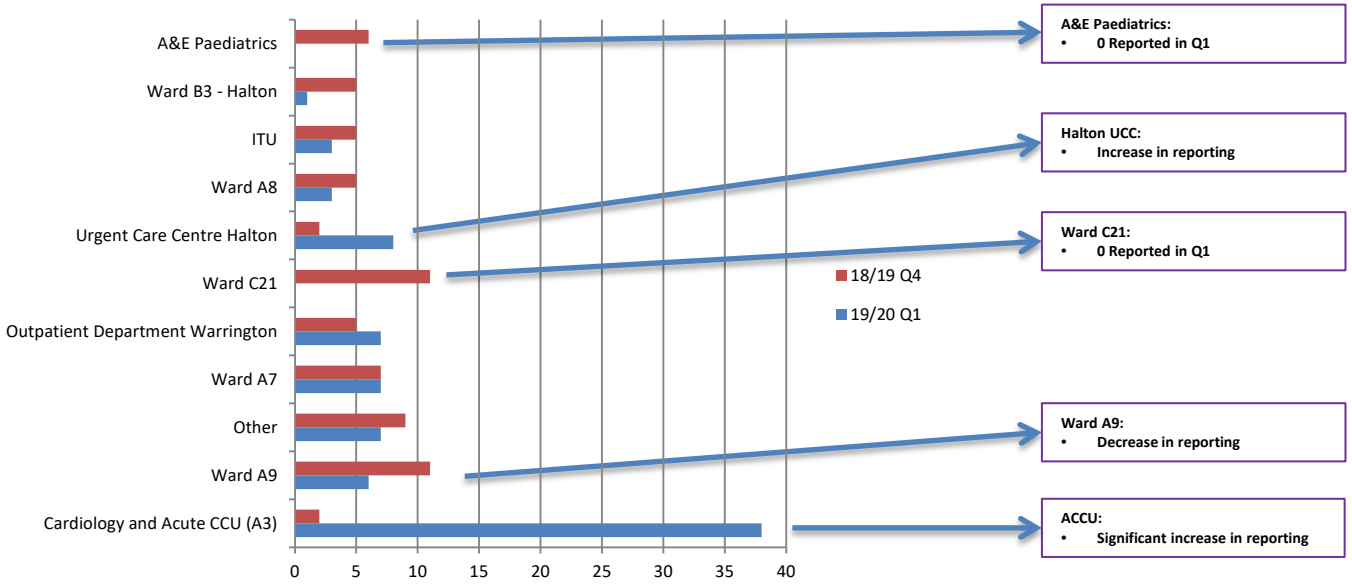
The information shows the top reporting locations and how they differ between the 2 quarters.



Staffing Incidents Location Analysis Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

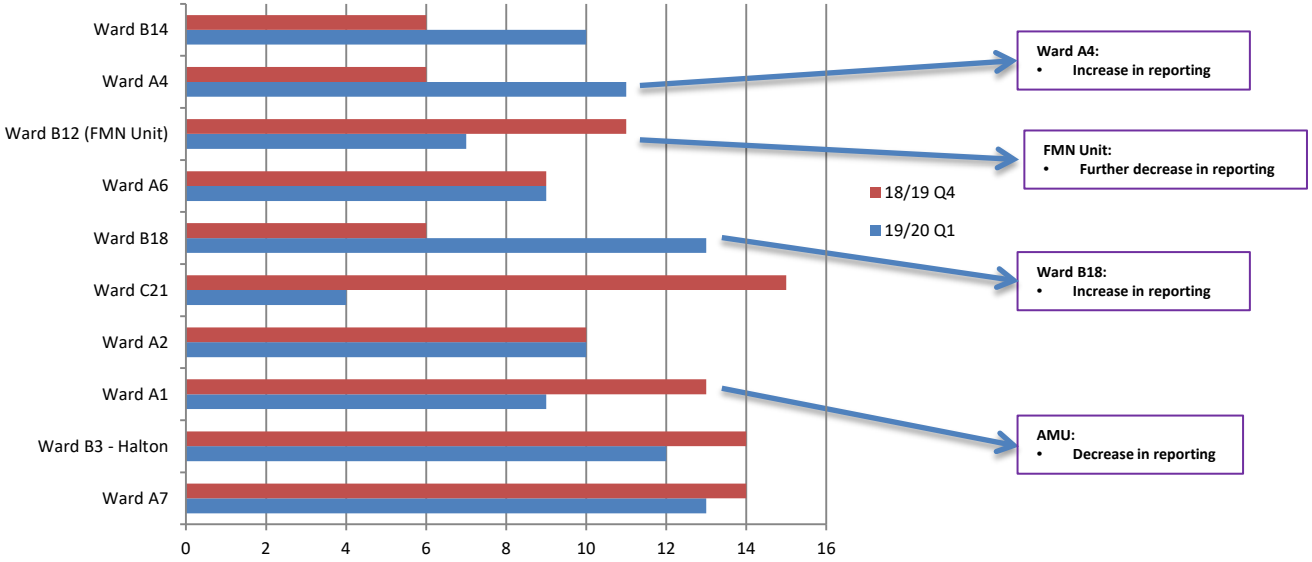
The information shows the top reporting locations in relation to staffing incidents and how they differ between the 2 quarters.



Patient Falls Location Analysis Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

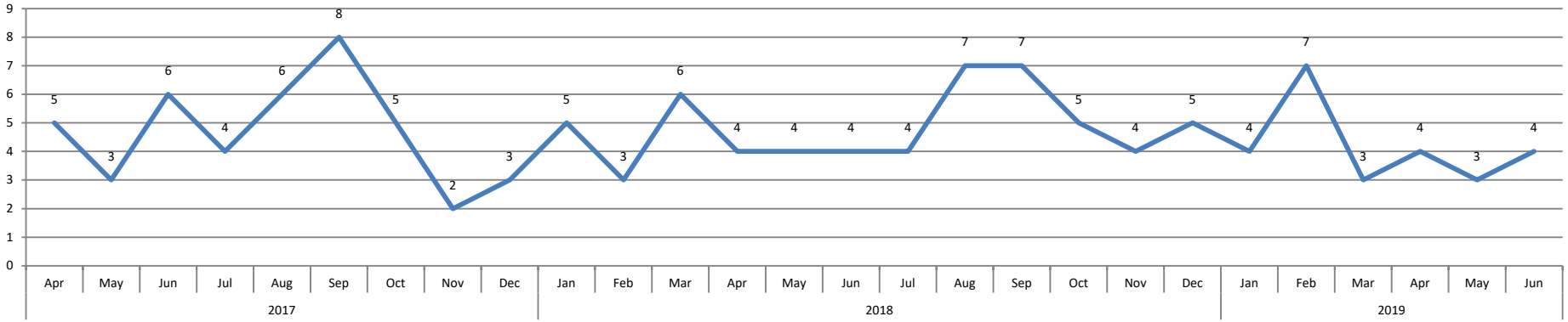
The information shows the top reporting locations in relation to patient falls and how they differ between the 2 quarters.



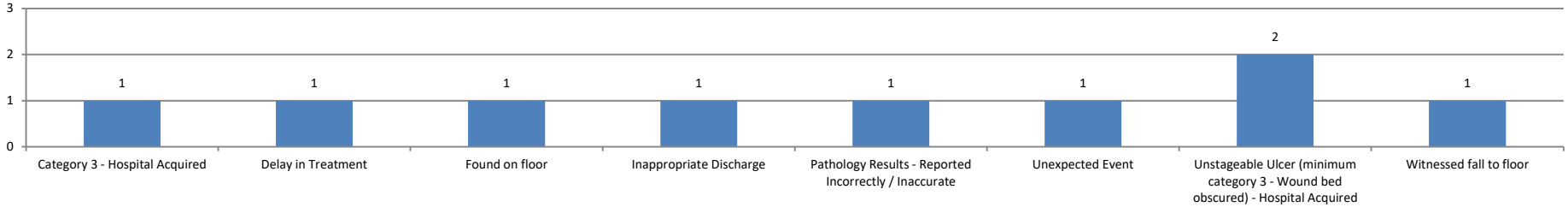
Serious Incident (SI) Reporting

Warrington and Halton Hospitals NHS
NHS Foundation Trust

SIs reported by Month



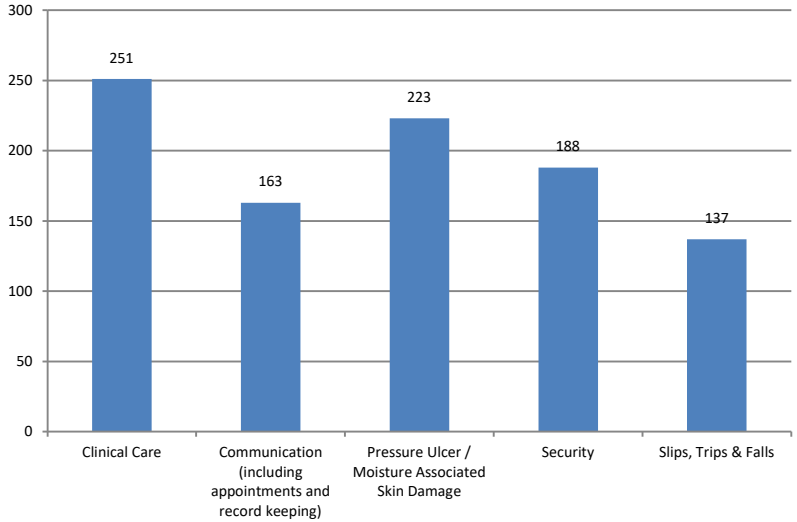
SI Cause Groups Q1

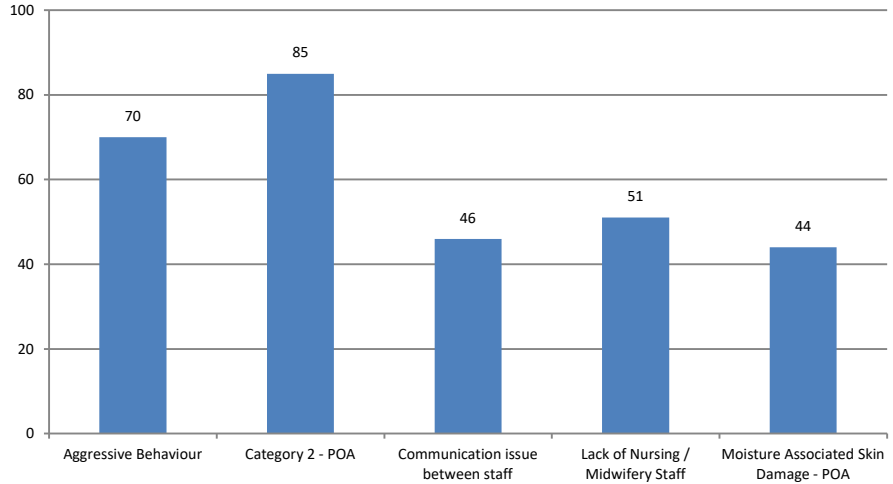


Urgent & Emergency Care, Medical Care, Diagnostics & Outpatients and Integrated Medicine & Community Incidents for Q1 (April to June 2019)

Warrington and Halton Hospitals NHS
NHS Foundation Trust

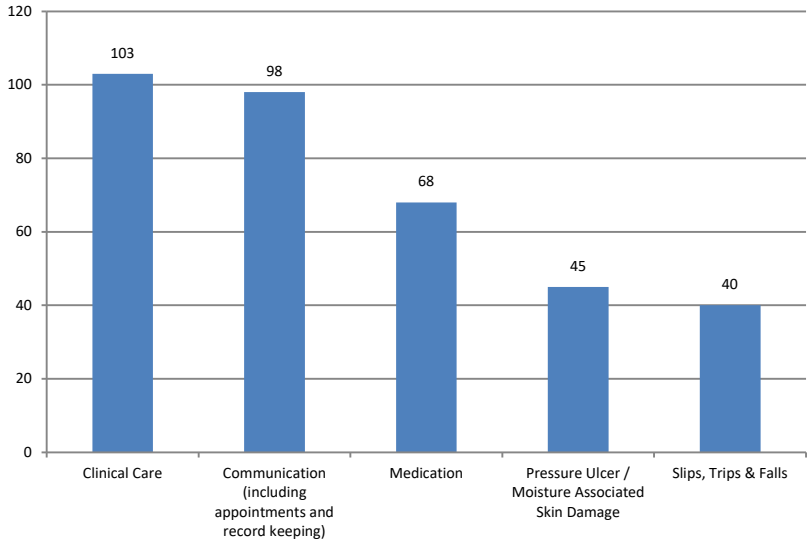
A total of 1532 incidents were reported across the 4 CBUs in Q1, this has decreased slightly from 1564 from Q4 . The top 5 categories and subcategories were reported as follows:

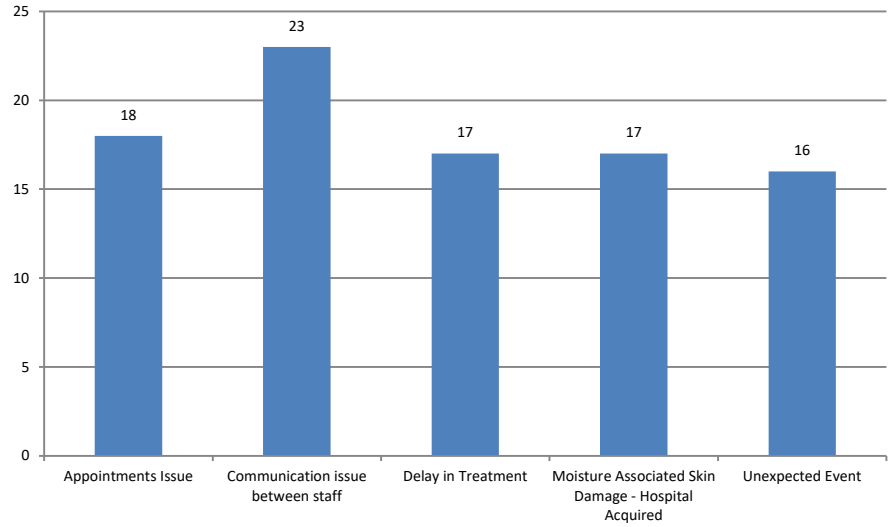




Digestive Diseases, Musculoskeletal Care and Specialist Surgery Incidents for Q1 (April to June 2019)

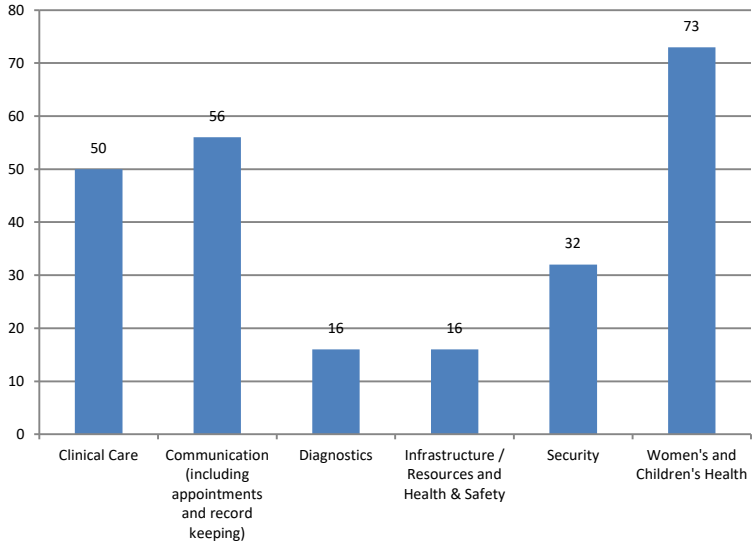
A total of 509 incidents were reported across the 3 CBUs, this has decreased slightly from 523 from Q4. The top 5 categories and subcategories were reported as follows:

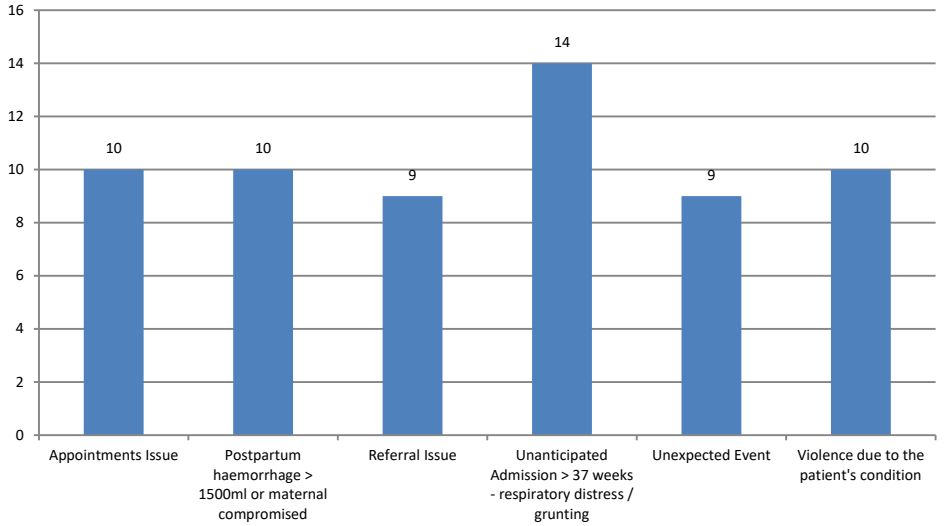




Women's and Children's Health Incidents for Q1 (April to June 2019)

A total of 312 incidents were reported in the CBU, this has decreased slightly from 323 from Q4. The top 5 categories and subcategories were reported as follows:





Learning from Incidents

What staff told us…….	Actions taken/Lessons Learned
Patient had an MRI scan which identified gall stones. The clinician who reviewed the MRI scan documented no gall stones and the patient was discharged. The patient had several admission with the same symptoms and each clinician reviewed previous documentations without reviewing the MRI scan and gave advice of no gall stones in their management plans. A consultant reviewed at another admission, reviewed the scan, informed the patient of the gall stone, booked a repeat MRI and a management plan was made for treatment.	Clinical results should be reviewed by the requesting clinician. Patient with multiple admissions and the same symptoms should be reviewed by a senior clinician.
Patient was diagnosed with hypokalemia and weighed <18kgs was prescribed 3 Sando K tablets 3 times a day which was given. The next day following administration the patient was hyperkaelemic and commenced on insulin therapy at a regime not suitable for the patient and this resulted in unstable blood sugars over a 48 hour period. Referral was made to the diabetic team who reviewed and made a management plan. The blood sugar became stable following involvement of the diabetic team.	Prescribers to consider the patient's clinical presentation when prescribing medication. Consider the relevant pathway when prescribing and contact the relevant specialist for advice. In this case the pharmacy team could have been contacted for advise on the prescription for Sando K.
Elderly patient was having rehabilitation on the ward, medical treatment and used a Zimmer frame to mobilise. Dosage of diuretic medication was increased. The patient used the Zimmer frame to stand, fell and sustained a fractured neck of femur.	There should be a clear management plan in place for patients at high risk of falls who have been prescribed increased doses of diuretics e.g. regular toileting on care and comfort rounds. The use of urinals for male patients should be considered in the care plan.

Learning from Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

What staff told us…….	Actions taken/Lessons Learned
Patient sustained a bowel perforation which is a rare but known complication of Colonoscopy and the patient sadly passed away. Advice was given to the primary team for CT colonoscopy prior to the procedure and this did not take place due to miscommunication.	Colonoscopy could have been avoided by better communication between endoscopy and the referring medical team. Advice requested from another specialty must be taken into consideration, when planning further management for a patient.
A very rare lesion was missed on MRI scan. The lesion was identified five months later when the MRI scan was repeated.	Awareness of rare pathologies as a cause of common presentations such as low back pain. Escalation to specialist clinical teams if no improvement of symptoms after standard care.
A surgical high risk patient attended for procedure. Lengthy discussion with patient and family regarding the risks of surgery. Surgery was required to give patient quality of life. The patient sadly passed away following the procedure.	The pre-operative discussion with patient and family were well documented in Lorenzo by the anaesthetist; this resulted in a much easier discussion with the family when the patient died and is excellent practice. It is good practice to include medical complications and death as risks when completing consent forms in high risk patients.

Learning from Incidents

Urgent and Emergency Care

Background

- A patient was extracted from the bottom of a quarry and transferred to Warrington Emergency Department at the recommendation of the Trauma Cell.
- The patient was booked in with the presenting condition of hypothermia.
- Patient disclosed the mechanism of injury (fall from 30-60ft) 15-20 minutes after arrival. This was not escalated at the time and the trauma team was not activated. Bloods were taken and escalated to the ED Consultant in view of the elevated lactate.
- The patient required an urgent chest drain and was transferred to CT which showed significant, serious injuries the patient was transferred to a Major Trauma Centre.
- Arriving at the Major Trauma Unit in a stable condition at 16.40, the patient deteriorated at 21.00 and was taken to theatre twice for haemorrhage control from a liver laceration. The patient had a further intra-abdominal bleed resulting in cardiac arrest. The patient is reported to have hypoxic brain injury and is listed for a rehabilitation unit.

Lessons Learned

- If a patient meets the Trauma Team activation criteria a Trauma Call should be made
- Trauma patients requiring CT scan should be scanned within 1 hour.
- Patients should be triaged within 15 minutes
- Ambulance handover must be supported by written documentation at the time of handover of patient.
- Trauma patients requiring transfer are to be escorted by an anaesthetist

Learning from Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Urgent and Emergency Care

Sharing Outcomes

Background

A patient was admitted from a Nursing home following a fall.

Ambulance paperwork notes GCS of 7/15.

No Neurological observations were taken by nursing or medical team, AVPU was noted.

Clinical examination refers to ambulance assessments of pupil reaction , pupil reaction not checked on initial nursing or medical review.

CT showed a large subdural hemorrhage, with midline shift. The patient was managed conservatively and died on the ward

Lessons Learned

Patients admitted with a head injury must receive a full neurological assessment including pupil reaction

Adult patients with head injuries must be commenced on the head injury fast track

Patients with GCS <14/15 should be transferred to Resus/ Majors

Learning from Incidents - WACH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

- There were three moderate and one major incidents reported in Q1.
- 13 Incidents required a 72 hour review.
- Two Incidents were Neonatal deaths, one over 37 weeks gestation which was therefore referred to HSIB.
- Following review one Incident has been declared a concise RCA (currently in progress) and another has been declared a Serious Incident (also in progress)

Background ~ SI

- The patient attended the trust in 2016 and was diagnosed with complex hyperplasia following this should have been under 6 monthly surveillance with endometrial biopsies. This did not happen and the patient has now been diagnosed with endometrial carcinoma.
- The patient was not kept under surveillance as per RCOG guidance. Surveillance may have detected the endometrial cancer earlier. It cannot be said with certainty if earlier detection would have changed her treatment outcome and prognosis.
- Expected completion ~ end of September.

Background ~ RCA

- The patient had a total abdominal hysterectomy:
- The patient's uterus was removed with both ovaries and tubes but the cervix was removed separately.
- Later revealed that part of the cervix still remains
- Possible cervical cancer

Learning from Incidents - Paediatrics

Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We Acted….
A known high risk CAMHS patient, refused routine observations by the carer providing 1: 1 care and pulled blanket over her head. Another member of staff was called to assist, noted the patients face was very flushed. The blanket was removed to reveal a ligature had been applied this was removed with a ligature cutter. No loss of consciousness or cyanosis at this time. Observations recorded , saturations 99%.	Appropriate nursing and medical intervention with no further medical input required at the time. The ligature applied was the headband from a doll; all equipment, belongings and furniture was removed from the room to minimise the risk whilst awaiting an alternative more appropriate placement. 1:1 observation continued and the daily ward safety huddles increased to communicate escalating concerns and to provide staff support.
A young male, deemed vulnerable absconded from the ward, on return it was confirmed he was carrying a small piece of glass. which was surrendered to staff, though it was believed he may still have retained some.	Police, Social Services, Parents and Site Manager informed. The Absconsion checklist was completed and the risk assessment adhered to. The checklist which is completed on admission will be amended to include informing both the safeguarding children team: for information only initially and the security team - to enable them to have a contingency plan in place if additional staffing is required when there is a high risk admission. CAMHS will be invited to any future 72 hour reviews to provide some valuable advice and input. The officers who escorted Daniel back to the ward did not perform a handover or provide their badge numbers to the ward as would have been expected – this was be fed back to the police.
Patient had 10mg of oral oramorph in PED at 06.00 and a further 2mg of IV morphine administered in theatre at approximately 08.20. Dose reported to have been given too soon . Child was monitored appropriately and there was no adverse effect. Parents informed of possible drug error.	Discussed with Pharmacy and is not an overdose. Discussed with anaesthetist who reported the morphine was given IV in theatre based upon clinical judgment for pain relief and did not exceed safe doses. Nursing staff advised that any questions regarding drugs or doses given should be discussed directly with the anaesthetist in question before speaking to the family.

Learning from Incidents - Women's Health

Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We Acted….
Patient 24 weeks pregnant, had a Fit/Seizure on ward C23. Known to have a history of non-epileptic seizures not on any medication. Emergency measures were triggered; appropriate assistance required patient safety ensured, iv access, bloods and blood sugar obtained, observations completed and Fetal heart auscultated.	Appeared like a Grand Mal seizure due to patient rigidity and behaviour there was no evidence of pre eclampsia or eclampsia. So following Obstetric and medical review the patient was transferred to ward C20 for nursing care.
Term baby admitted from labour ward following traumatic delivery, shoulder dystocia, Baby weighed, placed in incubator in ambient oxygen. Cannula sited bloods obtained. X-ray revealed showed fractured clavicle.	Shoulder dystocia is a known risk of vaginal delivery but was not documented as having been discussed when induction of labour was booked. This is not current practice but may be advisable to consider changing policy, to be discussed with senior staff. Induction was booked for 38 not 39 weeks as per the policy but induction occurred earlier due to development of PIH, the Governance lead will remind other clinicians.
Patient on C20, in a bay of 6 people including one pregnant lady has tested positive for mumps, Patient had not been isolated despite the associate nurse recording that screening for mumps had been sent.	No harm caused to the patient with mumps as appropriate treatment was given. The Pregnant woman was advised of signs and symptoms of mumps and to report any signs of illness. No antenatal action was required as she did not have any direct prolonged contact with the infected woman. The Screening midwife was informed of the incident and no further action was required. The occupational health department was also informed.
A patient was admitted, with three carers, to the ward from a local a secure mental health facility wearing handcuffs. Once the handcuffs were removed the patients wrists were noted to be very red with a blister present on the right wrist. The blister was dressed appropriately and a barrier cream was applied to the left wrist.	Carers from the secure facility were advised of the concerns regarding the skin integrity and advised that the handcuffs may need to be left off to ensure healing but the decision is theirs and needs to be discussed with their managers and the three carers would need to remain at all times.

Learning from Incidents - Radiology

Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We are doing….
An outpatient had a cardiac arrest in the waiting room whilst waiting for an MRI scan. A number of areas for learning were identified during the event, such as the confidence of the staff in managing the situation, locating and using the equipment.	• Amended the process for daily oxygen checks so that the cylinder is now turned on to check the oxygen flows rather than just observe the gauge. • Radiographers who work in CT and MRI now undertake intermediate life support (as opposed to basic life support) training as they did previously to ensure they feel capable and confident to manage a resus situation. • Reviewing the the procedure for the management of a cardiac arrest in the unique MRI environment and introducing a ‘practice drill’ for the procedure.
A patient from A&E had a cardiac arrest and died on the CT scanner outside normal working hours. The incident raised a number of concerns about the handling of patients who pass away outside of the ward/A&E environment such as in diagnostic areas.	• Developing a written procedure to cover the management of deceased patients in diagnostic and other outlying areas by putting together a working group including representation from A&E, ITU, theatre and Radiology. • Plans to share the completed procedure with all relevant staff to ensure awareness for all groups of staff potentially involved. • Radiology to keep a greater amount of items for re-stocking the resus trolley, to ensure it can be re-stocked without having to access stores.

Learning from Medication Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We Acted….
The number of diabetic incidents being reported on Datix each month for the Trust was increasing. An analysis of the diabetic incidents was completed and it was identified a significant number of the incidents were due to a patient's insulin dose being omitted or delayed.	Taken to the Trust Safety Huddle, Pharmacy Safety Huddle and Medical Handover to highlight: • Insulin is a critical medicine and should be administered as prescribed. • The importance of prescribing insulin on the white prescription chart. • If a patient is prescribed an IV insulin infusion and normally takes background long acting insulin (E.g. Lantus, Levemir, Toujeo), this should be continued at the usual dose and time. • Guideline on the Extranet: Short-term Management of Patients with Diabetes when Treatment Regimen Unknown.
An adult patient with cerebral palsy who only weighed 17 kg was hypokalaemic with a potassium level of 2.8. They were prescribed Sando K at a dose of 3 tablets TDS, higher than the usual dose for a full size adult. Next day potassium levels were 7.6 and an insulin and glucose infusion was administered to treat the hyperkalaemia. The patient subsequently experienced a number of hypoglycaemic episodes which required treatment and frequent monitoring.	Learning and actions from the 72 hour review included: • Prescribers to consider the patient's clinical presentation when prescribing medication. • The incident to be discussed at the next M&M meeting. • To consider implementing a hypokalaemia guideline. A concise root cause analysis is now being completed for the incident to identify further learning and actions. Taken to Medical Handover to advise when prescribing a medication to always consider the weight of the patient to ensure the dose is appropriate.
IV medications were made up for multiple patients at the same time. This resulted in one patient receiving IV co-amoxiclav which was intended for another patient. The patient had a documented allergy to penicillin, however did not experience a reaction to the co-amoxiclav administered.	A Safety Alert with recommendations on preparing and administering intravenous medications was sent across the Trust, as there was a concern that this practice of preparing IV medication for multiple patients at the same time may be happening in other wards/clinical areas. **This practice increases the risk to patients and is not safe.**

Learning from Incidents

Pressure Ulcers

Actions taken/Lessons Learned
Patients in ED at risk of pressure ulcers should be nursed on Repose trolley topper or dynamic mattress and hospital bed
Patients with orthopaedic devices to receive regular input from orthopaedic team
Dynamic mattress stores to be used out of hours if mattress required urgently
Accurate waterlow assessment will lead to the appropriate mattress being put in place from admission
All risk assessment should be completed within six hours of admission as per the Trust guideline
Education on correct fitting and care of NIV masks
Patients at risk of heel pressure ulcers to have heels floated to alleviate pressure

Learning from Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Information Governance

Radiology referral for patient A included in error in a letter sent to patient B

Action Taken

- Incident reported locally and escalated to NHSX
- Patient A contacted and given details of data items included in the referral
- Patient B initial complaint processed
- SIRO and Caldicott Guardian briefed

Lessons Learned

- A review of printing arrangements in Radiology has been conducted
- The re-siting of printers in Radiology will be considered in order to limit the possibility of re-occurrence
- Radiology staff awareness increased around the use of communal printers
- Review of IG incidents with a specific focus letters sent from the Trust at Information Governance and Corporate Records Sub-Committee scheduled for August 2019

Coroners referral forms containing person identifiable data became available on the hub.

Action Taken

- Documents removed from Hub
- Guidance to prevent re-occurrence of incident issued to users on the referral form

Lessons Learned

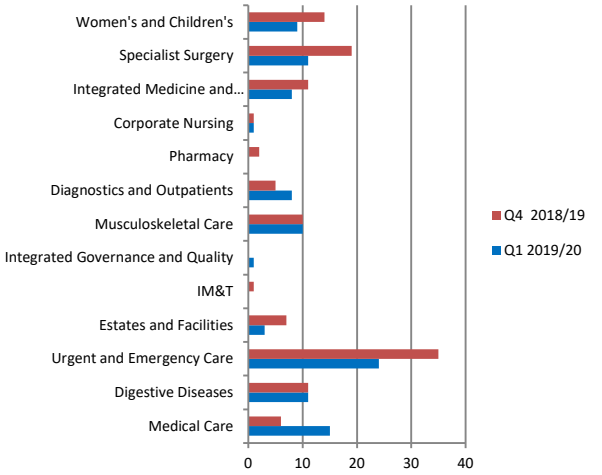
- The process has been changed so that the bereavement team will monitor all documents saved. The documents will now be saved a local temporary file of the individual user and sent to the coroner. This eliminates the possibility of re-occurrence.
- Processes changed in order to prevent further occurrences as a result of developing systems in-house. Robust arrangements to review all project documentation and the specification of systems developed in-house will be routinely adhered to via the Solutions Design Group.

Complaints Headlines Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

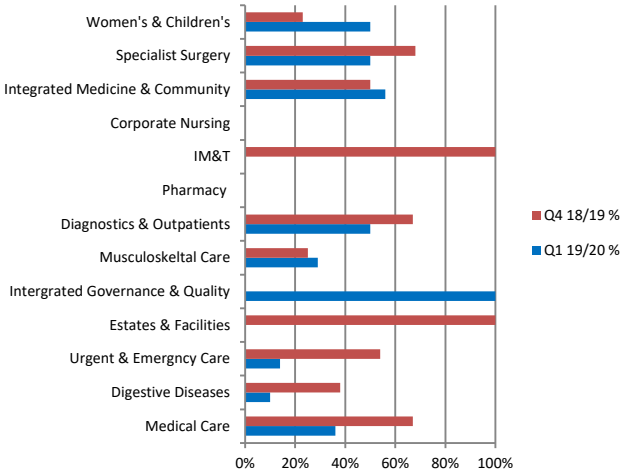
How many people are raising complaints Q4 vs Q1?

- There was an **increase** in complaints opened Trust wide in Q1 (101 versus 122 in Q4).
- Some CBU's saw an increase in the number of complaints received in Q1 (Medical Care and Diagnostics and Outpatients). Urgent and Emergency Care, Women's and Children's, Specialist Surgery, Integrated medicine and Community and Estates and Facilities saw a decrease in the number of complaints received in Q1.



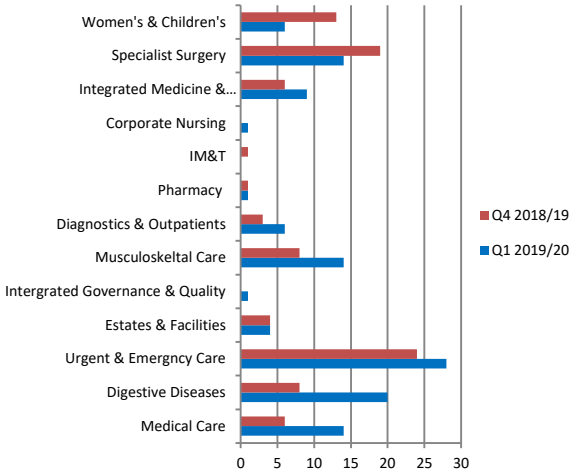
Are we Responsive Q4 vs Q1?

- Women's and Children's , MSK and Integrated Medicine and Community increased their performance for responding to complaints on time. Remaining CBU performance was decreased.
- The Trust currently has 10 breached complaints
- There are no complaints over 6 months old
- There is a plan in place to complete all the breached complaints.



How many complaints has the Trust closed Q4 vs Q1?

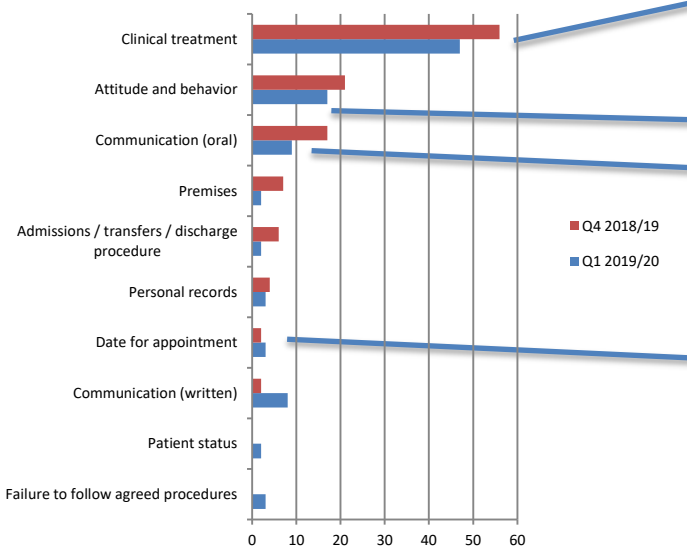
- There was an **increase** in complaints closed in the Trust in Q1 (118 in Q1 versus 93 in Q4).
- Medical Care, Digestive Diseases, MSK and Diagnostic and Outpatients have increased the amount of complaints they have closed. Specialist Surgery and Women's and Children's have decreased the amount of complaints they have closed.



Complaints Analysis Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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



Clinical treatment:

- There was a decrease in the number of complaints received in Q1 compared to Q4 regarding clinical treatment. Concerns include delay in treatment, co-ordination of medical treatment, treatment did not have expected outcome, staff attitude and wrong diagnosis.
- A lack of communication in relation to on going clinical treatment makes a perception that the treatment is incorrect.
- Theses issues can also be linked to when the Trust is on full capacity.

Communication and Attitude and Behaviour:

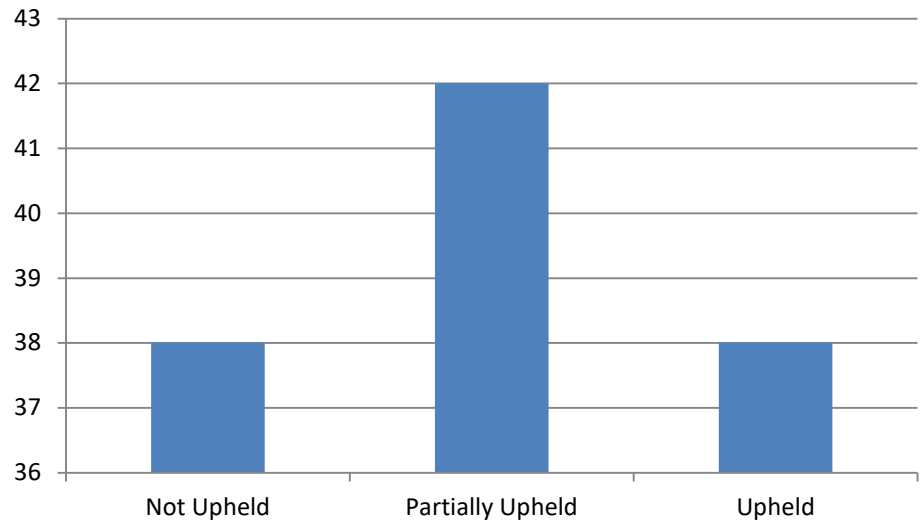
- Poor communication and staff attitude and behaviour has decreased in Q1 in line
- Training on First Impressions and Customer Care continues to be rolled out across the Trust.

Date for an appointment:

- Occurs when Out-patient Clinics are at full capacity, and appointments cannot be brought forward.
- Cancellation of appointments

Complaints Outcomes Q1

Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome will be recorded in line with the findings of the investigation. A complaint will be “upheld”, “upheld in part” or “not upheld”.

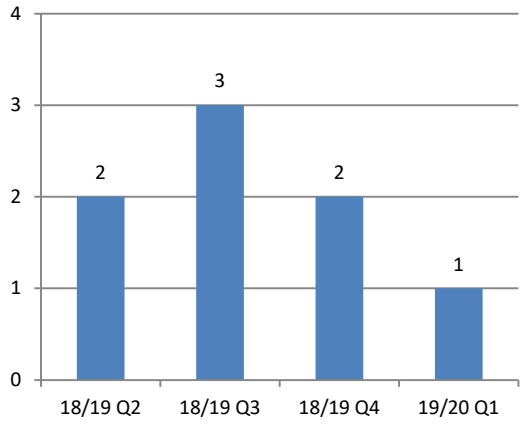


PHSO Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

So how many complaints do they investigate?

The PHSO has commenced 1 investigation into the Trust in Q1. The PHSO closed 4 investigations during Q1

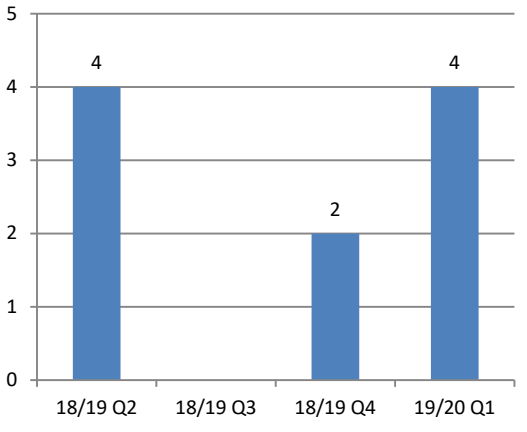


Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further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

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

And what are the outcomes?

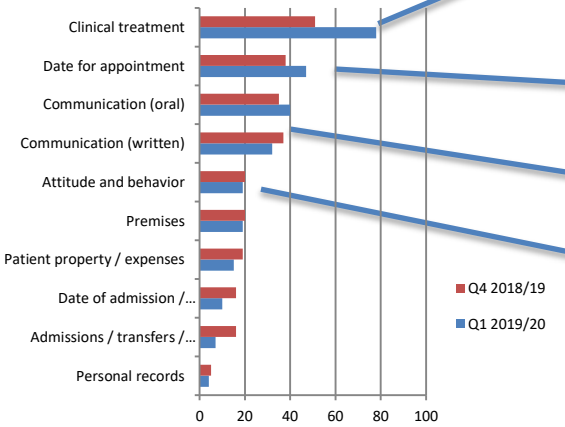
The Trust currently has 5 open PHSO cases. The PHSO finalised 4 investigations during Q1, 3 were not upheld and 1 was partially upheld with an action plans drafted and implemented.



PALS Analysis Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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



Clinical Treatment:
- Co-ordination of medical treatment
- Treatment did not have expected outcome
- Delay in treatment
- This is also mirrored in the complaints analysis.

Date for appointment:
- Unacceptable time to wait for an appointment
- Cancellation of appointment
- Appointment date continues to be rescheduled
- Too short notice given for appointment

Communication:
- Lack of clear explanation
- Patient has been sent no communication
- Test results not communicated to patient

Attitude and Behaviour:
- Issues in relation to communication have increased - may be linked to when the Trust is on full capacity
- Training on First Impressions and Customer Care continues to be rolled out across the Trust.
- This is mirrored in the complaints analysis.

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

Q4	Q1
6 days	5 days

PALS to complaints:

Q4	Q1
7	3

Learning from Complaints and PALS

Warrington and Halton Hospitals NHS
NHS Foundation Trust

You Said….	We Did….
Patient felt uncomfortable during an echo cardiogram appointment as she was not offered a chaperone whilst being treated by a male Cardiology Nurse.	The appointment letters have been amended to include the advice that “your test may be carried out by a female or male physiologist; please contact the department if you require a chaperone” to respect patients privacy and dignity.
Patient was concerned that there was a delay in the Pharmacy Service in dispensing medication for cancer treatments.	The Chemotherapy Pharmacist will ensure that the clinical checks are carried out in advance of the day of collection and new paperwork has been produced so that staff can track the medication when it is being transported between hospital sites.
Patient experienced poor communication during the management of her miscarriage which added to her distress.	The Ward Manager has held a teaching forum to share her experience and discuss pregnancy loss and the impact this has on families. Staff will provide telephone support and ensure communication is consistent and understood.

Complaints Headlines

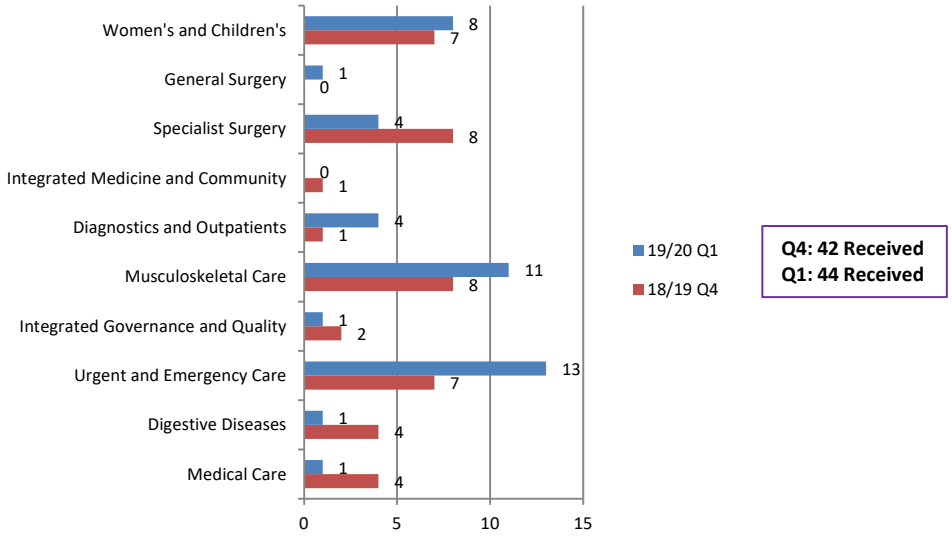
Warrington and Halton Hospitals NHS
NHS Foundation Trust

- There was an decrease in the number of complaints the Trust received in Q1 compared to Q4.
- There was an increase in complaints closed in the Trust in Q1.
- There is now a complaints meeting room where patients/families can meet with staff to resolve their concerns.
- Many of the issue raised with the PALS relate to delays in treatment and prolonged periods of waiting for appointments and cancellation of appointments. There has been an increase in timeliness of responding to concerns during Q1 compared to Q4.
- There is continued improvement in the Trust culture to resolve complaints locally and rapidly.
- Reporting on actions from complaints to ensure compliance. CBU staff are continuing to complete actions as they have access through Datix Web.
- Auditing of actions from complaints takes place to ensure that they have made the desired change.
- The CBU staff and managers have access to Governance dashboards to review their live data and meetings are held with the CBU to discuss the current positions and to plan responses.
- There has been a decrease in PHSO referrals and Trust continues to try and resolve all concerns locally at the Trust.
- There is a focus on learning in order to reduce the amount of complaints the Trust received.
- The main focus is to increase the timeliness of response and this is part of a QI project.

Claims Received Analysis

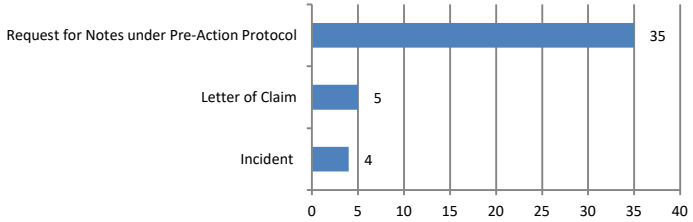
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Clinical Claims Received Q4 2018/19 vs Q1 2019/20



Q4: 42 Received
Q1: 44 Received

Analysis of Clinical Claims Received Qt1 2019/2020



- 33 of the claims were received as a request for notes under the preaction protocol for clinical disputes, of which 10 of them had previously been investigated as a complaint
- 5 Letter of Claim, 1 of which had previously been investigated as a complaint , 2 previously investigated as an incident and 1 previously investigated as an incident and coroners inquest
- 4 Incident *, 1 of which was initially reported to the NHSR because of risks identified during the SI investigation, this has subsequently become Request for notes and 3 were reported to NHSR under the Early Resolution Scheme

* We report all SIs which identify a risk to the NHSR for their consideration whether they are a claim or not.

None Clinical Claims Q4 2018/19 vs Q4 2019/20 – 7 (3 the previous quarter)

Row Labels	Acute Medicine	Catering	General Surgery	Outpatients	Trust Escalation
Assault	1				
Accident by other means		1	1	1	
Needlesick	1				
Slip/Falls				1	1

Claims Closed

Clinical Claims Closed Q1:

20 Withdrawn 1 closed with payment

CBU	Settled with Damages	Withdrawn
Diagnostics and Outpatients		2
Medical Care		3
Musculoskeletal Care		4
Specialist Surgery	1	5
Urgent and Emergency Care		4
Women's and Children's		1

Payments for claims settled with damages totalled £152,000.00 including costs

No Non-Clinical Claims closed Q1

Claims – Action Taken

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Specialist Surgery What did we do?

Inappropriate management of PEG feed	Standard operating policy on the insertion and care of PEGS updated

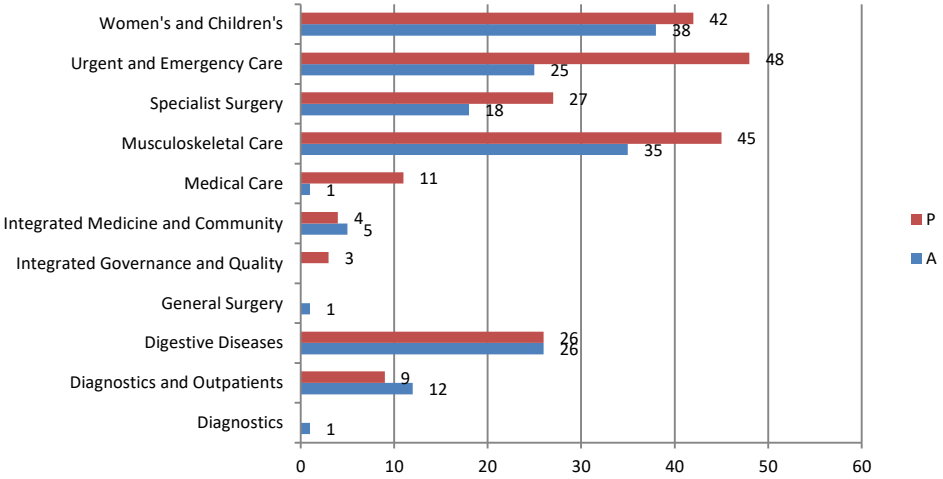
Radiology– What did we do?

Sub-standard reporting	Fed back to individual to learning and self reflection, also discussed at monthly discrepancies meeting for review.

Open Claims

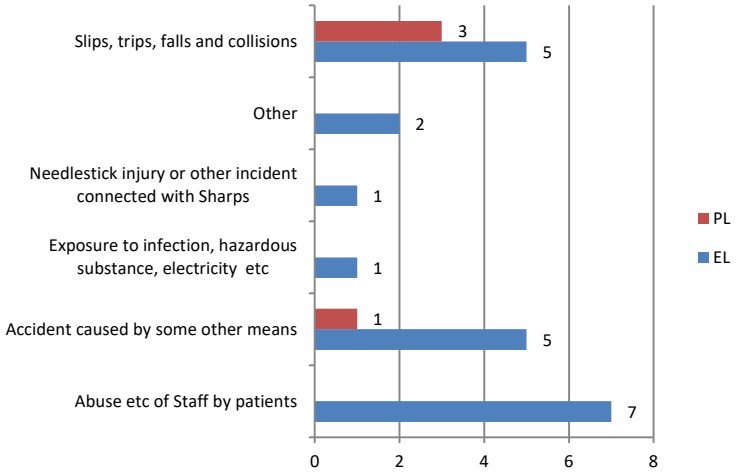
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Number of Open Claims as of 30 June 2019
Actual 162 | Potential 215



Potential = Request for notes
Actual = Formal claim, Letter of Claim / Proceedings

Number of Open Non-Clinical Claims as of 30 June 2019: Public 3 | Employer 21

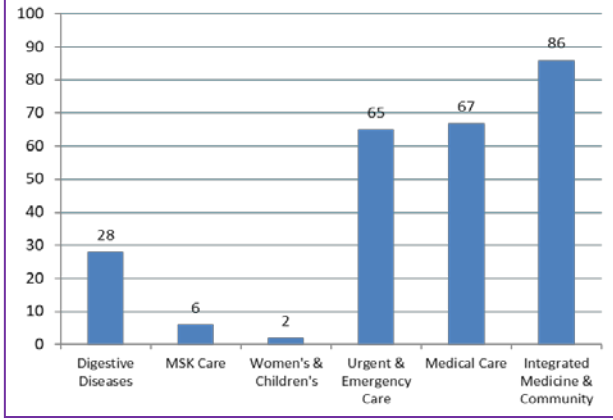


Mortality Headlines

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Q1 CBU Mortalities

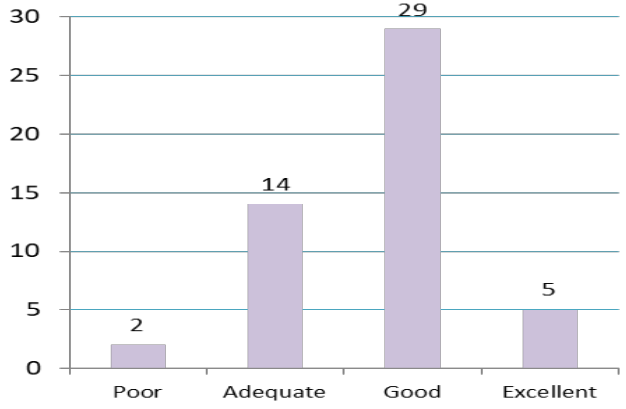
As expected, the three CBUs with the most mortalities are the ones with the greatest throughput and largest number of patients with multiple comorbidities: Medical Care, Integrated Medicine & Community and Urgent & Emergency Care.



Q1 SJRs – Overall Care Grading

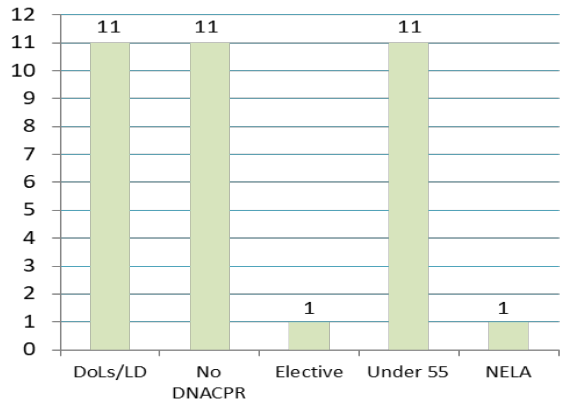
The majority of SJRs conducted have found that our overall standard of care is rated as "Good" or "Adequate", although evidence of "Excellent" care was also evident within the reviews.

There were 2 "Poor" ratings for Quarter 1 to date; these are discussed at MRG.



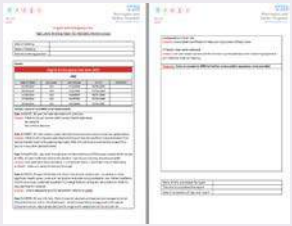
Q1 Triggers for SJRs

The below chart displays the triggers for conducting SJRs across Quarter 1. Comparing to Quarter 4, no DNACPR continues to be one of the largest triggers for an SJR. However, there has been an increase of DoLs/LD (of which 1 was an LD) and Under 55 reviews.



Learning from Deaths

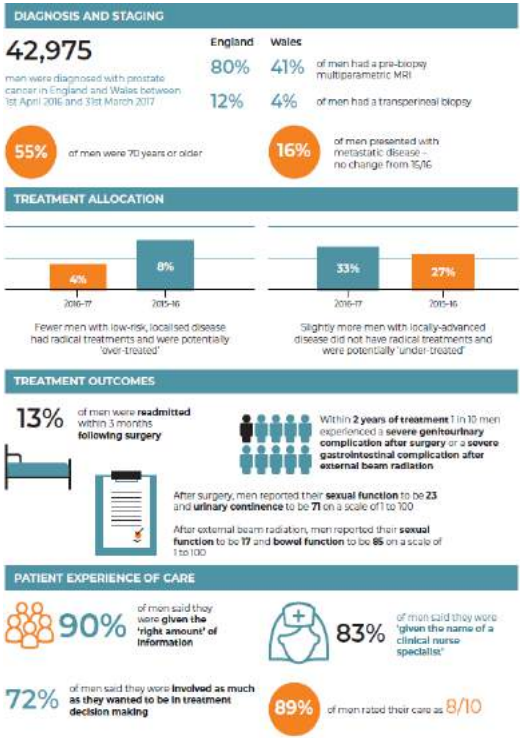
Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We are doing….
We are showing as an outlier for deaths with R-codes and Chronic Obstructive Pulmonary Disease & Bronchiectasis	As these areas are outliers we will establish which patients were involved and conduct focussed reviews, using the SJR template, to see if there is any learning from these deaths.
M&M meetings to be improved/standardised. 	A new template has been developed which includes the deaths by specialty for each CBU and will also include learning from MRG. Each CBU will be responsible for returning a HLBP from their M&M (Mortality & Morbidity) meetings to provide assurance that learning is being disseminated.
SHMI/HSMR further deterioration.	Processes of FCEs and documentation need to be rapidly managed, a task and finish group is in the process of being established to review this further, led by the Trust Mortality Lead.
Trauma cases were presented to MRG and we found that the main lesson was in relation to following the thoracic injuries pathway.	The thoracic injuries pathway was highlighted at the joint ED and medical team meeting to cascade to all relevant staff.
We found evidence of good practice in relation to the documentation of discussions on ITU. 	We have asked the SJR reviewer to highlight the learning so that this can be disseminated Trust wide through the M&M meetings.

Headlines of Learning from Deaths

- Mortality & Morbidity Meetings (M&M) are underway with feedback being provided back to MRG.
- SHMI and HSMR, although within the expected range, are both showing signs of deterioration.
- The SHMI was reviewed as it has been selected as an indicator to be audited as part of the Trust's annual Quality Account. Based on the results the auditors did not identify any material issues in relation to the calculation of this indicator or the six dimensions of data quality.
- A task and finish group is in the process of being established to review FCEs (first consultant episode) further, led by the Trust Mortality Lead.
- We continue our work with the Coding Team to identify improvements that can be made with documentation.

Learning from National Audits



NPCA
National Prostate Cancer Audit

Recommendations

For prostate cancer teams (local and specialist MDTs) within NHS Trusts/Health Boards

1. Increase the use of pre-biopsy multiparametric MRI and avoid its use post biopsy.
2. Increase the use of transperineal prostate biopsy where necessary to reduce the risk of post-biopsy sepsis and to maximise diagnostic accuracy and risk stratification.
3. Advocate active surveillance in the first instance for men with low risk prostate cancer.
4. Investigate why men with locally advanced disease are not considered for radical local treatment.
5. Use data on side effect prevalence from this report to ensure appropriate counselling and management for all patients.
6. When outlying performance is confirmed, engage with partners, including the NPCA, to review practice urgently and instigate quality improvement measures.
7. Engage with the NPCA Quality Improvement initiatives planned for 2019 (see Future Plans).
8. Review and improve data completeness focussing particularly on performance status, use of multiparametric MRI and biopsy route.

Learning from Local Audits

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Effectiveness of Rectus Sheath Catheters in Laparotomy Patients

Background:

Quality improvement action plan following Laparotomy Audit of 2015 recommended implementation of use of Rectus sheath catheters delivering continuous infusion of local anaesthetic for acute pain management following Laparotomy.

Key Findings:

- Pain scores have significantly improved with the use of the rectus sheath catheter infusion (RSCI)
- There appears to be approx. 50% less use of the PCA morphine with RSCI on day 1 compared to the laparotomy audit of 2015
- 68% of patients were able to deep breath easily on day of surgery with the use of RSCI
- By day 1, 50% of the patients with RSCI were comfortable enough to at least transfer out of the bed

Recommendations:

- Continue with data collection and possibly adapt to reflect discharge date to enable length of stay of patients to be determined
- Continue to support all members of the multidisciplinary team
- Look at other uses for these types of catheter in relation to pain control e.g Local anaesthetic infusion blocks for those suffering rib fractures

Assurance:

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

Non Clinical Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

From 1st April to 30th June 2019, there were 381 non clinical incidents. The top 2 categories were:

Security incidents = 116	Infrastructure/Health and Safety incidents = 110
The top sub-categories are: • Aggressive Behaviour • Violence due to patients condition • Doors not locked • Loss	The top sub-categories are: • Injury to staff • Equipment Malfunction • Sharps Injury • Hit by an object

During this Quarter, there were 13 sharp related incidents. 5 were during a clinical procedure such as suturing/during surgery/giving an injection. All other incidents occurred during the disposal process. These included re-sheathing needles, a used cannula found in a breakfast bowl, a domestic cleaning a cubicle and received a sharps injury, taking black waste bags out and felt a sharp through the bag and when closing up a black waste bag, found items such as venepuncture equipment, a cannulation pack, blood culture bottles, gloves etc inside. The patient where this equipment had originated from was Hep C+

Following health and safety inspections, it was disappointing to see a number of ward areas had items protruding from the sharp bin lids. On one ward, there was plastic tubing hanging out and on another, blood stained gauze. Other hazards identified were temporary lids were left open, sharp bin lids loose and numerous labels not being completed upon assembly. Some bins were even blood stained on the outside.

Learning from Non Clinical Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We Acted….
 When carrying out a health and safety inspection at Halton Hospital we found sharps bins that had been wall mounted too high for staff to use safely.	The health and safety department contacted the Estates Department direct and made arrangements for these to be lowered to a safe height.
A patient attended the Ophthalmology Department for an appointment. He had drops in his eyes to dilate the pupils. Whilst waiting, his wife went out to the car which was parked in a disabled bay, the patient decided to following. The patient was also blind in one eye. As he walked towards his wife, he tripped over a curb.	The gardeners added more shrubbery to the borders as a visual effect. The border is required to segregate cars from a pedestrian area therefore this was the best option to highlight the curbed area. 
 Linen continues to be left on beds that are stored along the Warrington Hospital corridors. This occurs when a patient arrives on a ward already in bed and the spare bed is taken off the ward	Regular reminders are sent to staff enforcing information that all beds and patient trolleys must be stripped of all bed linen and pillows before leaving them on Hospital corridors. This is an infection control issue, there is no-where to leave the linen and is a poor image to portray to patients and visitors who attend the site.
 When a member of staff entered a store room, they tripped over due to the amount of items being stored in a small area. Store rooms that are not managed regularly can become a hazardous area. They can become overwhelming and unmanageable. They can also become dangerous and cause accidents	 A wall mounted electrical heater was disconnected and removed to prevent a fire hazard. With a little effort and organisation, the area was cleared. Emails were circulated and unwanted files etc were collected and recycled. Regular monitoring to prevent this from getting out of hand again

National Guardian
Freedom to Speak Up

NHS

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

July 2019

NHS England and NHS Improvement

Contents

Introduction

Effective speaking up arrangements help to protect patients and improve the experience of workers. We know the main reasons workers do not speak up are because they fear they might be victimised or because they do not believe anything will change.

Since we first launched this guidance the NHS has published its interim People Plan, setting out its vision for people who work for the NHS to enable them to deliver the best care possible. Ensuring that everyone feels they have a voice, control and influence is at the forefront of the plan.

This guide supports boards to create that culture; one where workers feel safe and able to speak up about anything that gets in the way of delivering safe, high quality care or affects their experience in the workplace. This includes matters related to patient safety, the quality of care, and cultures of bullying and harassment. To support this, managers need to feel comfortable having their decisions and authority challenged: speaking up should be embraced. Speaking up, and the matters that speaking up highlights, should be welcomed and seen as opportunities to learn and improve.

We have aimed this guide at senior leaders because it is the behaviour of executives and non executives (which is then reinforced by managers) that has the biggest impact on organisational culture. How an executive director (or a manager) handles a matter raised by a worker is a strong indicator of a trust's speaking up culture and how well led it is.

Meeting the expectations set out in this guide will help a board create a culture responsive to feedback from workers and focused on learning and improving the quality of patient care and the experience of workers. Our expectations are accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to Freedom to Speak Up (FTSU) will help boards to identify areas for further development.

The Care Quality Commission assesses a trust's speaking up culture under Key Line of Enquiry (KLOE) 3 as part of the well-led domain of inspection. This guide forms part of the resource pack given to inspectors ahead of well-led inspections.

Completing the self-review tool and developing an improvement action plan will help trusts to reflect on their current speaking up culture as part of their overall strategy and create a coherent narrative for their patients, workforce and oversight bodies. Details of the support available to do this are on page 10.

About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office, with input from a group of executives and non-executive directors (which included chief executives and chairs), FTSU Guardians and leading academics in culture and leadership.

The guide sets out our expectations, details individual responsibilities and includes supplementary resources.

We expect the executive lead for FTSU to use the guide to help the board reflect on its current position and the improvement needed to meet our expectations. Ideally the board should repeat this self-reflection exercise at least every two years.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But obtaining the FTSU Guardian's views would be a useful way of testing the board's perception of itself.

The improvement work the board does as a result of reflecting on our expectations is best placed within a wider programme of work to improve culture. This programme should include a focus on creating a culture of compassionate and inclusive leadership; the creation of meaningful values that all workers buy into; tackling bullying and harassment; improving staff retention; reducing excessive workloads; ensuring people feel in control and autonomous, and building powerful and effective teams.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better culture. Equally, focusing on process and procedure at the expense of honestly reflecting on how you respond when someone speaks up will not improve the way the board leads the cultural improvement agenda. The attitude of the board to the review process and the connections it makes between speaking up and improved patient safety and staff experience are much more important.

We will review this guide in 2021. In the meantime, please provide any feedback to nhsi.ftsulearning@nhs.net

Our expectations

Behave in a way that encourages workers to speak up

All executive directors have a responsibility for creating a safe culture and an environment in which workers are able to highlight problems and make suggestions for improvement. FTSU is a fundamental part of that. They also understand that an organisational or department culture of bullying and harassment or one that is not welcoming of new ideas or different perspectives may prevent workers from speaking up which could put patients at risk, affect many aspects of their staff's working lives, and reduce the likelihood that improvements of all kinds can be made.

Executive directors understand the impact their behaviour can have on a trust's culture and therefore how important it is that they reflect on whether their behaviour may inhibit or encourage someone speaking up. To this end executive directors:

- are able to articulate both the importance of workers feeling able to speak up and the trust's own vision to achieve this
- speak up, listen and constructively challenge one another during board meetings
- are visible and approachable and welcome approaches from workers
- have insight into how their power could silence truth
- thank workers who speak up
- demonstrate that they have heard when workers speak up by providing feedback
- seek feedback from peers and workers and reflect on how effectively they demonstrate the trust's values and behaviours
- accept challenging feedback constructively, publicly acknowledge mistakes and make improvements.

Executive directors could test how their behaviour is perceived with direct and incidental feedback from staff surveys; pulse surveys; social media comments; reverse mentoring, 360º feedback and appraisals.

Demonstrate commitment

The board demonstrates its commitment to creating an open and honest culture where workers feel safe to speak up by:

- having named executive and non-executive leads responsible for speaking up, who can demonstrate that they are clear about their role and responsibility and can evidence the contribution they have made to leading the improvement of the trust's speaking up culture. **Section 1 of the supplementary information pack** sets out the responsibilities of the executive and non-executive lead

- including speaking up and other related cultural issues in its board development programme

- having a sustained and ongoing focus on the reduction of bullying, harassment and incivility

- sending out clear and repeated messages that it will not tolerate the victimisation of workers who have spoken up and taking action should this occur with these messages echoed in relevant policies and training. The executive lead for FTSU is responsible for gaining assurance that the experience of workers who speak up is a positive one

- investing in sustained and continuous leadership development

- having a well-resourced FTSU Guardian and champion model. **Section 2 of the supplementary information pack** sets out suggestions of how to assess your FTSU Guardian's capability and capacity

- supporting the creation of an effective communication and engagement strategy that encourages and enables workers to speak up and promotes changes made as a result of speaking up. **Section 3 of the supplementary information pack** sets out suggestions of how to evaluate the effectiveness of your communication strategy

- inviting workers who speak up to present their experiences in person to the board.

Have a strategy to improve your FTSU culture

Boards have a clear vision for the speaking up culture in their trust that links the importance of encouraging workers to speak up with patient safety, staff experience and continuous improvement. The vision is supported by a strategy that has been developed by the executive lead for FTSU; this sits under the trust's overarching strategy and supports the delivery of other relevant strategies.

The board discusses and agrees the strategy and is provided with regular updates. The executive lead for FTSU reviews the FTSU strategy annually, including how it fits with the overall trust strategy, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they will be overcome; and whether the right indicators are being used to measure success.

It doesn't matter whether the strategy document is called a plan or a strategy; as long as the executive lead has well-thought-out goals that are measurable and have been signed off by the board. **Section 4 of the supplementary information pack** sets out suggestions for what should be in your strategy and provides a checklist to help with the evaluation of your strategy.

Support your FTSU Guardian

Boards demonstrate their commitment to creating a positive speaking up culture by having a well-resourced FTSU Guardian, supported by an appropriate local network of 'champions' if needed. FTSU Guardians need access to enough ringfenced time and other resources to enable them to meet the needs of workers in your organisation. See **Section 2 of the supplementary information pack.**

The executive lead and the non-executive lead, along with the chief executive and chair meet regularly with the FTSU Guardian and provide appropriate advice and support. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate urgent matters rapidly (preserving confidence as appropriate). **Section1 of the supplementary information pack** sets out the individual responsibilities of relevant executives.

Relevant executive directors ensure the FTSU Guardian has ready access to applicable sources of data and other information to enable them to triangulate speaking up issues and proactively identify patterns, trends, and potential areas of concerns. **Section 5 of the supplementary information pack** sets out the kind of data and other information you could triangulate.

Finally, executive directors encourage and enable their FTSU Guardian to develop bilateral relationships with regulators, inspectors, and other FTSU Guardians, and attend regional network meetings, National Guardian conferences, training and other related events.

Be assured your FTSU culture is healthy and effective

The board needs to be assured that workers will speak up about things that get in the way of providing safe and effective care and that will improve the experience of workers. **Section 6 of the supplementary information pack** sets out the different elements that the board should consider seeking assurance for.

Boards may need further assurance when there have been significant changes, where changes are planned, or there have been negative experiences such as:

- before a significant change such as a merger or service change
- when an investigation has identified a team or department has been poorly led or a culture of bullying has developed
- when there has been a service failing
- following a Care Quality Commission (CQC) inspection where there has been a change in rating

It is the executive lead's responsibility to ensure that the board receives a range of assurance and regular updates in relation to the FTSU strategy.

An important piece of assurance is the report provided in person by the FTSU Guardian, at least every six months and **Section 7 of the supplementary information pack** sets out the kind of information the board should expect to be in the FTSU Guardian's report. To be clear this should not be the only assurance the board receives.

Another important piece of assurance is an audit report of the trust's speaking up policy. The trust's speaking up arrangements must be based on an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement and should be audited at least every two years. **Section 8 of the supplementary information pack** sets out what a comprehensive audit should cover. The audit report should not focus solely on FTSU Guardian activity but on the effectiveness of all the speaking up channels as well as the whole speaking up culture.

If the board is not assured its workers feel confident and safe to speak up, it should consider getting external support to understand what is driving that fear.

Be open and transparent with external stakeholders

A healthy speaking up culture is created by boards that are open and transparent and see speaking up as an opportunity to learn. Executives routinely discuss challenges and opportunities presented by the matters raised via speaking up with commissioners, CQC, NHS Improvement and their local quality surveillance groups. The board welcomes engagement with, and feedback from, the National Guardian and her staff.

The board regularly discusses progress against the FTSU strategy and (respecting the confidentiality of individuals) themes and issues arising from speaking up (across all the trust's speaking up channels) at the public board. The trust's annual report contains high level, anonymised data relating to speaking up, as well as information on actions the trust is taking to support a positive speaking up culture.

To enable learning and improvement, executive directors discuss learning from speaking up reviews, audits and complex cases among their peer networks. To support this learning, ideally, reviews and audits are shared on the trust's website.

The executive lead for FTSU requests external improvement support when required.

Conclusion

Meeting the expectations in this guide will help boards to send the message that ideas, concerns, feedback, whistleblowing and complaints are all seen as opportunities to stop and reflect on whether something could be done differently.

Valuing workers' opinions and acting on them, publicising the good that comes from speaking up, and making clear and unequivocal statements that you will not tolerate staff being victimised for speaking up, will all encourage workers to use their voice for the benefit of patients and their colleagues.

We have provided useful resources as supplementary information to this guide but if having completed your review you would like further support to improve aspects of your FTSU arrangements, please get in touch with:

- nhsi.ftsulearning@nhs.net for the following support to the executive lead:
  - review FTSU policy, strategy or action plans and provide feedback to bring them in line with national policy or recognised best practice
  - design and facilitate workshops to develop board understanding of speaking up and behaviour that encourages or inhibits it
  - host online surveys and facilitate focus groups with workers to identify issues, causes and solutions
  - facilitate an assessment of your trust's FTSU arrangements against national guidance and support the executive lead to build a FTSU improvement action plan
- enquiries@nationalguardianoffice.org.uk who will arrange for support for the FTSU Guardian in relation to their role.

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133-155 Waterloo Road
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This publication can be made available in a number of other formats on request.

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Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts

July 2019

NHS England and NHS Improvement

Contents

About this resource

This supplementary information accompanies the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* and the *Freedom to Speak Up review tool for NHS trust and foundation trusts*.

We are happy to provide further explanation about any of the following information. Please contact nhsi.ftsulearning@nhs.net

1. Individual responsibilities

Chief executive and chair

The chief executive is responsible for appointing the Freedom to Speak Up (FTSU) Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. The chief executive and chair role-model high standards of conduct around FTSU, and are responsible for ensuring the annual report contains information about FTSU and the trust is engaged with both the regional FTSU Guardian network and the National Guardian's Office.

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.

The chief executive should approve all confidentiality clauses that appear in settlement agreements to ensure they are assured that their use is in accordance with the good practice set out by NHS Employers. If the chief executive is party to the settlement agreement, the chair should obtain this assurance.

Executive lead for FTSU

The executive lead is responsible for:

- role-modelling high standards of conduct around FTSU
- ensuring they are aware of the latest guidance from the National Guardian's Office
- overseeing the creation of the FTSU vision and strategy
- ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- ensuring the FTSU Guardian has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence

- ensuring their FTSU Guardian has access to any emotional and psychological support they may need
- conducting a biennial review of the strategy, policy and process
- operationalising the learning from speaking up issues
- ensuring instances where individuals may have suffered detriment for speaking up are promptly and fairly investigated and acted on
- providing the board with a variety of assurances about the effectiveness of the trust's strategy, policy and process.

Non-executive lead for FTSU

The non-executive lead is responsible for:

- role-modelling high standards of conduct around FTSU
- ensuring they are aware of the latest guidance from National Guardian's Office
- challenging the chief executive, executive lead for FTSU and the board to reflect on whether they could do more to create a healthy and effective speaking up culture
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up matters regarding board members – see below.

We appreciate it can be challenging to maintain confidentiality and objectivity when investigating issues raised about board members. This is why the role of the designated non-executive lead is critical. Therefore, in exceptional circumstances, we would expect the non-executive lead to take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and
- if so, whether an appropriate fair and impartial investigation can be conducted, is proportionate, and what the terms of reference should be for escalating matters to regulators, as appropriate.

Depending on the circumstances, it may be appropriate for the non-executive lead to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive lead does take the lead, they inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive lead informs NHS Improvement and CQC that they are overseeing an investigation into a board member (depending on the circumstances we may require you to provide the name of the board member under investigation). NHS Improvement and CQC can then provide the non-executive with support and advice. The trust needs to consider how to enable a non-executive lead to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Human resource and organisational development directors

The human resource (HR) and/or organisational development (OD) directors are responsible for ensuring that:

- Values and behaviours associated with FTSU, such as courage, impartiality, empathy and learning, are embedded throughout the recruitment, appraisal and termination processes.
- All workers have the capability and the access to appropriate resources to enable them to role-model high standards of conduct around FTSU.
- Speaking up is understood and interpreted in the broadest sense: there is no artificial distinction made between ‘whistleblowing’ and other speaking up activities, or between ‘formal’ and ‘informal’ ‘concerns’. Workers and managers understand that speaking up encompasses matters that might be referred to as ‘raising concerns’, ‘complaining’, ‘raising a grievance’ or ‘whistleblowing’. It also includes making suggestions for improvement.
- The trust understands the impact that worker experience, including bullying and harassment, engagement levels, and other ‘cultural’ issues, can have on patient safety, staff health and wellbeing, and on trust performance.

- The trust has a robust process to review claims that workers have suffered detriment as result of speaking up, which could include asking the non-executive lead for FTSU to review the claims.

- The trust evaluates all speaking up routes (including speaking up to the FTSU Guardian) and assesses why particular routes are used, addressing any barriers that prevent workers from using non-Guardian routes. Similarly, the FTSU Guardian monitors and responds to any barriers that may prevent workers speaking up to them, as well as looking more broadly at barriers to speaking up in the organisation

- Values and behaviours associated with FTSU such as courage, impartiality, empathy and learning, are role-modelled and assessed during recruitment and appraisals.

- The FTSU Guardian has the full support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other cultural and worker experience indicators.

- The trust has a leadership development programme that supports managers to have meaningful and compassionate conversations; give and receive feedback constructively; and support others to work productively and develop themselves.

- Managers and executives are able to evidence how they reflect on the impact of their behaviour in 1-1s and appraisals. This self-reflection could be supported by a range of peer and staff feedback.

- Effective and, as appropriate, immediate action is taken when potential worker safety issues are highlighted by speaking up.

Medical director and director of nursing

The medical director and director of nursing are responsible for ensuring:

- role-modelling high standards of conduct around FTSU

- the FTSU Guardian having appropriate support and advice on clinical, patient safety and safeguarding issues

- effective and, as appropriate, immediate action taken when potential patient safety issues are highlighted by speaking up

- learning in relation to patient safety being disseminated across the trust
- learning operationalised within the teams and departments they oversee.

2. Evaluating Guardian resource

FTSU Guardians should be able to demonstrate they have the capacity and capability to fulfil the requirements of the National Guardian's FTSU Guardian job description**.** Ultimately, this means the board must satisfy itself that the way the role is implemented meets the needs of workers in the organisation.

Capability

The National Guardian's Office has developed an education and training pack to help FTSU guardians assess their strengths and weaknesses and identify potential training needs. FTSU Guardians should be given the time and access to the right support to enable them to address any areas for improvement and build on their strengths.

Wellbeing

Given the nature of the post, FTSU Guardians should be given the opportunity and time needed to access supervision, mentoring, and other sources of emotional and psychological support and advice.

Capacity

As the FTSU Guardian role is driven by the needs of workers, there is no minimum standard amount of time and support FTSU Guardians need. However, the National Guardian expects that the trust will allocate ringfenced time.

Other considerations

When considering the amount of ringfenced time required for the role, boards should consider:

- the needs of the job in the round, including the reactive elements (responding to workers who speak up) and the proactive elements (looking at barriers to speaking up and working in partnership to help reduce them, communicating the role, ensuring there is appropriate training on speaking up)

- the number of workers in the organisation, geographic spread, diversity, and, in particular, the needs of the most vulnerable
- the need to fulfil the expectations of the National Guardian, including recording cases, reading and carrying out gap-analyses based on case review reports, writing and presenting board reports, reporting data locally and nationally, supporting information-gathering exercises, ensuring contact details are kept up-to-date
- playing an active part in the FTSU Guardian network regionally and nationally, including attending regional and national meetings, training, and other events
- the requirement to, where necessary, liaise with external partners including CQC, NHS Improvement and the NGO
- the general environment in which the trust is currently operating – FTSU Guardians may have an increased workload at times of change, such as mergers, organisational and operational restructuring, changes in CQC rating, and entering special measures or being placed on the challenged provider list.

The board may also want to seek advice from trusts that provide similar services and have a similar size workforce, geographical spread and regulatory circumstances.

3. Communication strategy

Why a strategy is important

To create a positive FTSU culture, workers need to know how to speak up and to whom. They need regular messages that reinforce the message that speaking up is welcomed and actions result from speaking up.

Demonstrating the impact of speaking up, the improvements made and learning generated as a result are therefore important elements of any FTSU communications strategy.

Communications strategies need to consider ways in which more inaccessible workers can be reached and also how appropriate messages can be tailored to, and reach, vulnerable workers and those who may face particular barriers to speaking up. They should also be accompanied by measures so that impact can be assessed. Strategies should be regularly refreshed so that messaging remains effective and impactful.

Any FTSU-branded communication should be in line with NGO guidelines (for details contact enquiries@nationalguardianoffice.org.uk)

Ways to communicate across a dispersed trust

Written communication	Verbal communication
Intranet pages	All staff events
Electronic newsletters	Executive/senior leader drop in sessions
Screen savers	Executive/senior leader walkabouts
Posters/ flyers/business cards	Senor leader surgeries
Payslips	Directorate/Team meetings
Social media	Staff forums/ network meetings
Electronic message boards	Working groups to develop change ideas

Mobile phone app	Speaking Up culture awards
Paper newsletters	Speaking Up managers network
E learning	Pop up market stalls
Merchandise – mouse mats, pens, coasters, calendars, lanyards	Training webinars
Pop up PC/laptop screen alerts	Induction/training on FTSU as well as references within other training on bullying and harassment, effective communication

Ways to evaluate a communication strategy

Ways to track engagement
Email tracking tools – count how many people have opened, clicked through or deleted FTSU-related emails.
Polls/pulse surveys – track response rates and how knowledge and confidence increase. Quantify the number of positive versus negative verbatim comments.
Number of concerns – count the number of concerns raised via each speaking up channel. Identify which directorates they are coming from.
Track social media – count comments, likes and retweets and video views in relation to FTSU posts. Quantify the number of positive versus negative verbatim comments.
Intranet analytics – count page views or document downloads in relation to FTSU.
Online discussion forum – number of participants/comments. Quantify the number of positive versus negative verbatim comments.
Listen to what people are talking about!!!

4. FTSU improvement strategy

Creating your strategy

- Your strategy could be a separate document or a distinct section within a relevant policy or strategy (ie a quality or OD strategy). Regardless of presentation, it needs to set out clearly how it fits in with the trust's overall strategy and how it supports the delivery of related strategies.
- It aligns to your gap analysis against the recommendations from the National Guardian.
- It describes ambitions and aims based on a diagnosis of the issues the trust currently faces in relation to FTSU.
- It includes clear objectives, measures and targets to demonstrate improvement.
- The objectives include a focus on the development of leadership values, behaviours, skills and knowledge that would support the delivery of the speaking up vision. Any training in FTSU should be in accordance with national guidance from the National Guardian.
- It contains information about the systems needed to support delivery (ie IT, HR, quality, governance, communication and data analysis).
- Ideally, it will be co-produced with a diverse range of relevant stakeholders (including the FTSU Guardian) but at a minimum the draft plan should be shared with key stakeholders (eg staff side and employee representative groups) and their feedback acted on.

Evaluating your strategy

Strategy
What does our FTSU strategy describe?
Does the strategy contain an effective set of measures?
How have workers and managers been involved in the production of the strategy?
How has the board been involved in sign off the strategy?
Oversight
How is the implementation of the strategy monitored?
How have we tested the effectiveness of our assurance?
Systems to support delivery
What are we doing to support delivery of the strategy?
How are we evaluating the effectiveness of that support?
Managers
How are we involving managers in the implementation of the strategy?
Values and behaviours
What values and behaviours are we monitoring in relation to FTSU?
How effectively are we challenging when values and behaviours are not upheld?
Skills/capability/knowledge
What skills/capabilities/knowledge are we looking to develop to deliver the FTSU strategy?
How are workers being provided with these skills/capabilities/knowledge?
How are we assessing the capability of workers, managers and senior leaders in this respect?

5. Triangulating data

Data that could be compared to identify wider issues

Patient safety	Employee experience
Patient complaints	Grievance numbers and themes
Patient claims	Employment tribunal claims
Serious Incidents	Exit interviews themes
Near misses	Sickness rates
Never Events	Retention figures
	Staff survey results
	Polls/pulse surveys
	Workforce Race Equality Standard and Workforce Disability Equality Standard data
	Levels of suspension
	Use of settlement agreements

Questions to ask of your data

- Why do some departments and staff groups have no issues?
- Who are the outliers and why?
- Which departments and staff groups have consistently occurring issues?
- Why have some departments been able to reduce the number of issues?
- What is the cause of unexpected spikes?
- Do patient and employee issues overlap in a department or directorates?

People should be supported by experts to interpret statistical significance and all data and other intelligence should be presented in a way that maintains confidentiality.

6. Board assurance

Elements a board should seek assurance on

- Workers know how to speak up.
- Workers speak up with confidence and are treated well.
- Workers are not victimised or do not suffer reprisals after they have spoken up.
- Managers and senior leaders role-model the right behaviour to encourage speaking up.
- Confidentiality is maintained.
- Concerns are processed in a timely manner.
- Risks are quickly escalated.
- Action is taken to address any evidence that workers have been victimised as a result of speaking up.
- Workers who have suffered victimisation as a result of speaking up are provided with appropriate support and redress.
- Appropriate patient safety and worker experience data is triangulated with the themes emerging from speaking up channels to identify wider concerns or emerging issues.
- Learning is identified and shared across the trust.
- Improvement actions are monitored and evaluated to ensure they lead to improvements.
- The trust's FTSU arrangements are compliant with guidance from the National Guardian and NHS Improvement.

Examples of assurance

- Speaking up concerns: numbers and themes
- Incident reporting: numbers, quality of reports, levels of feedback
- Grievances: numbers and themes
- Initiatives like Safety Huddles or Listening into Action: number and quality
- FTSU Guardian user feedback
- Polls/surveys/focus group reports
- Analysis of exit interview themes
- Analysis of social media comments including internal electronic message boards
- Reports from boards doing walk-abouts
- FTSU focus group/steering group reports
- Gap analysis against case reviews produced by the National Guardian
- National staff experience surveys
- FTSU Guardian board report
- Internal audit reports
- Employment tribunal judgements
- National Guardian Office case reviews
- CQC/NHS Improvement led focus groups
- External culture reviews
- CQC inspection reports

National Guardian
Freedom to Speak Up

7. Guardian report content

Assessment of cases

- Information on the number and types of cases being dealt with by the FTSU Guardian and their local network.
- Analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of issue, particular groups of workers who speak up, areas in the trust where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up.
- Information on what the trust has learnt and what improvements have been made because of workers speaking up.

Potential patient safety or worker experience issues

- Information on how FTSU matters fit into a wider patient safety/worker experience context, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built.

Action taken to improve FTSU culture

- Actions taken to increase the visibility of the FTSU Guardian and promote all speaking up channels.
- Actions taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up.
- Assessments of the effectiveness of the speaking up process and individual case handling – including user feedback; pulse surveys and learning from case reviews.

- Information on instances where workers feel they have suffered detriment – including what the detriment was; what action has been taken, whether the issue has been resolved, and any learning.

- Information on actions taken to improve the skills, knowledge and capability of workers to speak up; to support others to do so, and respond to the issues they raise effectively

Recommendations

- Suggestions for any priority action needed.

Data and other intelligence must be presented in a way that maintains confidentiality.

8. Speaking Up policy audits

What a comprehensive audit report could include
Do workers feel safe to speak up?
Is the trust acting on allegations of victimisation or perceived detriment?
Is confidentiality being effectively maintained?
Do all workers, bank and agency staff, temporary workers, volunteers and governors know about the policy? How does the trust measure this?
Are managers responding effectively to workers who speak up?
Is the FTSU Guardian responding effectively to workers who speak up?
Are the executive and non executive leads for FTSU responding effectively to workers who speak up?
Are issues that raise patient safety concerns escalated quickly?
Is the training for workers and managers in relation to speaking up effective?
Do workers know about the support that is available to them to speak up?
Are workers thanked, updated and given feedback?
Is the FTSU Guardian collating, evaluating and responding to user feedback?
Is the trust identifying, compiling and sharing learning effectively?
Is the impact of change being measured?
Do board meeting minutes evidence informed and rigorous discussion on FTSU matters?
Are the trust's FTSU arrangements based on the latest guidance from NHS Improvement and the National Guardian?

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NATIONAL TRAINING SURVEY

General Medical Council

Regulating doctors
Ensuring good medical practice

GMC National Trainee Survey "WHH Results are in" 2019

Presenter: Lesley Sala – Medical Education Business Manager

NATIONAL TRAINING SURVEY

General Medical Council

Regulating doctors
Ensuring good medical practice

Each year the GMC ask Doctors in Training for their views on the training they receive. The GMC also ask their Trainers about the support they get in their role. Together, these results help us improve training programmes and posts across the UK.

You can download our initial findings report or use our online reporting tool.

COPMeD
CONFERENCE OF POSTGRADUATE MEDICAL DEANS OF THE UNITED KINGDOM

GMC Promoting Excellence: Standards for Medical Education

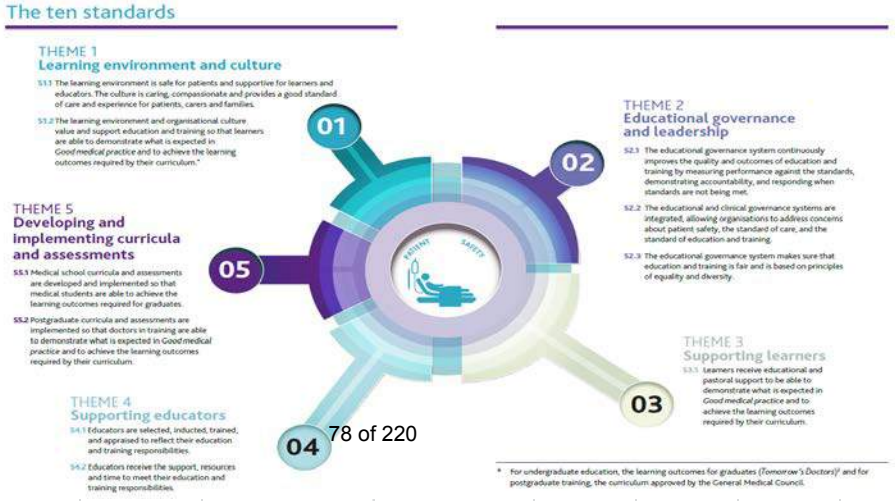
GMC Promoting Excellence: Standards for Medical Education and Training

These standards set out requirements for the management and delivery of undergraduate and postgraduate medical education and training. The standards and requirements are organised around five themes. Some requirements – what an organisation must do to show us they are meeting the standards – may apply to a specific stage of education and training

Patient Safety is the first priority

Patient safety runs through the GMC standards and requirements. Patient safety is inseparable from a good learning environment and culture that values and supports learners and educators. Where the GMC standards previously focused on protecting patients from any risk posed by medical students and doctors in training, the GMC will now make sure that education and training takes place where patients are safe, the care and experience of patients is good and education and training are valued.

	Themes	Standards	Requirements	% Compliance
1	*Learning Environment & Culture*	2	22	
2	*Educational Governance & Leadership*	3	20	
3	*Supporting Learners*	1	16	
4	*Supporting Educators*	2	6	
5	*Developing & Implementing curricula and assessments*	2	12	
	Totals	10	76	



The Survey Questions(19) /Topics

- Overall Satisfaction
- Clinical Supervision
- Clinical Supervision out of hours
- Reporting Systems
- Work Load
- Teamwork
- Handover
- Supportive Environment
- Induction
- Adequate Experience
- Curriculum Coverage
- Access to Educational Resources
- Educational Governance
- Educational Supervision
- Feedback
- Local Teaching
- Regional Teaching
- Study Leave
- Rota Design
- "Burn Out" Questions (voluntary)

THE GMC Portal for Results

https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports

Includes a 2min video covers how to find results for a site or specialty and what the scores mean.

https://webcache.gmc-uk.org/analyticsrep/saw.dll?Dashboard

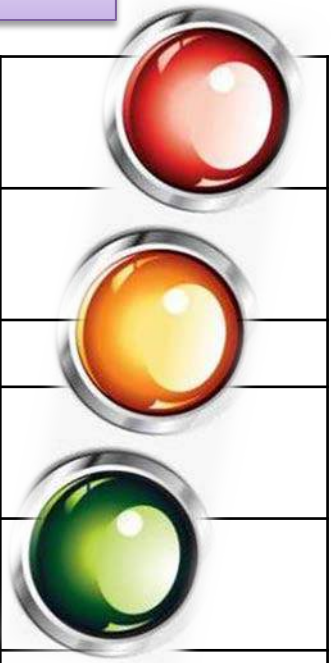
NTS Results – Data Analysis

Each box contains a score out of 100, which represents how positively or negatively trainees answered the questions for that indicator. You can also view question responses by clicking on the score.

If the score is significantly negative or positive compared to the national average, the box is highlighted red or green. Where it is negative or positive but shares a confidence interval with the national average, the box is highlighted pink or light green.

Indicator Analysis - colour codes

	Positive Outlier
	Quartile 3 but not an outlier
	Quartile 2
	Quartile 1 but not an outlier
	Negative Outlier
	N < 3
	No Responses (all respondents answered N/A)



GMC Initial Findings Report

- Over 75,000 Trainees/Trainers took part in the UK/Scot/NI/Wales
- DiT = 94.8% response rate *(lower)* – Trainers = 44.8% *(higher)*
- Over 1/3 of Trainers not able to use time allocated to them for training
- Over 1/3 of Trainees – intensity of work/day as heavy
- Over 2/3 of Trainers – intensity of work/day as heavy
- Over 1/4 of Trainers/Trainees – loose training opps due to rota gaps
- Over 1/2 did not receive their rotas with 6 weeks' notice.
- 1/3 of Trainees – unsure of who to approach for Health & Well Being
- 1/3 Trainees rate their Doctors Mess Facilities as poor
- Organisations ARE acting on Feedback from the Survey – not complacent
- If there are concerns about a Training Site – the GMC work with the PG Dean/HEENW
- This Year added Q's on Resources and Facilities for Rest/Study
- CAN use the Survey to REPORT on Patient Safety/Bullying or Undermining Concerns

GMC Initial Findings Report

- 9 in 10 Trainers enjoy their role in educating the next generation of doctors
- GMC Standards are clear – *Organisations must have suitably qualified doctors to Supervise Doctors in Training*
- 1/10 DiT have no Common Room/Mess
  - Of those - 2/10 "poor – very poor"
- Over 1/3 - weak Wi-Fi Signal – no connectivity
- Concerns about out-of-hours resources/facilities – travel – shifts
- 3/5 lack/difficulty - out-of-hours catering facilities
- 2018 – added 7 Q's around "burn out" (voluntary) – 50,000 answered
  - Over 1/5 of DiT and Trainers "High/very high degree"
  - Proportion of GP Trainers – decreased by sim % point.
- GMC Commissioned UK-Wide Review on "Wellbeing" - (West/Coia)
- GMC use "Enhanced Monitoring" to put measures in place to improve training.
- Later in 2019 the GMC will Publish an in-depth analysis on the Surveys

HEE Quality Framework

Risk Category	Description
Category 0	**NO Concerns** - ALL HEE Standards are met
Category 1	**Minor Concerns** – in one or more areas the HEE Standards are not being met, but we are assured by the Action Plans in place to address the concern,
Category 2	**Significant Concerns** – there are a significant number of areas in which the HEE Standards have not been met, and plans are not demonstrating improvements.
Category 3	**Major Concerns** – the placements concerned are well below the standards expected by HEE; the agreed improvements have not been delivered and there is a significant risk to the quality of education and training
Category 4	**Training Suspended** – when all other avenues have been explored, HEE may decide to suspend placements. This decision may only be made after careful consideration, and at the very highest level of the Organisation.

In June 2018….

Overall RISK Score Category 2 - with only 1 Action graded at CAT 3.

- ***Patient Safety Concern*** – GP - Referred A&E patients – ensure they are appropriately clerked, reviewed and treated within appropriate timeframes.
- **CAT 1 – Role of the CBU's/Structure** – alignment to Specialty groupings – rota issues.
- **CAT 1 – Equality & Diversity** – "challenging" intolerance
- **CAT 2 – HANDOVER – focus required for CMT's** – formalised/structured/dedicated room
- **CAT 2 – ROTAS – Medicine** - ALL Grades must factor in learning experience/curricula
- **CAT 2 – MEDICINE INDUCTION** (local) – "on-call arrangements"/Bleep process prior to beginning their placements.
- **CAT 2 – Clinical Supervisors in Medicine** – awareness of their duties and the curricula (esp. for GPST's) – locum consultants turnover
- **CAT 2 – Learning experience, particularly for FY's in Medicine** – to include Supervision/Assessments and Feedback.
- **CAT 3 - Governance and Quality Control** – Trainees' concerns/complaints addressed and resolved and that they can be empowered to raise concerns (even in conflict) and to be offered outcomes and solutions/improve feedback.

5= CAT 2……..2 CAT 1……..1 CAT 3/Patient Safety Concern

HEENW view the "Enhanced Monitoring" status of the Trust as "Departmental" rather than "Trust wide" concerns.

In June 2019….

- ✓ **10 Positive Outliers**
- ❖ **68 Negative Outliers – trend indicated in *Geriatric Medicine***
- ❖ **The "Feedback" Indicator is the *most consistent Negative trend***
- ✓ **Noted *many significant improvements* within MEDICINE**
  - **HANDOVER *improving by a significant 50 pts* from 2018**
  - **Improving scores for CMT most is *most noticeable* = RISK score from 2 to 1**
  - **Overall Medical Specialties – *Improvements are apparent* = RISK from 2 to 1**
  - **Monitoring and Reporting Systems (ALL Specialties) = RISK score from 2 to 1**
  - **Burnout Question – *(Gastro – but remains inconclusive)* = RISK Score of 1**
  - **Anaesthetic Trainees - *Managing patients in EM* = RISK Score of 1**
  - **2018 HEE Results 5 = CAT 2/2 CAT 1/1 CAT 3/Patient Safety**
  - **2019 HEE Results = 5 = CAT 1**

GPST's

Medicine/A&E/Paeds/O&G - requires some improvements in Experience, Curriculum Coverage, Rota Design and Feedback

GPST's in Paeds – RISK Score of 1

Acute Internal Medicine - *Improving*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Acute Internal Medicine	Overall Satisfaction	70.40	72.00	65.14	67.50	66.00	67.86	51.67	61.78
Acute Internal Medicine	Clinical Supervision	80.40	83.40	80.14	77.16	71.44	74.17	70.00	76.25
Acute Internal Medicine	Clinical Supervision out of hours				73.71	84.00	81.43	76.39	84.12
Acute Internal Medicine	Reporting systems					52.50	63.57	65.56	71.67
Acute Internal Medicine	Work Load	27.50	40.00	35.71	42.19	23.44	33.33	31.94	47.22
Acute Internal Medicine	Teamwork						61.90	65.74	62.96
Acute Internal Medicine	Handover	62.50			100.00		66.67	57.50	61.25
Acute Internal Medicine	Supportive environment				56.25	67.50	61.43	50.00	57.22
Acute Internal Medicine	Induction	73.00	82.00	70.71	74.38	60.00	75.00	73.33	55.00
	Adequate Experience						64.64	62.78	68.33
							58.33	59.26	71.30
	Access to Educational Resources	63.45	48.71	61.44	53.20	50.80			
	Educational Governance						63.09	59.26	66.67
	Educational Supervision	90.00	80.00	85.71	84.38	75.00	90.48	74.31	74.31
	Feedback	66.67	58.33	54.17	58.33	12.50	75.70	56.67	54.17
Acute Internal Medicine	Local Teaching	51.20			40.33		50.33	62.33	54.67
Acute Internal Medicine	Regional Teaching	72.33						80.67	69.00
Acute Internal Medicine	Study Leave				71.67		52.78	48.44	62.50
Acute Internal Medicine	Rota Design							29.17	47.92

Reduction from
4 REDS to 2 REDS
(continuing to improve)

Emergency Medicine – *Improvements Required*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Emergency Medicine	Overall Satisfaction	78.75	83.71	87.53	81.71	77.89	66.33	71.92	73.46
Emergency Medicine	Clinical Supervision	86.31	85.55	89.12	84.50	83.92	91.15	85.52	92.21
Emergency Medicine	Clinical Supervision out of hours				85.54	84.96	86.82	82.29	86.81
Emergency Medicine	Reporting systems					70.28	74.06	77.50	71.06
Emergency Medicine	Work Load	33.33	41.52	37.38	23.36	27.19	35.24	34.62	27.88
Emergency Medicine	Teamwork						74.31	75.64	66.67
Emergency Medicine	Handover	31.25	81.25	79.46	46.88	69.91	74.58	68.58	53.96
Emergency Medicine	Supportive environment				76.79	66.58	[illegible]	68.85	71.15
Emergency Medicine	Induction	90.00	95.36	92.65	[illegible]	93.61	90.63	79.62	80.38
Emergency Medicine	Adequate Experience	78.13	[illegible]	[illegible]	83.57	83.16	72.71	78.65	79.23
Emergency Medicine	Curriculum Coverage						70.49	70.51	71.15
Emergency Medicine	Access to Educ[illegible]	70.91	76.15	68.90	61.55	65.42			
	[illegible]ance						63.89	74.36	68.59
	[illegible]ational Supervision	93.75	94.64	91.18	94.64	88.89	85.07	83.17	80.77
	Feedback	78.87	80.77	75.00	74.04	73.15	67.92	69.32	60.26
	Local Teaching	73.06	70.00	77.70	65.57	75.10	52.33	65.95	57.86
	Regional Teaching	75.78	81.10	69.79	78.36	76.68	88.25	75.95	74.88
	Study Leave	76.56	69.83	70.00	85.50	66.11	54.74	58.85	49.65
Emergency Medicine	Rota Design							49.52	47.60

3 PINKS
1 RED

General Internal Medicine – *Improvements Required*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
General (internal) medicine	Overall Satisfaction	70.40	73.60	74.67	62.00	61.14	54.14	65.40	63.38
General (internal) medicine	Clinical Supervision	82.40	85.00	84.67	79.81	72.29	65.71	77.00	76.88
General (internal) medicine	Clinical Supervision out of hours				79.06	81.57	78.57	82.81	89.06
General (internal) medicine	Reporting systems					51.67	67.14	62.00	66.88
General (internal) medicine	Work Load	43.75	40.00	.33	37.50	25.00	30.36	40.00	46.88
General (internal) medicine	Teamwork						64.29	70.00	65.63
General (internal) medicine	Handover	80.00	80.00		100.00	61.90	64.29	47.50	73.44
	Sup ment				63.75	60.00	51.43	63.00	56.88
	action	63.00	83.00	75.00	28.75	41.90	62.50	68.00	67.19
	Adequate Experience	80.00	80.00	76.67	60.00	64.29	59.64	68.50	61.56
	Curriculum Coverage						52.38	63.33	56.25
General (internal) medicine	Access to Educational Resources	72.14	60.27	63.10	61.21	53.83			
General (internal) medicine	Educational Governance						42.86	63.33	66.67
General (internal) medicine	Educational Supervision	95.00	85.00	83.33	62.50	61.90	79.17	81.25	77.34
General (internal) medicine	Feedback	84.17	78.33			52.38	45.83		42.71
General (internal) medicine	Local Teaching	55.40	56.60	59.33	52.00	46.83	59.71	65.00	58.96
General (internal) medicine	Regional Teaching	57.63	72.55		59.92	66.13	61.05	57.17	56.87
General (internal) medicine	Study Leave	81.00	79.44	68.33		50.00	31.60	50.00	54.69
General (internal) medicine	Rota Design							40.00	38.28

Increase in REDS = 2
Increase in PINKS from 4 to 5

Geriatric Medicine – *Improving*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Geriatric medicine	Overall Satisfaction	58.50	58.00	71.00	74.67	73.71	67.44	53.11	58.73
Geriatric medicine	Clinical Supervision	80.50	70.79	73.97	83.78	81.00	82.22	76.25	69.43
Geriatric medicine	Clinical Supervision out of hours				82.69	82.43	77.78	[illegible]	77.08
Geriatric medicine	Reporting systems					60.71	[illegible]	54.44	60.91
Geriatric medicine	Work Load	26.56	29.17	45.31	35.42	[illegible]	32.64	39.58	37.50
Geriatric medicine	Teamwork						67.59	62.04	66.67
Geriatric medicine	Handover	45.31		[illegible]	87.50	61.11	79.17	46.88	60.42
Geriatric medicine	Supportive environment				66.67	69.29	60.56	44.44	55.91
Geriatric medicine	Induction	[illegible]	90.83	77.50	78.89	73.57	68.06	65.28	60.91
Geriatric medicine	Adequate Experience	68.75	55.00	72.50	71.11	65.71	66.94	57.50	60.45
Geriatric medicine	Curriculum Cover[illegible]						63.89	49.07	62.88
	Acces[illegible]onal Resources	55.02	58.93	57.50	66.92	62.08			
	[illegible]onal Governance						62.04	50.00	68.18
	Educational Supervision	75.00	79.17	84.38	94.44	85.71	82.87	69.44	76.14
	Feedback	45.00	61.67	50.00	66.67	70.24	57.81	54.17	46.43
	Local Teaching	51.13		45.67	49.67	52.33	41.25	60.42	61.39
Geriatric medicine	Regional Teaching	58.25		58.50	62.67		53.88	65.00	63.61
Geriatric medicine	Study Leave	63.33		76.67	62.22		65.63	45.83	62.85
Geriatric medicine	Rota Design							18.75	34.09

Equal = PINKS
Reduction in REDS
from 9 to 7

Respiratory Medicine – *Improving*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Respiratory Medicine	Overall Satisfaction	62.67	79.43	70.00	72.00	72.00	74.56	63.00	64.00
Respiratory Medicine	Clinical Supervision	78.56	85.43	84.38	88.00	85.00	90.97	74.29	76.25
Respiratory Medicine	Clinical Supervision out of hours				77.22	82.57	82.13	69.64	73.44
Respiratory Medicine	Reporting systems					66.13	61.67	64.17	70.00
Respiratory Medicine	Work Load	29.86	33.93	35.94	28.57	28.57	31.94	32.14	34.38
Respiratory Medicine	Teamwork						74.07	63.10	60.42
Respiratory Medicine	Handover	56.94	66.67	85.00	91.67	56.25	61.11	53.13	
Respiratory Medicine	Supportive environment				65.56	64.29	66.11	59.29	65.00
Respiratory Medicine	Induction	70.56	92.86	87.50	77.78	83.57	81.94	60.71	67.50
Respiratory Medicine	Adequate Experience	70.00	85.71	76.25	73.33	68.57	78.89	68.21	74.38
Respiratory Medicine	Curriculum Co						82.41	64.29	70.83
Respiratory Medicine	Acce ional Resources	59.37	59.33	59.23	62.59	68.03			
	nal Governance						68.52	60.72	70.83
	Educational Supervision	86.11	96.43	84.38	88.89	82.14	89.35	84.82	82.81
	Feedback	73.96	70.14	80.95	88.33	50.00	70.37	69.64	63.54
	Local Teaching	41.56	45.75	42.00	52.50	55.00	50.83	58.34	
	Regional Teaching	69.90	69.08	56.19	60.04	61.00	64.88	72.92	
	Study Leave	64.72	50.00	56.00	77.00	60.83	57.50	66.15	
	Rota Design							30.36	32.81

Reduction in PINKS
Reduction in REDS

Endo & Diab – *Improving*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Endocrinology and diabetes mellitus	Overall Satisfaction	60.80	68.80	84.00	75.00	77.60		50.67	63.00
Endocrinology and diabetes mellitus	Clinical Supervision	83.40	86.00	96.40	95.75	91.40		78.33	71.67
Endocrinology and diabetes mellitus	Clinical Supervision out of hours				91.50	78.80		85.42	75.00
Endocrinology and diabetes mellitus	Reporting systems					.00		53.33	
Endocrinology and diabetes mellitus	Work Load	36.25	40.00	48.75	.44	35.00		33.33	25.00
Endocrinology and diabetes mellitus	Teamwork							61.11	77.78
Endocrinology and diabetes mellitus	Handover	60.00		92.50	96.88	58.33		47.92	75.00
Endocrinology and diabetes mellitus	Supportive environment				76.25	56.00		60.00	65.00
Endocrinology and diabetes mellitus	Induction	51.00	87.00	96.00	93.75	81.00		55.00	55.00
Endocrinology and diabetes mellitus	Adequate Experience	66.00	66.00	88.00	75.00	72.00		51.67	77.50
Endocrinology and diabetes mellitus	Curriculum C							55.55	86.11
Endocrinology and diabetes mellitus	A tional Resources	52.68	63.45	71.20	66.61	59.29			
ellit	ional Governance							41.67	75.00
	Educational Supervision	75.00	100.00	95.00	93.75	75.00		50.00	93.75
ellitus	Feedback	65.63	69.17	90.83	76.04	80.00		48.61	58.33
ellitus	Local Teaching	42.40	53.60	58.20	49.00	38.40		49.44	52.78
ellitus	Regional Teaching	58.25	68.38	77.19	59.50	62.85		48.61	56.11
ellitus	Study Leave	69.67	66.00	56.00	73.33	62.00		43.06	
Endocrinology and diabetes mellitus	Rota Design							33.33	39.58

Reduction in PINKS 13 to 4
Increase in REDS = 2

Cardiology – *Improving*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Cardiology	Overall Satisfaction	82.40	87.33	74.00	77.33	48.00	60.00	51.40	74.20
Cardiology	Clinical Supervision	79.85	90.33	85.33	89.33	70.67	76.67	65.00	89.00
Cardiology	Clinical Supervision out of hours				90.33	69.33	85.00	68.75	85.00
Cardiology	Reporting systems					50.00	73.33	43.00	68.00
Cardiology	Work Load	46.25	33.33	47.92	40.63	39.58	33.33	31.25	40.00
Cardiology	Teamwork						72.22	53.33	68.33
Cardiology	Handover	55.00	81.25	93.75	93.75			18.75	68.75
Cardiology	Supportive environment				71.67	43.33	71.67	50.00	65.00
Cardiology	Induction	91.00	96.67	89.17	90.83	71.67	65.28	56.00	61.00
Cardiology	Adequate Experience	88.00	90.00	75.00	80.00		81.67	45.00	64.50
Cardiology	Curriculum Coverage						66.67	50.00	63.33
Cardiology	Access to Educational Resources		70.24	60.12	66.47	39.29			
	Educati						61.11	51.67	45.00
	pervision	90.00	95.83	100.00	95.83	66.67	79.17	63.75	75.00
	Feedback	83.33	77.78	75.00	58.33	48.61		39.58	50.00
	Local Teaching	70.80	58.00	56.33	57.00			35.00	8.89
	Regional Teaching				75.75			62.78	67.22
	Study Leave	85.00		71.67	83.33			47.22	56.94
Cardiology	Rota Design							17.50	33.75

Reduction in REDS
6 to 5
Reduction in PINKS
from 9 to 2

Clinical Radiology - *Holding*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Clinical radiology	Overall Satisfaction	84.80	97.00	94.40	93.60	97.60	100.00	91.14	86.86
Clinical radiology	Clinical Supervision	89.80	98.75	95.40	98.20	98.20	100.00	97.14	93.39
Clinical radiology	Clinical Supervision out of hours				92.33	94.88	84.69	88.89	96.25
Clinical radiology	Reporting systems					85.00	90.00	79.17	86.00
Clinical radiology	Work Load	66.25	65.11	63.33	60.00	73.75	66.67	59.82	63.69
Clinical radiology	Teamwork						93.33	83.34	87.50
Clinical radiology	Handover								
Clinical radiology	Supportive environment				80.00	93.00	95.00	82.86	87.86
Clinical radiology	Induction	89.00	97.50	98.00	96.00	98.00	97.50	91.43	94.29
Clinical radiology	Adequate Experience	80.00	92.50	92.00	90.00	94.00	98.00	90.36	85.36
Clinical radiology	Curriculum Coverage						94.17	83.93	84.52
Clinical radiology	Access to Educational Resources	67.62	81.62	75.54	72.68	88.15			
	Educational Governance						91.67	83.33	83.33
	Educational Supervision	93.33	93.75	95.00	95.00	100.00	97.50	92.86	91.07
	Feedback	93.33	91.67	95.84		90.63	100.00	91.67	88.89
									70.24
		82.00		83.88	79.50	76.63	84.50	61.17	52.33
	Study Leave	71.00	98.33	70.00	91.33	89.67	79.17	76.19	76.49

Explore Local & Regional Teaching

Anaesthetics – *Sustained Results*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Anaesthetics	Overall Satisfaction	86.50	82.86	89.20	83.56	82.22	67.36	85.11	88.91
Anaesthetics	Clinical Supervision	95.25	89.86	93.80	91.44	92.33	90.45	95.56	98.18
Anaesthetics	Clinical Supervision out of hours				91.33	92.97	89.38	96.53	94.89
Anaesthetics	Reporting systems					82.78	63.50	73.13	72.84
Anaesthetics	Work Load	57.81	44.64	56.88	59.03	43.06	52.46	57.64	60.23
Anaesthetics	Teamwork						59.09	73.15	72.73
Anaesthetics	Handover	56.25	57.14	61.25	70.83	69.44	45.83	63.99	62.08
Anaesthetics	Supportive environment				79.44	86.67	68.18	84.44	76.82
Anaesthetics	Induction	85.00	95.00	85.50	84.44	81.11	74.43	85.00	90.91
Anaesthetics	Adequate Experience	90.00	84.29	87.00	86.67	83.33	73.64	84.72	83.64
Anaesthetics	Curriculum Coverage						71.21	86.11	82.58
Anaesthetics	Access to Educational Resources	74.40	71.85	77.92	66.93	66.96			
Anaesthetics	Educational Governance						62.88	88.89	87.88
Anaesthetics	Educational Supervision	100.00	100.00	97.50	91.67	97.22	87.12	97.92	84.66
Anaesthetics	Feedback	75.00	82.14	86.67	75.00	80.21	46.43	91.67	92.86
Anaesthetics	Local Teaching	57.63	52.86	64.60	69.78	64.22	50.55	75.92	83.33
Anaesthetics	Regional Teaching	70.94	67.04	67.50	69.00	68.66	72.96	80.28	68.79
Anaesthetics	Study Leave	81.04	78.81	81.00	84.79	94.38	60.99	90.05	78.03
Anaesthetics	Rota Design							65.97	81.25

General Surgery - *Sustained Results*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
General surgery	Overall Satisfaction	76.62	77.24	77.04	78.72	80.33	79.26	80.39	82.14
General surgery	Clinical Supervision	84.54	87.13	87.88	89.04	87.63	89.89	87.50	86.82
General surgery	Clinical Supervision out of hours				92.41	89.63	90.68	85.81	86.93
General surgery	Reporting systems					68.30	71.50	76.14	73.33
General surgery	Work Load	40.87	39.87	42.93	47.25	43.49	49.73	44.02	56.25
General surgery	Teamwork						70.65	69.38	67.05
General surgery	Handover	80.29	81.25	91.25	85.58	79.17	68.75	68.94	68.13
General surgery	Supportive environment				75.00	68.75	75.65	74.57	67.95
General surgery	Induction	89.55	87.76	91.74	90.20	78.68	81.61	86.96	80.74
General surgery	Adequate Experience	80.00	78.62	80.00	81.20	84.17	81.41	84.67	82.39
General surgery	Curriculum Coverage						78.26	80.80	76.90
General surgery	Access to Educational Resources	62.10	66.47	71.17	66.67	65.73			
General surgery	Educational Governance						77.17	71.74	73.86
General surgery	Educational Supervision	87.50	84.20	91.30	94.00	88.54	84.60	87.77	85.51
General surgery	Feedback	75.21	55.30	76.47	71.05	72.62	65.89	75.00	61.98
General surgery	Local Teaching	53.35	43.31	52.13	43.89	56.38	56.38	85.63	79.29
General surgery	Regional Teaching	59.62	55.48	60.41	66.56	65.41	62.91	92.08	89.05
General surgery	Study Leave	83.89	73.21	83.52	86.67	66.30	65.28	77.46	72.29
General surgery	Rota Design							64.95	67.33

Gastroenterology -Needs Improvement

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Gastroenterology	Overall Satisfaction	81.33		75.33	78.40	80.57	66.25	59.20	61.00
Gastroenterology	Clinical Supervision	92.33		81.00	85.20	83.00	82.50	82.00	82.50
Gastroenterology	Clinical Supervision out of hours				76.80	77.43	81.25	81.25	73.44
Gastroenterology	Reporting systems					61.43		62.00	67.50
Gastroenterology	Work Load	38.54		37.50	27.50	52.14	26.56	32.50	34.38
Gastroenterology	Teamwork						50.00	61.67	52.09
Gastroenterology	Handover	67.50			95.83	56.67	51.39	43.75	
Gastroenterology	Supportive environment				61.00	70.71	62.50	54.00	52.50
Gastroenterology	Induction			75.83	71.00	85.71	85.94	48.00	62.50
Gastroenterology	Adequate Experience	85.00		86.67	86.00	81.43	71.25	59.50	73.75
Gastroenterology	Curriculum Coverage						64.58	63.33	75.00
Gastroenterology	Access to Educ arces	65.21		50.83	51.25	64.29			
	ucat ance						68.75	58.33	72.92
	Supervision	91.67		87.50	90.00	96.43	91.67	78.75	73.96
	edback	76.04		80.00	81.67	69.17	62.50	61.46	38.89
	cal Teaching	57.17		52.33		61.25		61.11	
	gional Teaching	73.63		56.00		58.50		56.67	
	dy Leave	73.33		92.22	40.00	56.25	81.94	57.64	
Gastroenterology	Rota Design							38.75	48.44

Reduction in PINKS 7 to 5
Increase in REDS 1 to 2

Obstetrics & Gynaecology – *Sustained Results*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Obstetrics and gynaecology	Overall Satisfaction	80.75	91.76	83.76	79.29	89.67	84.00	77.67	75.81
Obstetrics and gynaecology	Clinical Supervision	91.06	94.69	93.41	89.71	94.42	89.20	92.71	86.41
Obstetrics and gynaecology	Clinical Supervision out of hours				92.94	92.82	94.46	90.34	85.16
Obstetrics and gynaecology	Reporting systems					85.00	81.25	76.25	70.00
Obstetrics and gynaecology	Work Load	55.47	58.46	48.16	50.25	55.73	50.45	53.65	54.69
Obstetrics and gynaecology	Teamwork						80.77	75.00	70.83
Obstetrics and gynaecology	Handover	77.50	85.16	74.22	85.16	84.38	81.25	65.97	68.19
Obstetrics and gynaecology	Supportive environment				82.35	90.83	80.00	73.33	70.94
Obstetrics and gynaecology	Induction	87.50	90.29	83.24	93.53	96.25	86.16	79.58	77.81
Obstetrics and gynaecology	Adequate Experience	80.63	88.24	79.41	77.06	89.17	79.11	84.17	75.94
Obstetrics and gynaecology	Curriculum Coverage						73.21	83.33	73.70
Obstetrics and gynaecology	Access to Educational Resources	67.95	77.95	64.81	68.30	71.43			
Obstetrics and gynaecology	Educational Governance						71.43	75.70	66.67
Obstetrics and gynaecology	Educational Supervision	92.19	100.00	98.53	95.59	97.92	88.27	75.00	79.30
Obstetrics and gynaecology	Feedback	71.94	80.00	75.00	76.79	88.54	67.63	91.67	59.94
Obstetrics and gynaecology	Local Teaching	63.25	68.23	50.31	48.92	56.00	59.46	51.95	64.22
Obstetrics and gynaecology	Regional Teaching	66.57	59.66	68.15	66.33	68.11	61.89	75.83	64.39
Obstetrics and gynaecology	Study Leave	72.44	73.45	87.62	84.00	90.00	72.60	83.71	75.69
Obstetrics and gynaecology	Rota Design							57.47	46.88

Paediatrics – *Needs Improvement*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Paediatrics	Overall Satisfaction	84.62	84.71	83.06	82.12	81.71	78.87	77.50	73.19
Paediatrics	Clinical Supervision	91.48	91.78	91.31	88.28	94.11	90.22	93.75	91.06
Paediatrics	Clinical Supervision out of hours				90.20	94.32	92.80	95.70	90.73
Paediatrics	Reporting systems					78.48	73.95	76.52	67.43
Paediatrics	Work Load	56.25	58.33	41.91	44.98	33.78	38.95	40.10	43.65
Paediatrics	Teamwork						67.75	82.55	69.25
Paediatrics	Handover	75.96	75.00	76.79	79.46	72.57	70.61	74.41	63.19
Paediatrics	Supportive environment				84.41	81.43	66.74	72.81	66.67
Paediatrics	Induction	92.69	94.71	93.53	86.76	78.93	75.27	70.31	74.76
Paediatrics	Adequate Experience	86.92	84.12	84.12	79.41	82.14	79.46	[illegible]	72.86
Paediatrics	Curriculum Coverage						78.08	77.60	67.06
Paediatrics	Access to Educational Resources			67.09	63.81	62.86			
	Educ[illegible]						67.03	71.35	63.49
	[illegible]upervision	92.31	94.12	95.59	95.59	83.93	83.70	77.73	77.08
	Feedback	81.25	78.27	72.62	68.75	66.67	63.89	69.58	50.32
	Local Teaching	66.15	60.07	56.45	53.67	46.10	53.78	47.22	55.09
	Regional Teaching	67.38	63.61	64.17	56.78	62.75	67.22	65.53	66.13
	Study Leave	82.69	74.29	63.48	79.86	68.71	52.60	59.82	54.63
Paediatrics	Rota Design							50.13	57.08

Increase in REDS – 1 to 3

Increase in PINKS – 0 to 2

ENT – *Continue to Monitor*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Otolaryngology	Overall Satisfaction		85.33				74.67	63.00	
Otolaryngology	Clinical Supervision		97.00				95.00	70.00	
Otolaryngology	Clinical Supervision out of hours						93.33	76.56	
Otolaryngology	Reporting systems						68.33	52.50	
Otolaryngology	Work Load		66.67				47.92	59.38	
Otolaryngology	Teamwork						69.44	62.50	
Otolaryngology	Handover						77.78	39.06	
Otolaryngology	Supportive environment						66.67	53.75	
Otolaryngology	Induction		96.67				66.67	46.25	
Otolaryngology	Adequate Experience		90.00				70.00	49.38	
Otolaryngology	Curriculum Coverage						75.00	56.25	
Otolaryngology	Access to Educational Resources		67.86						
Otolaryngology	Educational Governance						77.78	52.08	
Otolaryngology	Educational Supervision		100.00				90.28	75.00	
Otolaryngology	Feedback		88.89					56.25	
Otolaryngology	Local Teaching								
Otolaryngology	Regional Teaching								
Otolaryngology	Study Leave		94.44				50.69	43.75	
Otolaryngology	Rota Design							43.75	

Trauma & Orthopaedics – *Improving*

Post Specialty	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Trauma and orthopaedic surgery	Overall Satisfaction	68.62	77.45	64.62	71.00	71.00	66.09	69.30	67.27
Trauma and orthopaedic surgery	Clinical Supervision	82.48	86.68	81.31	82.00	84.73	85.00	79.50	85.68
Trauma and orthopaedic surgery	Clinical Supervision out of hours				83.33	83.91	85.00	71.09	76.70
Trauma and orthopaedic surgery	Reporting systems					68.33	69.50	74.38	70.00
Trauma and orthopaedic surgery	Work Load	43.59	44.32	39.90	51.22		43.75	53.54	38.45
Trauma and orthopaedic surgery	Teamwork						67.42	71.67	70.46
Trauma and orthopaedic surgery	Handover	68.27		80.56	63.75	66.67	60.18	61.98	60.16
Trauma and orthopaedic surgery	Supportive environment				65.00	67.92	65.45	67.50	63.18
Trauma and orthopaedic surgery	Induction	89.23	90.45	88.85	79.58	70.42	67.61	76.50	78.64
[illegible]	Adequat	65.38	76.36	65.38	71.67	76.67	70.45	72.75	73.41
[illegible]	[illegible]overage						74.24	82.50	72.73
[illegible]	[illegible]ccess to Educational Resources	56.64	70.36	67.70	65.74	66.64			
[illegible]	Educational Governance						70.45	72.50	69.70
[illegible]	Educational Supervision	88.46	90.91	96.15	87.50	93.75	87.50	79.38	79.55
[illegible]	Feedback	75.32	82.15	73.26	60.12	73.75	57.74	61.98	73.75
[illegible]	Local Teaching	48.62	64.33	60.38	56.57	60.43	55.00	78.33	59.00
Trauma and orthopaedic surgery	Regional Teaching	82.25	88.67	88.04	86.79	87.32	91.00	86.00	92.33
Trauma and orthopaedic surgery	Study Leave	63.33	70.21	72.27	75.37	71.11	56.48	55.65	59.52
Trauma and orthopaedic surgery	Rota Design							65.83	57.64

Reduction in PINKS = from 4 to 2
1 GREEN

Improving Medical Training – Trust Headlines

- ❑ 2018 = 31 REDS – reduced to 25 REDS in 2019 (19% overall improvement)
- ❑ 2018 - 58 PINKS – reduced to 40 PINKS in 2019 (31% overall improvement)

- ✓ Does Influence WHH AAV/Dean's Report/CQC Rating for the Trust
- ✓ Does affect the "GMC Enhanced Monitoring Category/Grade 1,2,3
- ✓ Does affect Medical Workforce Recruitment and Attraction
- ✓ Does Remains Confidential
- ✓ +VE & -VE Outliers - what is Trending? *(teamwork/local teaching/feedback)*
- ✓ Can access Comparative Results with other Trusts
- ❖ Bullying & Undermining (1 CASE/Action Plan to be submitted by 26th July
- ❖ Patient Safety (NO Cases)

How the Trust has supported Med ED to Achieve these Improvements

- ✓ Medical Handover Structure and interface with Trust Wide Safety Brief
- ✓ Developing Trainee Experience Group
- ✓ Medical Education Newsletter
- ✓ Medical Education Weekly Huddle – NEW DME/Dep. MD – Dr Alex Crowe

For the future:

- face to face meetings with CBU over GMC trainee survey action plan
- Ward Round Accreditation
- RCP and RCS Educational events at WHH, Medical Education Faculty Away Day
- Development of Primary Care and Secondary Care Medical Education Plan
- Explore Med Ed Fellows aligned with Universities.

Next Steps.....

- **Med Ed Quality Committee – for discussion with the RCT's who support Trainees in Service – Paper for inclusion in the ED GOV Committee**

- **GMC Action Plans to be submitted with each Specialty**
  - **CBU Meetings will be requested by LS**

- **Await the HEENW decision regarding "Enhanced Monitoring" CATEGRORY**
  - ***CAT 2 Status to be reviewed***

thanks for listening!

Appendix 1

Board Assurance Framework

Board Assurance Framework

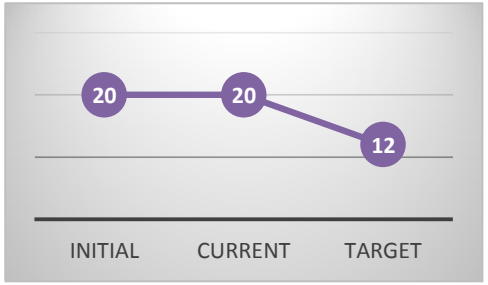
The Board Assurance Framework (BAF) focusses on the key strategic risks i.e. those that may affect the achievement of the Trust's Strategic Objectives

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
115	Kimberley Salmon-Jamieson	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	1	20 (5x4)	12 (4x3)	TBC	Trust Operations Board
134	Andrea McGee	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
135	Phill James	Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	1	16 (4x4)	10 (5x2)	TBC	Trust Operations Board
224	Chris Evans	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience.	1	16 (4x4)	8 (4x2)	TBC	Trust Operations Board
125	Chris Evans	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	1	16 (4x4)	4 (4x1)	TBC	Trust Operations Board
145	Mel Pickup	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial	3	15 (5x3)	8 (4x2)	TBC	Trust Operations Board

		position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.					
143	Phill James	Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation	1	12 (4x3)	8 (4x2)	TBC	Trust Operations Board
414	Phill James	Failure to implement best practice information governance and information security policies and procedures caused by increased competing priorities due to an outdated IM&T workforce plan resulting in ineffective information governance advice and guidance to reduce information breaches.	3	12 (4x3)	8 (4x2)	TBC	Quality Assurance Committee
695	Kimberley Salmon-Jamieson	Failure to keep the national invasive cancer audit up to date to comply with NHS Cervical screening programme standards; which caused a backlog of cervical screening reviews which resulted in a non-compliance with the cervical screening specification 2018/2019.	1	9 (3x3)	6 (2x3)	TBC	Quality Assurance Committee
241	Alex Crowe	Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.	2	8 (4x2)	4 (4x1)	TBC	Trust Operations Board

Strategic Objective 1: We will … always put our patients first through high quality, safe care and excellent patient experience.
Strategic Objective 2: We will … be the best place to work with a diverse, engaged workforce that is fit for the future.
Strategic Objective 3: We will … work in partnership to design and provide high quality, financially sustainable services.

Board Assurance Framework

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	12 (4x3)
Assurance Details:	Recruitment and Retention strategy has been developed for nursing and is being operationalised Nursing Recruitment and Retention meetings held 3 weekly Nursing Recruitment Leads x 2 Matrons in place Business case developed to support Nursing recruitment and retention Senior staffing meeting put in place and processes at an operational level to ensure safe nurse staffing along with staffing checks at every capacity meeting Reporting on safe staffing monthly to Board and staffing will be reported on all wards in line with national requirements. Risk Management Systems allow for reporting of incidents re staffing and escalation of risk, when required Individual staffing action plans for high risk areas Review of skill mix and creating roles in teams e.g. pharmacy technicians to support medication administration With regards to Consultant Recruitment – an external company has been appointed to recruit at Consultant Level with a review of JD's/Marketing of our posts; supported by EXIT Interviews for Leavers. Staffing rates monitored on a shift by shift basis (actual versus planned numbers) and reported to the Board 6 monthly acuity & Dependency review undertaken across all areas – Adults, Paediatric, Maternity & NICU. Results to be reported to Board. Incident data regarding staffing reviewed by Chief Nurse Escalation protocols in place – evidence of these being activated by nursing team We have recently been successful in appointing 4 Cardiology Consultants and are attending ES Training in due course and will be allocated Trainees as required. The Trust is ensuring safe medical staffing via use of long term locums in some specialities and also by breaking the cap, when required. There is an action plan in place following concerns raised by HENW/Deanery Approval for 7 Trust grades across the Acute Care division (3 appointed) , with a business case for additional 3 (Dec 17) 3 speciality Drs recruited in acute care Division in past 6 months (Dec 17) -Daily nurse staffing report which forms part of the bed management reporting framework, underpinned with the staffing escalation process. This was audited in April 2018 with further Audit due October 2018. -Sickness pilot commenced in August 2018 for a period of three months. This is due for evaluation in March 2019. -Red Flag Events which relate to unmet care need due to staffing are now in place across the Trust and are responded to by the Lead Nurse or Matron on a daily basis. •Undertaking 'itchy feet' conversations with staff who are thinking of leaving to improve retention. •Undertaking a staffing escalation audit in Oct to review the effectiveness of the staffing escalation plans. - Joined cohort 4 of the NHSi retention improvement programme which commences in Nov 2018. - First meeting of the NHSi Retention Collaborative on 22nd November 2018 – retention plan underway to include full data review and staff engagement. NHSI site meetings planned for February 2019 in relation to the Retention Collaborative Paediatric Staffing Review undertaken Birthrate + Business Case approved Staffing Update – January 2019 -Full review of ward establishments in 2017/18 -Approval of a staffing business case with 3 million investment in nurse staffing				

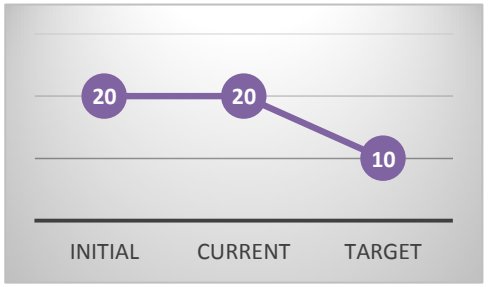
	-Recruitment campaign for the uplift of establishment in registered nurses and health care assistants -Targeted recruitment campaigns for registered nurses, open days careers events both locally in the Trust and regionally with the Universities RCN and Nursing times – plan in place for the next 12months -Career advice events in local colleges and schools 'steps to success' focus groups for year 10's Recruited 95 registered nurses and 92 health care assistants since the beginning of the 2018 -Robust process in place for staffing escalation actions • Daily staffing meeting • Monthly staffing operational meeting Workforce Development as part of the retention campaign • Strengthened preceptorship programme • Band 5 competency programme • Advance Practice Development programme 28 nurses currently in training • Registered Nurse with Specialist Interest – Nursing Times Workforce Awards Finalists • Introduction of Nursing Associates • Ward Managers Development Programme • Lead Nurse Development Programme WHH are part of Cohort 4 Retention Collaborative with NHSI Joined in Dec 2018 • Staffing data review • Deep dive on retention • Developed a retention plan with implementation initiatives -Nursing Retention and Recruitment Group in place to review track and monitor progress -Recruitment and Retention KPI dashboard in place and report monthly to the Recruitment and Retention Group -Monthly Safe Staffing Assurance Report to Board -6 monthly Safe Staffing Report to Board in March 2019 -12monthly staffing review with Ward Managers undertaken by the Chief Nurse - reporting on 22nd March 2019 First site meeting with NHSi in February 2019 – Plan to be submitted in March 2019 Nursing & Midwifery Dashboard reviewed monthly at the Recruitment & Retention Group Retention Strategy Completed and will be presented on 15th March 2019 Nursing and Midwifery Turnover monitored at the Recruitment & Retention Group and reduction is in line with the plan. Staffing escalation Audit Update. Staffing escalation audit was undertaken in October and presented to the Recruitment and Retention Group in November. Recommendations have been undertaken and a further audit will be undertaken in April 2019. Retention plan in place and submitted to NHSi end of March 2019. The plan commits to reduce registered nurse turnover by 1.5% in the next 12 months. Progress will be monitored monthly at the Recruitment & Retention Group. The Retention Plan is being monitored at the Recruitment and Retention Group and we have seen a reduction in Registered Nurse Turnover for the past 4 months the current rate is 12.91% which is less than the National rate of 13%. Current vacancies are as follows: Registered Nurses 92 vacancies with 72 nurses having accepted an offer of a post at WHH and are due to commence no later than Sept 19 Further recruitment events are planned as part of the recruitment calendar. Winter Ward (K25) closed on 7th June 2019 releasing staff back to their base Wards. Associate Chief Nurse undertaken 6 month staffing review on all patient areas Currently a Bank vacancy rate of 106 • August - 5 booked for induction • Sept – 19 booked for induction • Oct – 4 booked for induction • Further 15 going through pre-employment checks	

	HCA – 25 vacancies • Aug – 2 booked for induction • Sept – 2 booked for induction • Oct - 1 booked for induction Turnover continues to be monitored monthly and as part of the NHSi Collaborative with an overall reduction of RN turnover of 2.44%	

Assurance Gaps:

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Undertake the Allocate Safer Nursing Care Acuity review to understand establishments with regard to acuity	Allocate Safer Nursing Care Acuity	Acuity / Dependency review undertaken in May 2017. Results being collated	Goodenough, John	30/06/2017	30/06/2017
Develop a risk assessment process for opening/closing beds/ward	Risk assessment	Develop a risk assessment process for opening/closing beds/ward	Goodenough, John	31/03/2017	31/03/2017
Monthly reporting of Recruitment and Retention Strategy to Strategic People Committee and Nursing and Midwifery Board.	Recruitment and Retention Strategy	Monthly reporting of Recruitment and Retention Strategy to Strategic People Committee and Nursing and Midwifery Board.	Salmon-Jamieson, Kimberley	30/04/2018	30/04/2018
Ensure a report is given to the Board of Directors regarding medical staffing in medical specialities, including a progress update of the action plan	Report for Board of Directors	Ensure a report is given to the Board of Directors regarding medical staffing in medical specialities, including a progress update of the action plan	Constable, Simon	31/03/2017	31/03/2017
Ensure a report is given to the Board on nurse staffing assurance processes	Report to the Board nurse staffing assurance processes	Ensure a report is given to the Board on nurse staffing assurance processes	Salmon-Jamieson, Kimberley	31/03/2017	31/03/2017
All areas to have risk assessed implications of IR35	All areas to have risk assessed implications of IR35	All areas to have risk assessed implications of IR35	Carmichael, Mark	28/04/2017	28/04/2017
Ensure a deep dive is undertaken of the risk regarding staffing and reported to Quality Committee	deep dive is undertaken of the risk regarding staffing	Ensure a deep dive is undertaken of the risk regarding staffing and reported to Quality Committee	Salmon-Jamieson, Kimberley	30/06/2017	30/06/2017
Ensure a monthly incident report on staffing incidents is presented to Patient Safety & Effectiveness Sub Committee	Monthly incident report	Ensure a monthly incident report on staffing incidents is presented to Patient Safety & Effectiveness Sub Committee	Martin, Ursula	30/06/2017	30/06/2017
Ensure practice reviews are undertaken across all areas reporting high staffing incidents to understand level of risk	Practice reviews are undertaken	Ensure practice reviews are undertaken across all areas reporting high staffing incidents to understand level of risk	Goodenough, John	30/11/2017	04/09/2018
Medical staffing dashboard to be in place	Medical staffing dashboard	Medical staffing dashboard to be in place	Constable, Simon	29/12/2017	29/12/2017
Develop Terms of Reference for Medical Staffing HR Group	Terms of Reference for Medical Staffing HR Group	Develop Terms of Reference for Medical Staffing HR Group	Constable, Simon	31/01/2017	31/01/2017
Identify KPIs to be monitored Development of e-rostering Dashboard Monitor implementation of KPIs and any subsequent improvements.	Roster Management	This is reviewed at the monthly Operational Staffing Meeting. Review performance against the E-Rostering Guidance	Browning, Mrs Rachael	31/08/2018	31/07/2018

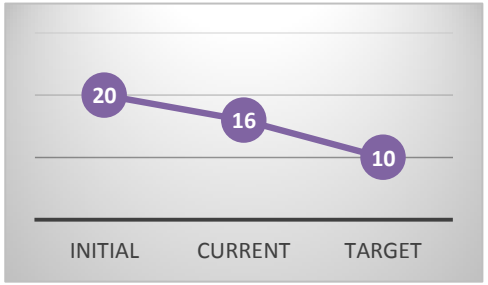
Board Assurance Framework

Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 10 (5x2)
Assurance Details:	•Core financial policies controls in place across the Trust •Revised governance structure within the Trust to enable strengthened accountability •Finance and Sustainability Committee (FSC) established overseeing financial planning •Monthly financial monitoring with NHSI •Regular review at Executive team meeting and development sessions •Annual plan development process •Performance monitoring in QPS meeting •Signed up to a Controlled Expenditure Programme (CEP) process with main Commissioners to support financial planning, sharing of risk and agreement of schemes that are in the interest of the whole local economy •Entered in to a Block Contract with Warrington & Halton CCGs for 2019/20 supported by an agreed set of principles under the CEP Lite Framework •Work with the Commissioners on QIPP and CIP schemes through the Collaborative and Sustainability Group to ensure the schemes have a positive impact on sustainability across the whole health economy •Monthly FRG meeting with CBU led by Dof •Corporate Trustee Charities Commission Checklist, reporting bi-annually through Board •Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports •Regular updates to Executive Team, FSC and Trust Board •Regular updates to NHSI regarding the risks linked to the current financial position; including regular performance review meetings to discuss the current position and financial risk. These meeting have resulted in the Trust's change from segment three to segment two. •Accepted offer from NHSi of a control total for 2019/20 giving the Trust access to £17.9m additional funds. This also exempts the Trust from national fines and penalties. •Transfer of resources in to operational teams to support CIP delivery at the front line. •Transfer of reporting of CIP to DoF and delivery to Chief Operating Officer •Trust teams are working within the place based teams to bid for additional STP monies to improve sustainability •Regarding the aged debt in dispute, a pack of evidence for each invoice is being collated in preparation for a joint legal actions with other providers. The matter has been escalated to NHSi & NHSE and financial support has been requested while this is under review by the regulators. •Legal advice obtained re: aged debt dispute Control re employment legislation - Sub group established for OT payments reporting through premium pay spend and review group - Commissioned an audit review of OT processes subject to Chair of Audit Chair Approval - Recommendation for internal OT processes to be presented to Exec Team - Introduced the Financial Resources Group (FRG)that reports to FSC - CIP Workshops taking place to improve the CIP Position - Memorandum of understanding agreed with Bridgewater Community Trust - WLI process reviewed and strengthened.				

	•Regular planning meetings in place with Commissioners. Activity plans and contract agreed for 2019/20. • Workshop undertaken with - Exec, CBU, Corporate to review of 2019/20 cost pressures •Market Analysis is now included in the CBU monthly dashboard and forms part of the monthly review •Financial Strategy approved by Trust Board in March 2019 • In relation to the aged debt, the supplier/debtor has gone in to administration; this will avoid further growth of the debt. The Trust has provided the Administrator with proof of debt. • The Trust will write to Wirral CCG in relation to financial support for the existing debt. • Submitted System Recovery Plan on 2nd August 2019. • Update on System Recovery Plan to be provided to NHSE/I by 13th September 2019, along with the first draft of the 5 year plan. • CEO / Accountable Officer led Financial System Recovery Group established to oversee the system financial recovery plan • Capital prioritisation process in place • Review of CBU Forecast Outturns has taken place. • Following £1b increase in NHS Capital investment, NHSE/I have instructed Trusts to revert to their original capital plans.	
Assurance Gaps:	•Failure to achieve Financial control total may result in loss of FRF, MRET and STF and worsening cash position. •Failure to manage fines and penalties and CQUIN which may result in loss of STF and worsening cash position •Risk to financial stability due to loss of income relating to STP changes •Inability to develop a strategic plan to deliver a break even position over the next 5 to 10 years •Loss of contracts due to competitive market which may result in Trust no longer being sustainable. There is a gap in Market analysis and Knowledge of our competitors •Loss of income through the failure of WHH Charity •Failure to repay existing loans leading to the inability to apply for future financial support and threat to the Trust as a going concern. •Increased risk relating to an aged debtor as continuing dispute regarding charges levied by the Trust are being challenged. •Risk of under delivery of CIP due to insufficient schemes identified to deliver the full program and the organisational ability to translate improvement work into financial improvement - Extended Loan repayment confirmation of further extension from NHSi received and extended to Nov 19. Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims. •Medical Staffing pressures identified at budget settings have not all been addressed putting pressure on the financial position. •Halton additional capacity may not be able to close if the Commissioner's alternative community plans are not put in place by the end of February 2019 This service remains open and funding has yet to be agreed •No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Mitigated system risk of circa £10m – plans required to address across the system of Warrington & Halton CCGs. WHH NHS FT and Bridgewater Community Healthcare NHS FT. • Risk that capital needs exceed capital funding resources available.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continue to seek support from Commissioners	Continue to seek support from Commissioners	Continue to seek support from Commissioners	Hurst, Jane	31/12/2018	31/12/2018
Continue to seek support from NHSI approach to management and repayment of loans	Continue to seek support from NHSI approach to management and repayment of loans	Continue to seek support from NHSI approach to management and repayment of loans	Hurst, Jane	31/03/2019	31/03/2019
Development of a Market analysis of Trust competitors to understand imminent and future risk to income	Development of a Market analysis of Trust competitors to understand imminent and future risk to income	Development of a Market analysis of Trust competitors to understand imminent and future risk to income	Hurst, Jane	31/03/2019	31/03/2019
Review of a Financial Strategy (aligned to the Trust Strategy) with a sensitivity analysis of delivery	Review Financial Strategy (aligned to the Trust Strategy) with a sensitivity analysis of delivery	Reviewed strategy to be presented to Trust Board in February 2019	Hurst, Jane	27/02/2019	27/02/2019

Board Assurance Framework

Risk ID:	135	**Executive Lead:**	James, Phill	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.			**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	10 (5x2)
Assurance Details:	IT Strategy in place Routine RAG reporting of IM&T projects to ePR Programme Board and upwards to Finance and Sustainability Committee Reviewing EPR system upgrade plans with suppliers and agreeing revised dates based around resource contention Working with CBUs to involve more admin and clinical staff for testing upgrades Reviewing contingency plans Cross training staff to increase leveraging of resources and minimise single points of failures Cross skilling help desk to strengthen first line support IG sub-group reviews contingency plans with Information Asset Owners from the CBUs Anti-virus has been added to IM&T Capital Shortlist for 17/18 and will be agreed at the next Capital Planning Group IT Seniors routinely act upon CareCERT information security bulletins released by NHS Digital's Data Security Centre. Actions performed in response to bulletins are documented. Information Security Management System reports to Information Governance and Corporate Records Sub-Committee to provide assurance on the effectiveness of controls Inspection by Trust's auditors on IT infrastructure security Capital paper submitted to secure funding for hardware to improve infrastructure in time for requisite Windows 10 migration Monitoring of Data Quality in systems implemented and reporting of DQ metrics via Data Quality and Management Steering Group Monitoring of external data quality reports such as the NHS Digital Data Quality Maturity index and benchmarking with other organisations Clear communications of upgrades changes Good user engagement for testing Monitoring of helpdesk tickets to understand trends after upgrades Assess hot stops from IMT Helpdesk calls Critical systems continuity plans identify key staff who will work to ensure systems return to normal as quickly as possible Capital programme spend reviewed by Capital group and F&S, hardware inventory maintained to ensure end user equipment remains fit for purpose. ePR programme Board reviews each project progress against Programme Plan expectations Internal IMT department progress recorded at Seniors meetings New diagnostic post being recruited linking to identifying single points of failure The Director of IT has undertaken a review regarding IT infrastructure risks, which may impact upon 24/7 availability of key services and systems and the capital programme has been updated to reflect these risks. Actions have been completed regarding commencement of a information and IT restructure. An additional diagnostic team member has been recruited. Regular analysis of data to show compliance with processes in place – Data Quality dashboard work and links back to Clinical Directors. A business case for ICE resilience has been approved by the Executive Team with the installation and configuration will be completed by the end of Oct 2018. A TNA analysis and plan is currently being developed for critical systems. The TNA for critical systems is now available and due to be published with supporting guidance for managers.				

	The ICE infrastructure has been migrated to an existing server however this only adequate in the short term. A paper on the options for the medium to long-term was prepared which included an option for external hosting and covered - Using the current new internal hardware, Improving the current new internal hardware with extra resilience, providing new hardware A paper on the potential options and preferred solution was presented at the Digital Board on 18/3/19. Following the meeting the preferred option is to be presented to Execs in April for consideration. Approval secured to procure two new servers to create a resilient platform for the ICE system which supports disaster recovery. Setup of servers and migration to new platform is scheduled for mid-July 2019 MIAA undertaking IT Business Continuity Audit in August 2019 Clinisys (the supplier of the ICE system) have advised a provisional date for the migration of Sunday 15th September. They have indicated that a maximum 9 hour outage of the ICE system will be required. This information has been shared with the EPG held on 20th August. A further meeting is scheduled for Thursday 22nd August with IT, clinicians and CBU leads to discuss the impact of the downtime and to agree robust contingency plans. ICE data migration due to new resilient servers is due to commence on 15th September 2019. MIAA have produced the draft report entitled 'IT Service Continuity & Resilience Review'. The action plan to address findings has been formulated and contains actions to address 36 separate findings	
Assurance Gaps:	• Certification to the Cyber Essentials standard in quarter 1 Financial year 2017/18 is required. This was recommended in the National Data Guardian/CQC report of 2016. • Routine training for all staff, including Locums, on all Trust Key systems The new platform has not been implemented but will be completed circa mid-July.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Work with other Trusts to share testing resources	Work with other Trusts to share testing resources	Work with other Trusts to share testing resources	Caisley, Sue	29/09/2017	29/09/2017
Invest in additional IMT staffing as workload increases, restructures based on work being reviewed with IMT management	Invest in additional IMT staffing	Invest in additional IMT staffing	Caisley, Sue	27/03/2018	27/03/2018
Comprehensively identify all single points of failure and assess risks surrounding each	Comprehensively identify all single points of failure and assess risks surrounding each	Comprehensively identify all single points of failure and assess risks surrounding each	Caisley, Sue	30/06/2017	30/06/2017
Test contingency plans regularly-development of a plan	Test contingency plans regularly-development of a plan	Test contingency plans regularly-development of a plan	Caisley, Sue	31/05/2017	31/05/2017
Routinely report all Cyber-attacks via Datix incident reporting system to ensure SIRO and Caldicott Guardian are sighted on the issues	report all Cyber-attacks via Datix incident reporting system	report all Cyber-attacks via Datix incident reporting system	Caisley, Sue	30/06/2017	30/06/2017
Include Cyber Security element in annual SIRO report	Include Cyber Security element in annual SIRO report	Include Cyber Security element in annual SIRO report	Caisley, Sue	28/04/2017	28/04/2017
IT Manager to produce a report detailing IT infrastructure risks which may impact upon 24/7 availability of key services and systems	IT Manager to produce a report detailing IT infrastructure risks	IT Manager to produce a report detailing IT infrastructure risks	Caisley, Sue	28/04/2017	28/04/2017
Continuous audit of IMT infrastructure-development of a plan	Continuous audit of IMT infrastructure-development of a plan	Continuous audit of IMT infrastructure-development of a plan	Caisley, Sue	31/05/2017	31/05/2017
Disaster recovery plan and its relevance to key IT systems to be reviewed	Disaster recovery plan and its relevance to key IT systems to be reviewed	Disaster recovery plan and its relevance to key IT systems to be reviewed	Caisley, Sue	31/08/2017	31/08/2017

Improve the disaster recovery for the ICE system (currently hosted on a physical server with limited resilience)	Improve the disaster recovery for the ICE system	Improve the disaster recovery for the ICE system Business case for ICE has been submitted to Execs Meeting(Complete) Obtain budget code (Complete) Submit tender waiver form (Complete) Scope of work discussed (Started - Sept 2018) Place order (Started - Sept 2018) Install and configure (Required Oct 2018)	Caisley, Sue	30/03/2018	07/09/2018
Undertake a Training Needs Analysis and assessment of training on Critical systems in the Trust and develop a plan as appropriate	Training Needs Analysis and assessment of training on Critical systems	Training Needs Analysis and assessment of training on Critical systems - 07/09/18 will be completed after additional staff start in the team.	Caisley, Sue	31/01/2019	07/02/2019
ICE has a business case in for SQL (database licensing) to enable to help virtualise the physical servers to help reduce unplanned downtime.	We would be able to switch ICE from Warrington over to Halton server rooms.	05/06/19--Migration to the new hardware environment by mid-July 2019. 05/09/19 - Data Migration to start on the 25/09/19	Garnett, Joe	30/09/2019	

Board Assurance Framework

Risk ID:	224	**Executive Lead:**	Evans, Chris	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience.			**Initial:**	16 (4x4)
				Current:	16 (4x4)
				Target:	8 (4x2)

Assurance Details:

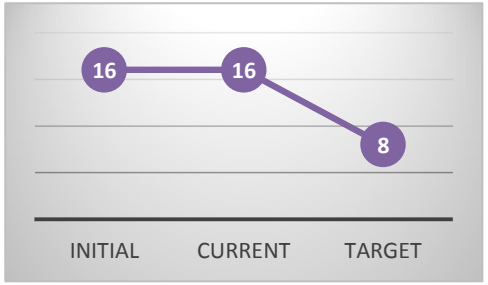
Trust Bed Meeting 2 hourly from 08:00 to 18:00
Systemwide relationships including social care, community, mental health and CCGs
Discharge Lounge/Patient Flow Team
Red to Green - Discharge Planning
ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing Controller
Chloe Care Transport to complement patient providers out of hours
FAU/Hub operational from June 2018 - Now operating 5 days per week.
Discharge Lounge opened 26th November 2018
Full ED business case approved from Q4 18/19 re: vision for ED Footprint creating assessment capacity.
System actions agreed supporting the Winter Plan
Warrington Together Board have asked for focussed work to take forward outputs from the Venn Work

1. Further development of Rapid Response to avoid admission
2. Increase IMC
3. Increase IMC at home

Regular monitored at the Mid Mersey A&E Board
Long Length of Stay Collaborative in association with ECIST / NHSI. Bespoke approach for the Trust in embedding and sustaining LLoS review. To commence May 19 through until September 19.
Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. Co-location of teams approved in April 19. This will support harmonisation of pathways and increase integrated working between health and social care.
Co-location of teams to take place in June 2019 (Kendrick Wing)
Urgent Care Improvement Committee to commence form May/June 2019 focussing on 5 priorities:

1. CQC Actions
2. Acute Medicine
3. Assessment Capacity/Environment
4. Decision to admit
5. Collective decision making

The Committee will report to the Quality Assurance Committee and Exec Team
New ED 'at a glance' dashboard gone live – supports organisational visibility and proactive response from specialties.
Participating as a pilot site for recording of Same Day Emergency Care (SDEC) in association with NHSi & NHSE
Urgent Care Improvement Committee High Level Briefing received at Quality Assurance Committee.
Pilot of a co-located medical and surgical assessment unit taking place between 3 Sept – 10 Sept 2019. A review will then take place to inform the long term strategy for an Assessment Plaza.
Trajectory achieved in Month 1, Month 2, Month 3, Month 4 and Month 5 (84.97%).
Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput – reports monitored via Patient Flow Sub-Committee and Trust Operations Board



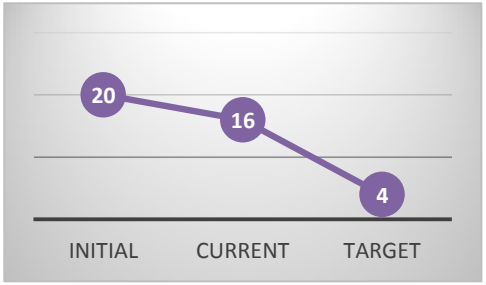
Assurance Gaps:

Fully embedding actions associated with system wide capacity & demand review undertaken by Venn Consulting – 3 key actions being progressed for Winter 2019 – 8 IMC Beds agreed via IBCF, Rapid Response Service and increased home reablement capacity (c 20 beds worth of capacity total)
ED footprint with a view of right sizing for the future based on demand trends – review taking place in Sept 19

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

A Weekend Bed Meeting following the Discharge Ward Rounds to support Flow in the ED	Weekend Bed Meetings	Discuss with Trust SMT	Liversedge, Tom	29/03/2019	10/06/2018
Discharge Lounge available 24/7 to enhance Flow in the Hospital to aid Flow and Patient Journey in ED	Discharge Lounge	Discuss with Trust SMT	Palin, Bradley	30/11/2018	26/11/2018
RN is available on each Shift to Nurse Patients in the ED Escalation Area	RN Cover for Escalation Areas	ED off duty to be checked and Escalation procedure followed to ensure Staffing level matches demand	Smith, Rachel	27/07/2018	15/05/2018
Frailty Unit to assess up to Max 50 Patients weekly Mon - Fri 09:00 to 17:00 - has the potential to relieve pressure on the ED	Frailty Unit	To discuss with SMT	Liversedge, Tom	29/06/2018	10/06/2018
Discharged Lounge to be renovated.	Discharge Lounge	Discharge lounge approved for renovation; estimated date of completion is December 2018.	Liversedge, Tom	12/12/2018	26/11/2018

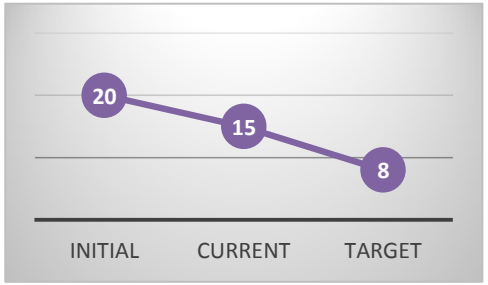
Board Assurance Framework

Risk ID:	125	**Executive Lead:**	Evans, Chris	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.			**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Controls: Estates strategy PLACE assessment action plan Risk Management systems and incident reporting General capital investment Compass reporting re: water flushing Matron and estates walkabouts Reporting structure for maintenance On call service for OOH issues Maintenance log Assurance: Water quality group Fire safety group Medical gases group Estates safety Medical Equipment group Capital Planning group Six Facet survey – condition appraisal of estate (annually) 5 Year program 20% each year Asbestos survey annually Premises Assurance model (PAM) Self-assessment tool estate compliance Good Corporate Citizen self-assessment (review of sustainability) Estates 10 year capital program Risk based approach to managing gaps in capital investment Medical equipment maintenance is managed by a risk assessed approach whereby equipment is identified as: High Medium Medium/Low Low All high and medium is fully maintained. Medium/low and low is operator assessed and reported to medical equipment engineering as required. - Generator sets are regularly serviced and tested and inspected by the Estates Operational Team.. Replacement of the generator sets is included within the Estates 10 Year Plan.. Two generator sets, with the highest risk of failure, have been replaced this financial year as part of the capital program. All generator sets regardless of age or condition are subject to monthly and annual testing and maintenance and resilience issues brought to the attention of the capital planning group should emergency funding be required to mitigate any risk of failure. - Work undertaken with Cheshire & Merseyside Fire & Rescue to mitigate any potential breaches of fire regulations resulting in enforcement. - Daily checks on main power supplies carried out to the system and maintenance service agreement in place with the manufacturer. 18.09.18 - - Order raised and parts ordered by contractor. Completion date is now 29.4.19 - Draft Estates & Facilities Strategy presented to the Trust Operations Board 25.03.2019				

	Main power supply work commenced Work completed to main power to Trust Main IT Network Room equipment.	
Assurance Gaps:	-Remaining generator sets are approaching the end of their useful life and spare parts are difficult to obtain and without investment for replacement there is a risk of loss of HV resilience for the Trust.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy	Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy	Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy	Wright, Ian	30/06/2019	30/06/2019
Participate in Halton Healthy Hospitals strategy	Participate in Halton Healthy Hospitals strategy	Participate in Halton Healthy Hospitals strategy	Gardner, Mrs Lucy	31/12/2018	30/04/2018
Review of the Health & Safety risks aligned to estates and facilities to be undertaken	Health & Safety risks aligned to estates and facilities	Health & Safety risks aligned to estates and facilities	Wardley, Darren	31/07/2017	31/07/2017
Review the governance/meetings structure regarding Estates	Review the governance/meetings structure regarding Estates	Review the governance/meetings structure regarding Estates	Wardley, Darren	29/09/2017	29/09/2017
Obtain quotation from supplier in relation to the main power equipment with a view to an order being placed and installation completed	Obtain quotation from supplier in relation to the main power equipment with a view to an order being placed and installation completed	Paperwork and permits required for the ITU replacement. Once that is complete, we are going to take 2 of the racks from that UPS which are still ok and install them in the IT server room UPS to ensure this risk is also completed and addressed. By the time we have the plates manufactured to cover the holes from the 2no. missing UPS racks, the spare racks from the ITU UPS will be ready. Therefore we plan to wait until the end of May for the ITU UPS to be completed.	Wright, Ian	30/07/2019	05/08/2019

Board Assurance Framework

Risk ID:	145	**Executive Lead:**	Pickup, Mel	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			**Initial:**	20 (5x4)
				Current:	15 (5x3)
				Target:	8 (4x2)
Assurance Details:	Members of the board have secured lead roles on a range of programmes within the LDS and STP. The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. We are developing plans, with partners, to establish Accountable Care Organisations in both Halton and Warrington. We have developed an engagement strategy in partnership with our Governing Council We have established a community-wide newsletter Your Hospitals Evidenced by lead roles in STP and LDS. No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the STP. The Trust has developed effective clinical networking and integrated partnership arrangements: The Trust is successfully leading and co-ordinating the delivery of new integrated care pathways for the frail elderly with partners from primary and social care, the voluntary sector, NW Boroughs NHSFT and Bridgewater Community NHSFT. The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool for complex spinal patients. Monitoring engagement by stakeholders (attendance at events, membership survey) Reports and Feedback from Healthwatch 'What Matters to Me' conversation cafes held across both sites in partnership with patient experience committee and governors. Will also include WHH volunteers, WHH careers and WHH charity - Memorandum of Understanding and work plan with Bridgewater Community Healthcare NHS FT approved. - Working in partnership with GP Federation in Halton on relation to improving joint clinical pathways. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. - Agreement of sustainability contract with Warrington CCG. - Work plan agreed with StHK - Shared a presentation demonstrating Halton Hospital's suitability to host the Eastern Sector Cancer Hub with Clatterbridge and other stakeholders. This forms part of the formal decision making process on the location of the hub - Regular GP engagement events held. - Regular Strategy updates are provided to the Council of Governors. - Clinical strategy engagement held with Trust Board - Submitted bid to provide UTCs in Runcorn & Widnes - Financial feasibility assessment for Halton Healthy New Town completed following unsuccessful bid to NHSE - Clinical Strategy approved by Trust Board - CBU specialty level strategies complete and incorporated in business plans - Successful in One Public Estate revenue funding bid for Halton - Initial talks held with Elective Care STP Lead in relation to the suitability of Halton as a potential Elective Care Hub Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. NHSE and local Commissioners supportive of draft strategy for breast screening.				

	First Group Committee in Common held with BCH and Joint Sustainability plan being developed. Revised process for evaluation of potential sites for the Eastern Sector Cancer Hub shared with the Trust, StHK, Clatterbridge and NHSE by Knowsley CCG. Submission due 24th July 2019. Decision expected January/February 2020. UTC Procurement process abandoned Initial meeting for Cheshire & Merseyside respiratory review held. Trust presentation well received. No funding received in latest capital allocation. Additional £1b capital promised but allocation criteria yet tbc. Positive meeting the Medical Director and Director of Strategy at Alderhey confirming their intention to work with the Trust to repatriate WHH patients Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include an Essential Services Lab (ESL) at WHH. Currently providing detailed feedback on strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESL Eastern Sector Cancer Hub – Letter received providing feedback following submission. Letter has been sent from the Trust to the Lead for the Eastern Sector Cancer Hub process requesting details of the public consultation and formal procurement process as well as requests for further information in relation to our submission and the scoring under the evaluation process. Further Committee in Common with Bridgewater and consensus received on operational model. Updated Pathology outline business case received and will be presented to the Trust Board for feedback. Confirmation received that there will be a new single lot open tender process to commence to determine the provider for both Runcorn and Widnes UTCs. Intention for the contract to commence 1 April 2020.	
Assurance Gaps:	Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress. Limitations of the size of the catchment area. Risk to Women's and Children's future provision due to Cheshire & Merseyside led review.	

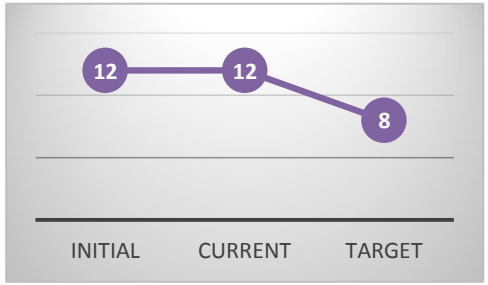
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Ensure WHH are in a strong position to influence the agenda	Influencing the agenda	CEO to ensure that she continues in her role as STP Chair to ensure that we can have an influence in the agenda	Pickup, Mel	31/03/2019	31.12.2019
Ensure evidence is provided to support strategic development and decision making.	Development of Trust Strategy document aligned to Trust planning priorities and	Development of Trust Strategy document aligned to Trust planning and priorities	Gardner, Mrs Lucy	30/06/2018	30/06/2018
Re-establish 'Board Talk' stakeholder newsletter	Re-establish 'Board Talk' stakeholder newsletter	Re-establish 'Board Talk' stakeholder newsletter	McLaren, Patricia	31/05/2017	31/05/2017
Create more opportunities for stakeholder engagement at our hospitals	Create more opportunities for stakeholder engagement at our hospitals	Create more opportunities for stakeholder engagement at our hospitals	Ryan, Candice	30/06/2017	31/05/2017
Revisit the Your Hospitals newsletter/membership communications to ensure optimised	Revisit the Your Hospitals newsletter/membership communications to ensure optimised	Revisit the Your Hospitals newsletter/membership communications to ensure optimised	Ryan, Candice	31/05/2017	31/05/2017
Establish clinician-led GP engagement opportunities	Establish clinician-led GP engagement opportunities	Establish clinician-led GP engagement opportunities	Crowe, Dr Alex	31/12/2018	10/07/2018
Ensure clinical strategies in place for all specialties.	Ensure clinical strategies in place for all specialties	Ensure clinical strategies in place for all specialties.	Crowe, Dr Alex	30/11/2018	14/12/2018
Establish formal partnership with Bridgewater. Establish formal partnership with St Helen's and Knowsley.	Formalise partnerships with other local organisations	Signed memorandums of understanding and agreed workplans.	Gardner, Mrs Lucy	30/11/2018	30/11/2018

Board Assurance Framework

Risk ID:	143	**Executive Lead:**	Deacon, Stephen	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation			**Initial:**	12 (4x3)
				Current:	12 (4x3)
				Target:	8 (4x2)

Assurance Details:

Firewall deployed to protect the network by filtering the traffic that is permitted in and out of the WHH network.
Blocking file extensions recommended by NHS Digital on WHH Fileshare areas. CareCert bulletins containing information security measures which need to be implemented are produced by NHS Digital and measures taken to implement their requirements are documented at IT Seniors meeting on a weekly basis.
Information Security Management System (ISMS) in use to protect WHH IT assets. The ISMS is based on the principles contained within the ISO27001 standard in use to control physical and network access and the controls required to protect said assets.
Daily backups and 4 hour replication to the Halton site which replicates data on the Halton site storage area network (SAN). Data loss in the event of a Cyber-attack would be minimised due to the replication of data.
Achievement of Cyber essentials certification and completion of the requisite network penetration testing. Certification to the Cyber Essentials standard has been recommended for all Trusts and compliance with its requirements can enhance protection against circa 80% of Cyber-attacks.
Removal of obsolete operating systems (eg Windows XP) and automatic patching of critical updates offered by Microsoft.
Removal of XP operating system across WHH continues and three tier patching regime is proposed
A robust patching regime has been implemented and automated using Solar Winds software which allows time to be spent on the complex areas for patching. Patching completion has increased to 96%.
17/4/19: Network Penetration Tests - MIAA have completed an external penetration testing of our network and we are awaiting the formal report. The Trust has also purchased software that will test any internal vulnerabilities on our servers. The server has been set up and software has been installed and the next steps are to do the server configuration.
MIAA Health Check and Vulnerability Assessment (Report delivered on 2/03/2019) action plan being monitored at IGCRSC.
The data domain repository that is in Kendrick holds all of the backups and that has hardware encryption built in which has been tested and is now enabled.



Assurance Gaps:

The version of Java cannot be updated due to the restrictions in place by NHS Digital for national systems including SBS and ESR. These systems require a certain version (which is many versions out-of-date) for them to work properly and remain supported by the NHS Digitals Service Desk.
Windows 7 support expires ends security updates for Windows 7 PC 14th Jan 2020. The Trust must move over to Windows 10 before then. All new devices are Windows 10 only and rebuilds or tech refresh is Windows 10 only. This is covered by IT Services BAU.
07/11/2018
Trust only has a handful of Windows XP in Radiology which are hardened which means their code cannot be altered by an attack, we are happy from a desktop point of view all Windows unsupported operating systems are now been cleared. We are working on migrating all desktops to Windows 10, removing Windows 7 and 8 from the desktops.
The cyber business case is in draft and Director of IT and Information at the Wirral has asked for feedback from the other two trusts. WHHT have feedback to Wirral.
04/01/2019 - The migration of the back ups have been delayed due to the Trust prioritising the domain controller migration other IT projects. All other actions have been reviewed and no further action.
04/01/2019 - SharedData and 12 SQL servers have been added, however, 6 of them are not truncating, will require resolving.
13/03/2019 - Medical devices need to be moved into medical VLAN 'bubble'. 17.04.2019 - This still incomplete due to the work required to move medical devices across to within the protection. This requires co-ordination between the operational teams in Pathology and Radiology, external suppliers and adequate IT resources all of which are impacting on the completion of this task
17/4/19 - The VLAN bubble work - This still incomplete due to the work required to move medical devices across to within the protection. This requires co-ordination between the operational teams in Pathology and Radiology, external suppliers and adequate IT resources all of which are impacting on the completion of this task.
17/4/19 - Encryption of backups – The encryption software has been switched however sense checks are to be undertaken before this can be completed.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Ensure capital monies are available in	capital monies are available in 2018/19	capital monies are available in 2018/19	McGee, Andrea	30/04/2018	27/04/2018

2018/19 for upgrade of vital security software and hardware	for upgrade of vital security software and hardware	for upgrade of vital security software and hardware			
Implement security 'bubble' around the medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment – development of a plan	Implement security 'bubble' around the medical VLAN	Implement security 'bubble' around the medical VLAN	Caisley, Sue	30/03/2018	05/09/2018
Act on recommendations made in the Cyber essentials report to ensure improved cyber security.	Act on recommendations made in the Cyber essentials report to ensure improved cyber security.	Act on recommendations made in the Cyber essentials report to ensure improved cyber security. 04/01/2019 Reviewed, no further action 17/01/2019 Reviewed with other members of the STP Cyber Group internal server vulnerability scanning options. Nessus was the recommended option. The CIO has approved the purchase of the software and is on order. 27/03/19 External penetration has been completed, waiting on MIAA to write the report. Expected within the next 2 weeks. 10/04/2019 We have completed an external penetration test and the report has come back. This report has been sent to the IG Manager, CIO, Network Manager and Deputy Director of IT. 06/06/19--Monitor IT Vulnerability Assessment via IGCRSC. 05/09/2019 – Software has been installed on the server, Network Manager looking at IP ranges for the software to scan and provide reports for.	Deacon, Stephen	30/10/2020	
Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan	Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan	Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan	Caisley, Sue	30/03/2018	31/03/2017
Ensure that Information Governance messages around safe use of IT assets	Information Governance messages around safe use of IT assets	Information Governance messages around safe use of IT assets	Caisley, Sue	31/12/2018	31/03/2017

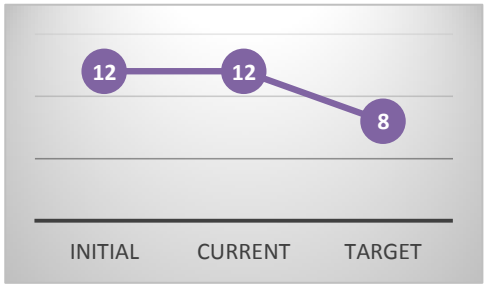
are reiterated via corporate induction and training					
Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system – send out an alert to all staff on a regular basis and report quarterly to Information Governance and Corporate Records Sub-Committee	Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system	Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system	Caisley, Sue	31/12/2018	05/09/2018
NHS Digital issues CareCERT advisory bulletins to support the NHS in maintaining high standards of cyber security. Trusts are to confirm that they have acted on the most critical of these, where applicable to their IT infrastructure. All Trusts give a template setting out 39 of the critical CareCERT advisories, all issued over the last three months after WannaCry, which have been deemed most critical in preventing successful cyber-attacks.	Complete actions on NHS England's CareCERT 39	Download template and update it with current status and when all 39 CareCERTS are to be completed. 07/11/2018 All CareCERT's are now completed and sent back to NHS Enlgand.	Deacon, Stephen	30/11/2018	07/11/2018
Several desktop devices still on Windows XP due to systems not compatible with Windows 7 onwards. IT working closely with the departments and third party supplies to ascertain a plan to migrate to Windows 7/Windows 10	Removal of Unsupported Windows XP from Desktop Devices	08/08/18 Supporting each department helping them to remove Windows XP from their areas replacing them with Windows 7 onwards, some systems will need upgrading or replacing dependant on funding (On-going) 04/09/2018 A report has been created for the IM&T Programme Board the following XP devices/systems using XP have been identified: 26/09/2018 Paper was presented to the IM&T Programme Board, discussions with Radiology has reduce the numbers further due to hardening of the XP Servers.	Whitfield, Simon	26/10/2018	10/10/2018
Move medical devices into VLAN bubble. This will involve participation of multiple 3rd parties and internal WHH staff.	Add medical devices to VLAN bubble	04/01/2019 Network Manager has begun pre work on the VLAN protective bubble 05/09/2019 Network Manager to liaise with PACS	Smith, Mr Philip	31/04/2020	

		Manager to arrange 3rd party support for migration over to VLAN			
Additional network security (Phase 2) to replace aging hardware around web filtering and file blocking is required.	Additional network security	Submit capital form to capital meeting (Complete) Obtain budget code (Complete) Place order (Complete) Install and configure (Complete) 04/09/18 Waiting on arrival of the ASA firewalls for remote access , but training required to utilise the product	Smith, Mr Philip	31/12/2018	14/09/2018
Review of security options with HSCN when upgrading our N3 link to HSCN.	Review security options with HSCN	Review of security options with HSCN when upgrading our N3 link to HSCN (Completed - Sticking with local security)	Smith, Mr Philip	29/03/2019	14/06/2018
Requiring to beef up our Cyber Security including patching for servers This includes server security patches.	Implement robust server patching regime	20/11/18 Automatic software has been purchased and will require a period of time to configure before we can automate majority of servers. 05/12/18 The Server Manager and Technical Specialist are meeting this week to start looking at looking at configuration the server. 04/01/2019 Reviewed, no further action	Garnett, Joseph	31/05/2019	10/04/2019
There are 39 out of 150 outstand hidden shares that are accessible by specialist software to view contents of those shares. This includes e-outcome, these need to be secured.	E-outcome hidden share accessible to all users	10/10/2018 We have been told this is no longer an issue, the IG Manager and IT Manager cannot access the area, but passing over the IT Specialist to double check as he raised the issue originally, however, waiting for him to return back from A/L	Deacon, Stephen	19/10/2018	19/10/2018
Part of the Cyber Essentials+ recommendations the Trust needs a corporate policy for IT logs retention	Corporate Policy for IT Logs Retention	Update the ISMS to contain the corporate policy for IT logs retention	Deacon, Stephen	28/09/2018	26/09/2018
26/09/2018 Update the infrastructure for the ASA's (Remote Access Secure Token System).	Renew the ASA (Remote Access Secure Token System)	26/09/2018 Update the hardware infrastructure for the ASA's (Remote Access Secure Token System. The new hardware is in the department but requires configuration from the supplier (SoftCat) next week, currently waiting on an action plan. Once	Smith, Mr Philip	19/10/2018	24/10/2018

		configured will be put through change control to replace the old hardware, however, there will be downtime for remote access (token based) , mainly suppler based, NHS guest Wi-Fi and staff Wi-Fi and IPAD users using VDI externally but will be minimal. 10/10/2018 ASA's are being replaced w/c 15/10/18			
As part of the Windows 10 agreement from NHS Digital, ATP (Advance Threat Protection) across all our desktop devices before the end of December 2018	Install Advance Threat Protection on all desktop PC's and laptops	Install ATP across the desktop estate	Whitfield, Simon	31/12/2018	30/11/2018
From the C&M Cyber Group: To share those Cyber Essentials Plus questionnaires that were unsuccessful? As they may reveal common areas of improvement that we could work on together.	Provide the C&M Cyber Group with the answers from the CE+	To send to the C&M Cyber Group the answers from the Cyber Essentials+ assessment.	Deacon, Stephen	31/10/2018	10/10/2018
Encrypt backup data to stop any successful cyber-attack from affecting the backup data	Encrypt backups	03/12/18 The Data Domain is now configured and has been tested with one server. The Server Manager will perform a phased migration of all other servers. With the speed being faster we are able to look at changing/when how the backups are performed. 04/01/2019 The Trust prioritised the Domain Controller migration over other IT projects 04/01/2019 SharedData and 12 SQL servers have been added, however, 6 of them are not truncating, will require resolving. 10/01/2019 18 servers have been migrated to the new backup system. The 6 SQL servers issues with truncation of their logs has also been resolved. 15/03/2019 Server manager to ascertain how to implement encryption on data domain	Garnett, Joseph	30/04/2019	05/06/2019
Support for Windows Server 2003 has	Review Server 2003 servers	24/10/2018	Garnett, Joseph	31/12/2019	

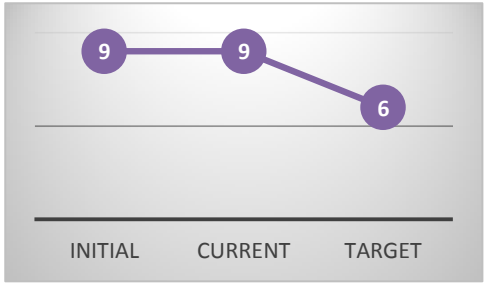
now ceased and as a consequence, Microsoft no longer provide security updates or technical support for this operating system. Consequently, any server or system reliant on Windows Server 2003 presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 to Windows 2016 (Latest server operating system)		Obtained a list of servers using Server 2003 and provide a report to the next Digital Board. Currently, the Trust still has 20 servers which use Windows Server 2003, however today we have been able to decommission 1 of the servers already. 20/11/18 The paper was discussed at the digital board. Estates are migrating the rest of the users to the cloud for Resman system and one more can be shutdown. 04/01/2019 Reviewed, no further action 15/03/2019 17 2003 servers left to complete			
Wirral are the lead for the STP Cyber Group. They required to create a business case which covers a programme of work with a number of project areas which together will provide joint and collective assurance on the work around cyber security for the Health and Care Partnership. The strands of work include support for joint work on: - Cyber Essentials Plus accreditation - Strategy and Policy Development - Training and skills development - Business Continuity Planning - Procurement and Vendor relations The creation of the business case is restricted to a limited number of Trusts within the STP to ensure we are able to meet the deadline. WHHT along with Mid-Cheshire and Wirral are the only Trusts involved with the business case, allowing WHHT to be at the forefront of cyber security.	WHHT to help Wirral create the STP Cyber Business Case	07/11/2018 The cyber business case is in draft and Director of IT and Information at the Wirral has asked for feedback from the other two trusts. WHHT have feedback to Wirral. 20/11/18 Final draft has been sent out for comment. 05/09/19 IT Manager will enquire at the next STP Cyber meeting	Deacon, Stephen	30/09/2019	

Board Assurance Framework

Risk ID:	414	**Executive Lead:**	James, Phill	**Rating**	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Failure to implement best practice information governance and information security policies and procedures caused by increased competing priorities due to an outdated IM&T workforce plan resulting in ineffective information governance advice and guidance to reduce information breaches.			**Initial:**	12 (4x3)
				Current:	12 (4x3)
				Target:	8 (4x2)
Assurance Details:	• Data Security and Protection Toolkit Returns (NHS Digital) • MIAA Annual Data Security and Protection Toolkit Assurance Audit (significant assurance in 2018) • Cyber Essentials Plus Certification Audits • MIAA Cyber Security baseline • Firewall Health Check • Reporting to Information Governance and Corporate Records Sub-Committee and Quality Committee • MIAA GDPR Readiness assessment Information Governance Manager now reports to IT Services Manager for support & guidance and cross-cover, which reduces the risk of single point dependency. A draft re-structure that includes an Information Security Manager has been produced and will be presented to the newly appointed CIO in due course. Audits on wards underway to establish whether IG best practice is in place Options for improving security of access to Lorenzo other than smartcards, which will include deploying VDI Trustwide (currently in ED Department) will be formulated and submitted to the Digital Optimisation Group and Digital Board for consideration regards costs vs risks and benefits in advance of NHS Digital deploying any security solutions in the future. Follow up audit on IG compliance across all wards and clinical areas to be undertaken by the IG •Follow up audit on IG compliance completed across all wards. Reports provided to Ward Managers and CQC G2G meetings. Key messages disseminated at Safety Huddle and 'You Didn't Think Privacy' unannounced mini-audit initiative launched. New IM&T Department structure developed. The increase in support for IG and Information Security has been recognised. MIAA IG Assurance Review delivered moderate assurance rating for 2018/19 The draft Digital strategy is currently being consulted on following the publishing of which, the restructure will be based. The structure proposal will now be conducted throughout October with an aim to gain approval late November.				
Assurance Gaps:	• Full compliance with EU NIS Directove •Ongoing audit of information governance and application of IG controls in the general environment including storage of records and training requirements • Embedding of best practice following IG Ward audits • Delivery of unmet assertions on Data Protection Security Toolkit • Ensure business as usual patching cycle • Maintain adherence to IG Policy & Procedures in ward/clinical areas • Maintenance of an effective asset register and information flow mapping				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
IT operational restructure in order to provide information governance support to deal with the burgeoning IG/Cyber Security agenda	IT Dept restructure to increase sources targeted at Information Governance	IT Manager to draft IT operational services restructure CIO is reviewing structure of department and resources committed to IG/Information Security	Deacon, Stephen	30/09/19	

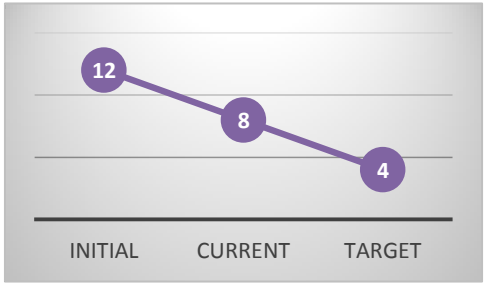
Board Assurance Framework

Risk ID:	695	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to keep the national invasive cancer audit up to date to comply with NHS Cervical screening programme standards; which caused a backlog of cervical screening reviews which resulted in a non-compliance with the cervical screening specification 2018/2019.			**Initial:**	9 (3x3)
				Current:	9 (3x3)
				Target:	6 (2x3)
Assurance Details:	Trust has now implemented NHS Cervical Screening Guidance in NHSCSP Publication 28 (1) and Disclosure of audit results in cancer screening best practice (2) i. There is now a ratified policy in place I /12/18 so we are now compliant ii. The Recommendation from SQAS to implement policy for audit and disclosure has now been implemented. Patients diagnosed with cervical cancer will be informed of the audit and offered disclosure from December 2018 iii. The Recommendation from SQAS to review screening histories of patients diagnosed with cervical cancer at the Trust from April 2013 to date and discussed at Colposcopy MDT if indicated. This is in progress. Briefing paper and action was plan presented for Patient Safety & Clinical Effectiveness 30/10/18 and will be monitored by this committee. A final report has been received by WHH and the commissioner on the 22nd January 2019. A comprehensive action plan is in development and will be available within 4 weeks of receiving the final report, Developed and returned action plan to SQAS on 22nd February 2019 SQAS and CCG Screening team (SIT) are working with the Trust to complete the action plan within 12 months. Monthly progress meetings are being held with the clinical team, Cervical Screening Provider Lead, SQAS and CCG SIT to review the actions and evidence from a monthly Task & Finish Group Monitored monthly in Patient Safety & Clinical Effectiveness Sub-Committee The audit of all women diagnosed between 2013 and 2018 is in progress and ongoing. <u>SQAS Action Plan:</u> Monitoring meeting took place on 24/07/2019 50 recommendations in total 5/50 recommendations are for the CCG to complete. (1 green, 4 amber) **Warrington Actions** 27/45 are complete 16/45 are amber and progressing 2/45 are red. **Update on the Red Rated Actions** Increase number of Registered Nurse and HCA hours to support colposcopy clinics Review the capacity and shared space within the patient gynaecology waiting area to ensure that it meets the specification outlined. **Update on the Amber Rated High Priority Actions** Ensure that there are suitable monitors for image viewing and the availability of image capture. A business case and risk assessment has been completed to support the procurement of the new equipment as part of a capital funding bid. Complete procurement process for cold coagulation to ensure that women with high grade have alternative treatment choices. A business case and risk assessment has been completed to support the procurement of the new equipment as part of a capital funding bid. Progress of the SQAS action plan continues to be monitored at monthly WH Governance Meeting Risk assessments completed to support non-compliance with the SAQA recommendations are monitored as part of the risk register process.				
Assurance Gaps:	Any patients diagnosed with cervical cancer prior to 2018 have not been informed of the audit. Based on the audit details a discussion will be taken at Colposcopy MDT meeting. Patients who require disclosure or possible duty of candour will need sensitive and skilled consultation.				

	The current gap in assurance is the unknown results of all of the audit as it is still in progress with a completion date set by SQAS of November 2019.				
Recommendation	**Action Description**	**Actions Required**	**Responsible Officer**	**Deadline Date**	**Completion Date**
Draft policy for National Invasive Cervical Cancer Audit Draft policy for Disclosure of results for National Invasive Cervical Cancer	Policy for National Invasive Cervical Cancer Audit	Requires ratification and implementation	Cooper, Tracey	31/12/2018	27/12/2018
Identify unit numbers/NHS numbers for backlog of patients (approx. 100 -120) Lists of cervical cancer patients in timescale requested from Pathology manager and Cancer Services to ensure all patients captured	Identify backlog of patients	Lists of cervical cancer patients in timescale requested from Pathology manager and Cancer Services to ensure all patients captured Using standard proforma in draft policy systematically review cervical screening histories of above cohort of patients Refer complete reviews to a MDT meeting as required. (Patients diagnosed with cervical cancer who have not engaged or defaulted from the programme can be excluded) Cases where the care or treatment after discussion at MDT is potentially a serious incident the case will be discussed with SQAS as per Managing Screening Incidents guidance.	Cooper, Tracey	08/11/2019	
Undertake a review of identified patients cervical screening history	Identify time and staff to undertake review of screening history	Identify time and clinical staff to undertake cervical screening history reviews	Cooper, Tracey	08/11/2019	
MDT will confirm if disclosure would not be appropriate (i.e. if patient has died or is terminally ill and routine disclosure) but otherwise patients will be offered the option of disclosure by a letter explaining the background to the national audit. Draft letter to be drawn up	MDT confirm when disclosure would not be appropriate	Any patient requesting disclosure or duty of candour will have the option for results in a meeting with the Lead Colposcopist/Lead Colposcopy Nurse/ and with clinical input form Cytology/Histopathology if required	Rauf, Ambreen	08/11/2019	
Disseminate NHS guidance for cervical smear takers re training, updates; responsibilities to the patient and screening programme through Cervical Screening Management Meeting once established in 2019	Disseminate NHS guidance for cervical smear takers re training, updates; responsibilities to the patient and screening programme through Cervical Screening Management Meeting once established in 2019	Implement a PHE e-learning package as part of the Trust's mandatory training and monitoring of compliance Gynaecology and GUM managers to ensure a rolling register of all smear takers in their area including trainees Undertake audit of smear takers	Rauf, Ambreen	09/07/2019	

		inadequate rates; rejection rates Undertake audit of cervical screening failsafe systems once in place			

Board Assurance Framework

Risk ID:	241	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.			**Initial:**	12 (4x3)
				Current:	8 (4x2)
				Target:	4 (4x1)
Assurance Details:	Regular monthly meetings taking place with HENW involving The Deanery. An agreed action plan has commenced and is progressing. Regular weekly journal/ educational meetings on Mondays co-ordinated by a clinical fellow. Trust Locum Consultants have been approved as educational supervisors and are providing educational supervision to the ST3s in geriatric medicine. Appointment of a Chief Registrar; popular interest by doctors for future Chief Registrar appointments. Recruited to Medical Utilisation Manager Role. Trust wide work stream for rota management. An E-Rostering Bid has been made to NHSi Working on getting more bank doctors, rather than agency. Establishment of Medical Trainees Experience Improvement Group. Deputy Medical Director to have Director of Medical Education portfolio. Senior management presence at Medical handover to review any safety issues, escalated to Trust Wide Safety Brief. Weekly Medical Educational Huddle. Business Case currently being developed to support the recruitment of substantive consultant physicians. Clinic attendance for trainees to ensure they can be released from wards to attend – record log in place and escalation process if not occurring. Subsequent plans to improve training available clinics. 3 substantive consultant appointments in Acute Medicine, 1 consultant in Care of the Elderly who is also Clinical Director for Integrated Medical and Social Care CBU. Ward Round Accreditation quality improvement work stream. Access for trainees to Quality Academy and Quality Improvement work streams. Monthly Medical Education newsletter From August 2019, the Trust will have 3 additional International Training Fellows in Acute, Gastroenterology and Rheumatology. Completed HEENW Action Plan returned to HEENW GMC National Training Survey results received in July 2019, noting 6 Category 1 (minor) risks, no patient safety issues resulting in an overall Trust risk score of Category 1. This is a significant improvement compared to 2018, when the Trust was scored as Category 2. Key areas to note: Decreases in category 1 and 2 risks; significant improvement in GMC training feedback scoring; there is an action plan in place to resolve any concerns. Currently awaiting feedback in relation to enhanced monitoring.				
Assurance Gaps:	Recruitment of substantive consultant physicians ongoing Review of Digital Strategy on going				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Identify lead to create a biweekly newsletter for trainees to provide vehicle for educational supervisors to deliver updates and good news.	improving experience for trainees	medical education business manager to co-ordinate across the Trust for all trainees	McKee, Spencer	29/03/2019	01.03.2019
To provide timetabled clinic slots for CMTs co-ordinated by the MUM and to be communicated through the ward cover rota	protected clinic time for CMTs across medicine	MUM to implement	Barker, Sophie	06/08/2018	13/07/2018

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/98**
SUBJECT:	**Risk Management Annual Report and revised Risk Management Strategy**
DATE OF MEETING:	September 2019
ACTION REQUIRED	**Review, Discuss and approve**
AUTHOR(S):	Ursula Martin, Director of Governance & Quality
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.
LINK TO STRATEGIC OBJECTIVES:	All
EXECUTIVE SUMMARY (KEY ISSUES):	The following report gives a review of how the Trust has implemented its Risk Management Strategy since being revised in May 2017 and specifically the work over the last 12 months. This includes: • Having a revised Risk Management Strategy with clear objectives • A clear and understandable process has been put in place for all staff to assess, score, manage and escalate risks. • DATIX risk module has been purchased to record, manage and monitor all risk registers. This is now fully embedded within the Trust. • The monthly Risk Review Group is now embedded and all risk registers are reviewed and scrutinised on a 12 month rolling programme. The Group is chaired by the Chief Nurse. • Guidance documents have been produced on Risk Management Awareness and DATIX guides for risk • A programme of dates for Risk Management training has been set up for Senior Managers and Ward/Departmental Managers. • An integrated self-assessment tool has been developed which includes all Trust risks e.g. clinical risks and this is aligned to the Care Quality Committee regulatory framework.
	Assurance statement - The Trust now has a fully implemented risk management process, with a significant improvement to the position 2 years ago, which the Trust was able to evidence at its 2019 CQC inspection.
	In addition appended to the report is the Trust revised Risk Management Strategy and action plan to implement this. This

	sets out a clear direction to further develop the risk management systems and processes within the Trust. The Trust Quality and Assurance Committee are asked to approve this ahead of ratification at the Board of Directors.	
RECOMMENDATION:	Review the review of risk management in 2018/19 for information and receive as significant assurance of implementation of the strategy Review and approve the revised Risk Management Strategy, and ratify.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	July 2019
	Summary of Outcome	Accepted the assurance level and approved the strategy.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

1. BACKGROUND/CONTEXT

The annual report describes the management of risk throughout the Trust over the last 12 months.

Over the past two years a comprehensive review of risk management has been undertaken and a new fully embedded process can now be evidenced across all areas of the Trust.

During the CQC inspection in 2017, the CQC raised concerns around risk management within the Trust. The CQC found that there was no consistency with grading of risks and the way risks were described. There was no distinction between risk assessments and risk registers and so both were added to CIRIS (the system in place in 2017) which meant the Trust had a considerable amount of risks recorded on the system. Managers had little knowledge of how to use CIRIS which consequently made it problematic to maintain and manage these risks. The concerns raised by the CQC resulted in the Trust having a regulatory breach with regard to risk management (Regulation 17 – Governance a) Risk Management b) record keeping c) IG and records being maintained securely).

The following annual report describes the improvements put in place since the review of the Trust Risk Management Strategy (May 2017) and how this has been implemented in the past 12 months.

2. KEY ELEMENTS

2.1 Review of the Risk Management Process

A full review of the overall risk management process was undertaken. This started with a revised Risk Management Strategy which was approved by the Quality and Assurance Committee in May 2017.

For risk management to be successful in the Trust, it was vital that a single approach was adopted for the management of risks throughout all levels of the Trust. The revised strategy set out clear, understandable objectives to enable the Trust to begin to embed a robust and effective risk management process.

The table below sets out those objectives that were set within the Trust revised Risk Management Strategy and how we achieved them:

Objectives 2017/2019	How we met these
Develop a clear and understandable process for all staff to assess, score and escalate risk	A clear process was developed to support with better decision making through good understanding of risks and their likely impact. A risk descriptor was outlined to support with writing the risks. "Failure to…….. Caused by…… Resulting in……" This ensured the descriptor would give a clear understanding of what the actual risk was. The governance processes regarding review and escalation of risk were reviewed, and risks were incorporated onto speciality governance dashboards, reporting to Clinical Business Units, who report to Trust Risk Review Group- this process was shared with all staff and the Trust is confident in its processes of risk escalation.
Develop an integrated self-assessment tool which will include all Trust risks and will be aligned to the CQC regulatory framework	An integrated self-assessment risk tool has been aligned to the CQC regulatory framework. The tool is made up of a number of standards and managers need to self-assess against full compliance, partial compliance and non-compliance. Any standard which does not meet full compliance will need to be added to the risk register on DATIX. This tool forms the basis for the risk registers and highlights any areas, trends/themes of non-compliance. This has enabled ward to Board risk escalation processes.
Develop an easy to use IT system regarding risk management	The Trust purchased the risk management module license for DATIX. This was developed to the needs of the Trust to ensure all risk registers could be managed, monitored and maintained effectively and easily.

Objectives 2017/2019	How we met these
Develop training and guidance to support and implement and embed the process throughout the Trust	A training needs analysis was developed to look at risk training throughout the Trust. A programme of mandatory training sessions have been developed and arranged for different levels of staff: A senior manager risk management training session, a training session for ward/departmental managers and an awareness booklet for staff.

2.2 Risk Assessment Tool

The integrated self-assessment tool is a formal document that ensures that service managers at ward and department level understand their responsibilities and provides WHH Trust Board with the assurance that risks are being effectively managed.

The purpose of this tool is to ensure that there is ward to Board reporting in place and that this is used as a tool for identification of risk and improvement. The tool is the also process by which, the Trust can provide assurance that there is an effective system of internal control to monitor risk and continually improve to provide a safe and healthy environment at ward and department level.

The tool consists of a number of standards each supported by a set of performance criteria and policies and guidance. The standards and criteria have been taken from key legal requirements relating to health, safety and from the CQC fundamental standards. Each standard and performance criteria is designed to be clear, measurable and achievable.

Each Service assesses its level of compliance against each criterion using a simple system identifying, Compliant, Partial Compliant and Non-Compliant. Services are required to outline a brief rationale behind their score, ensuring that they can provide evidence and assurance of their assessment.

Once the Assessment Tool has been utilised, Services will be able to identify from their compliance scores the areas where they need to make improvements. This will then form the basis of risk registers within each area.

In 2018/19 all relevant wards/departments completed their integrated risk assessment processes – this will be reviewed and completed at least once a year.

2.3 Risk Registers

The risk register process is now fully embedded within the Trust and each area has a risk register in place.

Strategic Risk Register	The risks that may prevent the Trust from achieving its strategic objectives.
Corporate Risk Register	The risks that may prevent the Trust from achieving its operational objectives – **this is to be fully developed and embedded over the next 12 months.**

Board Assurance Framework	Provides assurance to the Board that the Trust is managing those risks listed on the strategic risk register. This details controls, gaps in assurances and action plans.
CBU Risk Registers	Each CBU has a risk register in place to ensure they are aware of the risks within their areas and these risks are managed, monitored, reviewed and escalated when required. Risks that sit on the CBU risk register are graded 10 and above.
Local Risk Registers	Each Ward/Department will have a local risk register in place to manage risks of 8 and below. This ensures that lower grading risks are identified, managed and reviewed at a local level. Any risks that require escalation would be reviewed by the CBU and the decision made if this risk would be transferred to the CBU risk register.

All risks are monitored weekly be the Head of Safety and Risk. This ensures all risks are described accurately, graded appropriately and are in date with clear action plans attached.

The table below gives a position statement of all risk register in September 2019:

Specialist Surgery	Risk Register fully up to date.
Urgent and Emergency Care	Risk Register fully up to date.
Digestive Diseases	Risk Register fully up to date.
MSK Care	Risk Register fully up to date.
Women's and Children	Risk Register fully up to date.
Medical Care	Risk Register fully up to date.
Integrated Medicine and Community	Risk Register fully up to date.
Diagnostics and Outpatients	Risk Register fully up to date.
Estates and Facilities	Risk Register fully up to date.
Human Resources	Risk Register fully up to date.
Corporate Nursing	Risk Register fully up to date.
Governance Department	Risk Register fully up to date.
IM&T	Risk Register fully up to date.
Communications	Risk Register fully up to date.
Finance	Risk Register fully up to date.
Pharmacy	Risk Register fully up to date.

The table below gives a position statement of the CQC Core Services risk registers in September 2019:

Urgent and Emergency Care	Risk Register fully up to date.
Medicine	Risk Register fully up to date.
Surgery	Risk Register fully up to date.
Maternity	Risk Register fully up to date.
Children and Young People	Risk Register fully up to date.
Diagnostics and Outpatients	Risk Register fully up to date.
Critical Care	Risk Register fully up to date.
End of Life Care	Risk Register fully up to date.

2.4 Risk Training

A review of all risk training was undertaken and a new programme of training was put in place. A full programme of dates is in place for 2019/20.

Staff Role	Training Requirement	Frequency	Training Delivery Method
Executives Non-Executives	Senior Risk Management Training DATIX Risk Training	One off training	Class room
Deputy Directors Associate Directors Clinical Directors	Senior Risk Management Training DATIX Risk Training	One off training	Class room
CBU Managers Heads of Service	Senior Risk Management Training DATIX Risk Training	One off training	Class room
Lead Nurse Matron Department Manager	Risk Management Training DATIX Risk Training Integrated Risk Tool	One off training	Class room
All Staff	Risk Assessment Training	One of training	Class room

2.5 Risk Management Strategy Objectives for 2019

The Risk Management Strategy has been reviewed for 2019/2021- this is appended as Appendix 1 to this report. The revised strategy is to ensure a continued approach towards risk management and to develop the process further. We want to continue to encourage a culture where risk management is seen as an essential process of the Trust's activities.

The reviewed strategy acknowledges the current positive arrangements for managing risks and sets out further objectives to continually improve the management of risk by:

- Defining and setting out the benefits of risk management
- Help the Trust to understand risk appetite and tolerances
- Continuously improve risk management arrangements within Warrington and Halton Hospitals NHS Foundation Trust
- Assess the current status of risk management within the Trust
- Outline the approach to managing, maintaining and reviewing of risk registers

3. SUMMARY AND LOOKING FORWARD

There has been considerable amount of work put into the development of a new risk management process. This has included:

- A revised Risk Management Strategy with clear objectives
- A clear and understandable process has been put in place for all staff to assess, score, manage and escalate risks.
- DATIX risk module has been purchased to record, manage and monitor all risk registers. This is now fully embedded within the Trust.
- The monthly Risk Review Group is now embedded and all risk registers are reviewed and scrutinised on a 12 month rolling programme. The Group is chaired by the Chief Nurse.
- Guidance documents have been produced on Risk Management Awareness and DATIX guides for risk
- A programme of dates for Risk Management training has been set up for Senior Managers and Ward/Departmental Managers.
- An integrated self-assessment tool has been developed which includes all Trust risks e.g. clinical risks and this is aligned to the Care Quality Committee regulatory framework.

The Trust now has a fully implemented risk management process, with a significant improvement to the position 2 years ago, which the Trust was able to evidence at its 2019 CQC inspection.

There is a greater understanding of risk management and the importance of managing risks effectively. Grading of risks is a lot more consistent across the Trust, with scores reflecting the actually risk, not just being scored high for visibility.

There is an action plan in place to develop and improve on the processes in place and this can be found in Appendix 2 of the report.

The Quality and Assurance Committee on behalf of the Trust Board is requested to discuss, and note the information in this report.

4. RECOMMENDATIONS

The Board of Directors is asked to discuss and note the information within the annual report and ratify the revise risk management strategy.

Risk Management Strategy & Policy

Lead executive	Kimberley Salmon-Jamieson (Chief Nurse)		
Author's details	Ursula Martin- Director of Integrated Governance & Quality		
Type of document	Policy		
Target audience	Warrington and Halton Hospitals NHS Foundation Trust		
Document purpose	The purpose of this document is to outline the Risk Management Strategy for the Trust and outline the policy standards associated with its implementation		
Ratification meeting	Trust Board		
Approval meeting	Choose an item.		
Implementation date	Thursday, 01 August 2019	Review date	31 July 2021
WHH Documents to be read in conjunction with			
	Health and Safety Policy Incident and Investigations Policy Risk Assessment Policy		
Document change history			
Version	2.0		
What is different?	Updated risk management processes Description of Corporate Risk Register processes and reporting Description of Risk Appetite Framework Updated Training Needs Analysis		
Appendices/electronic forms			
What is the impact of change?	Not applicable		
Training requirements	Refer to Section 12 - Training		

Taxonomy	**Type**	**Policy Category Non-Clinical**	**Policy Category Clinical**
	Clinical	Choose an item.	Choose an item.

Contents

1. Flowchart of process

<table>
<tr><td>Identification</td><td>Identification

Using incidents, complaints, claims, patient feedback, safety inspections, external review, objectives or ad hoc assessments</td><td>Board assesses risks to objectives

Risk identification to be aligned to annual/business planning process</td></tr>
<tr><td>Quantification</td><td colspan="2">Risks Scored

Using a matrix of 1 to 5 in likelihood & severity giving a maximum score of 25; this affects how the risk is escalated. Support for risk assessment can be given by the Governance Department.</td></tr>
<tr><td>Risk Registers</td><td>Strategic Risk Register

• Those risks mapped against delivery of strategic objectives
• Those operational risks either 15 and below deemed to be strategic

Corporate Risk Register

• Risk aligned to Trust Executive portfolios
• Those operational risks deemed to be corporate following cross sectional analysis of impact and likelihood
• The risks that may prevent the Trust from achieving its operational objectives</td><td>Operational Risk Registers

• Risks 8 and below – Local Risk Registers managed at Ward/Departmental Level
• Risk 9 and above – CBU Risk Register managed by the CBU
All risks 15 or above will be escalated & considered for inclusion on the Corporate/Strategic Risk Register at the Risk Review Group</td></tr>
</table>

Audit Committee • Annual Governance statement – reviewing systems of internal control • Internal audits of issues linked to strategic risks & monitoring of these action plans	**Quality Assurance Committee** • Delegated Committee responsible for overseeing risk on behalf of the Board • Monthly review of strategic risk register • Assurance regarding review of divisional risks via Divisional Quality Dashboard reports	**Finance & Sustainability Committee** • Oversees financial risk on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register
Strategic People Committee • Oversees all workforce risks on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register	**Trust Operational Board** • Monthly review of strategic operational risks • Identification of operational risks and escalation of risk to be recorded on the appropriate risk register	**Risk Review Group** • Monthly report to Quality Committee highlighting exceptions, recommendations for new strategic risks, review of existing strategic risks and an assurance review of a divisional risk register • Rolling review of Divisional Risk Register at the Risk Review Group – at least six monthly review for each CBU
CBU Meetings • Review and discuss all risks at a score of 8 or above • Review and discuss all their services risks from Wards, Departments on a monthly basis.	**Ward and Departmental Meetings** • Discuss all the Department's active risks • Risks scored less than 8 managed locally	

1. Executive Summary

Having a robust risk management system means having a planned and systematic approach to the identification, evaluation and control of the risks facing Warrington and Halton NHS Foundation Trust (WHH) and is a means of preventing harm to patients and staff, minimising costs and disruption to the Trust, caused by undesired events.

The aim of this document is to ensure the Trust has an effective process to support better decision making through good understanding of risks and their likely impact.

2. Purpose and Scope

The purpose of the Risk Management Strategy & Policy is to encourage a culture where risk management is seen as an essential process of the Trusts activities. To ensure structures and processes are put in place to support the assessment and management of risks throughout WHH.
The strategy outlines the processes in place to manage risks at all levels to enable the Trust to delivery its organisational objectives.

The strategy applies to all employees within the Trust.

3. Risk Management Objectives

This strategy acknowledges the current positive arrangements for managing risks and sets out the Trust's objectives for further improving the management of risk.

The strategy will further develop the Trust's framework by;

- Defining and setting out the benefits of risk management
- Help the Trust to understand risk appetite and tolerances
- Continuously improve risk management arrangements within WHH
- Assess the current status of risk management within the Trust
- Outline the approach to managing, maintaining and reviewing of risk registers

4. Benefits of Risk Management to the Trust

The benefits gained from effectively managing risk include:

- Keeping our patients, our staff and the public safe from harm;
- Greater ability to deliver against objectives and targets;
- Improved decision making;
- Reduction in time spent dealing with the consequences of a risk event having occurred;
- Improved service delivery;
- Better informed financial decision making;
- Greater financial control;
- Reduction in claims against the Trust

5. Roles and Responsibilities

Role	Responsibilities
Board of Directors	Responsible for approval of this strategy and policy and for the review of the strategic risk register and Board Assurance Framework.
Chief Executive	Is the overall Accountable Officer for the delivery of integrated governance and is therefore responsible for all aspects of clinical governance, risk management and performance management. This responsibility is delegated to the executive team, outlined within designated executive portfolios, as below.
Chief Nurse	Has executive responsibilities, which include delegated executive director responsible for risk management and clinical governance. In addition patient safety, nursing midwifery, Allied healthcare professionals practice and associated quality and safety initiatives and child and adult safeguarding, all come under the Chief Nurse portfolio. The Chief Nurse is accountable to the Chief Executive for risks arising in these areas.
Medical Director	Has executive responsibilities, which include, education & research and medical practice (including professional lead for pharmacists). He is accountable to the Chief Executive for risks arising from these areas. The Medical Director is accountable to the Chief Executive for risks arising from these areas.
Director of Operations	Has executive responsibilities, which include effective and safe delivery of clinical services. The Director of Operations is accountable to the Chief Executive for risks arising from these areas.
Director of Finance	Has executive responsibilities, which include overseeing financial risks and the performance management framework at corporate and operational levels.
Director of Human Resources and Organisational Development	Has an executive responsibility, which include ensuring the development of a workforce and organisational development strategy within the Trust and that any risks associated with this are identified and actions put in place.
Director of Strategy	Has executive responsibilities, which include identifying and reporting risks which arise and implementation of our overall Trust Strategy.
Director of Governance and Quality	Has delegated responsibility from the Chief Nurse and Chief Executive to ensure that there are effective risk management systems in place throughout the Trust and holds the portfolios for patient harm, clinical

	effectiveness, complaints, PALS, legal, compliance and Health & Safety.
Clinical Business Unit Managers and Corporate Service Managers	Accountable for the effective management of risk with their services and the implementation of this strategy.
Matron, Lead Nurse, Heads of Service, Ward Managers	Are responsible for identifying, assessing, responding, reporting and reviewing risks within their wards/departments. They must ensure risks are reviewed and updated at least annually, and that the risk entries are kept updated to reflect current position and activity.
Head of Corporate Affairs	Has responsibility for maintaining the Strategic Risk Register and reporting to Trust Board and Quality Committee on strategic risk.
Head of Health & Safety and Risk Management	Ensure risk management training is provided as per the Trust training needs analysis (TNA) Review health and safety risk assessments
All Staff and Contractors	Have a responsibility to: • Observe and comply with the policies and procedures of the Trust; • Take reasonable care for the health, safety and welfare of themselves and others; • Co-operate on matters of risk management and health and safety; • Participate in induction and all relevant mandatory training as defined by the Induction and Mandatory Training Policy (as amended); • Report all identified hazards and adverse incidents;

6. Governing Risk in the Trust

The Quality Committee is the delegated committee of the Board of Directors to oversee the strategic risk register. Strategic risks are discussed at each meeting. It approves amendments to the strategic risk register / board assurance framework for ratification by the Board of Directors.
The Finance and Sustainability Committee will oversee financial risk and risks arising through transformation on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register.
The Strategic People Committee will oversee workforce risk on behalf of the Trust and report on any

additional risk/controls/assurances which will be recorded on the appropriate risk register
The Risk Review Group will report to Trust Quality Committee and oversee divisional risk registers and make recommendations to Quality Committee regarding risks for inclusion on the Trust Strategic Risk Register.
The Trust Operational Board (TOB) oversees the Trust's operations and any risks associated with delivery of this and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register. Any operational risks are monitored at Quality Committee and items relating to risks may be referred to COB from the Quality Committee and vice versa.
The Audit Committee oversees the risk management system. It commissions an annual audit of the Board Assurance Framework and strategic risk register, as part of the internal audit plan, to satisfy itself that the system of internal control is effective. It examines the assurances on the effectiveness of controls for all strategic risks received from the chair of the Quality Committee, and from internal and external auditors.
Clinical Business Unit Meetings / Speciality Meetings / Corporate Services Meetings will review and discuss all their service risks, and risks scoring ≥ 10 escalated from their wards, departments and directorates, on a monthly basis. Any changes agreed must be recorded on the risk register and communicated to relevant managers and staff. As part of a rolling programme, the committee also reviews the risks scoring ≥ 8 for each directorate at least annually.
Ward Managers Meeting and Corporate Manager Meetings will discuss all the department's active risks, at least two-monthly, in order to raise awareness amongst the staff and to highlight specific difficulties or the introduction of new control measures. Any changes agreed must be recorded on the risk register and communicated to relevant managers and staff.

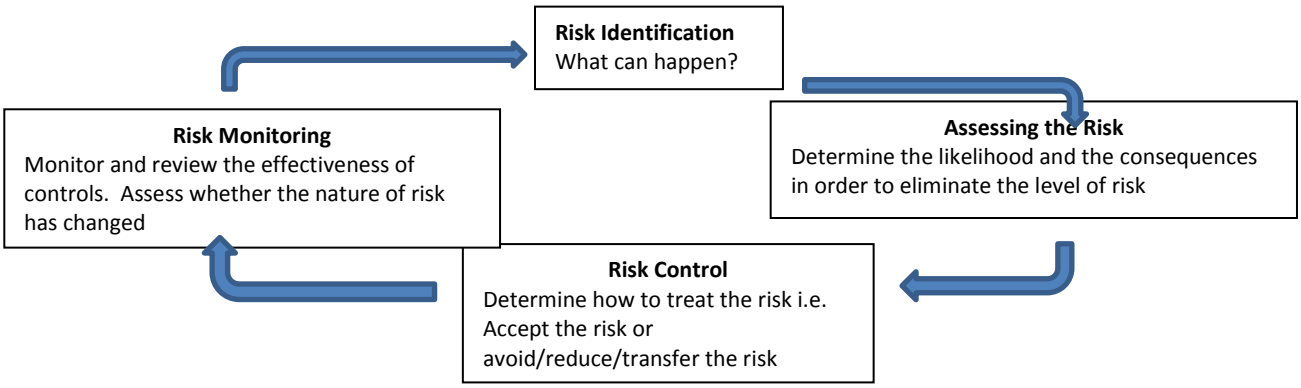
7. What is Risk Management?

What is Risk Management?
Risk management is the process of identifying possible risks or problems before they happen. This allows for the development of procedures and process to avoid the risk, minimise its impact, or at the very least help cope with its impact.

When assessing risks, a realistic evaluation should be made of all potential risks and controls put in place to mitigate any harm or loss.

It is important that we have this process in place, as it is a measure of how well led an organisation is. Risks that are left unchecked can escalate into serious issues, which put patients, staff, the public at risk of harm.

How does Risk Management support achievement of the Trust's Objectives?
Through the risk management process, the Trust can identify significant risks to enable the achievement of the organisation's strategic and operational objectives. The potential consequences and impacts are evaluated to ensure the most effective way of controlling them.



8. Risk Registers

Strategic Risk Register	Is a list of risks that may prevent the Trust from achieving its strategic objectives.
Corporate Risk Register	Is a list of risks that may prevent the Trust from achieving its operational objectives.
Board Assurance Framework	Provides assurance to the Board that the Trust is managing those risks listed on the strategic risk register. This details controls, gaps in assurances and action plans.
CBU Risk Registers	Each CBU has a risk register in place to ensure they are aware of the risks within their areas and these risks are managed, monitored, reviewed and escalated when required. Risks that sit on the CBU risk register are graded 10 and above.
Local Risk Registers	Each Ward/Department will have a local risk register in place to manage risks of 8 and below. This ensures that lower grading risks are identified, managed and reviewed at a local level. Any risks that require escalation would be reviewed by the CBU and the decision made if this risk would be transferred to the CBU risk register.

All risk registers are managed, maintained and reviewed on the DATIX Risk Management System.

9. Board Assurance Framework

Board Assurance Framework
The Board Assurance Framework (BAF) records the principal risks that could impact on the Trust achieving its strategic objectives. It provides a framework for reporting key information to the Board, identifying key controls in place to manage those objectives, assurance about the effectiveness of the controls and as a results identifying those objectives at risk because of gaps in assurance.

The Board of Directors receives an assurance report on a monthly basis.

9. Risk Appetite and Tolerances

The Institute of Risk Management defines risk appetite as:

"The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives"

Whilst risk appetite is about the pursuit of risk, risk tolerance is about what an organisation can deal with. All organisations have to take some risks and they have to avoid others.

Risk appetite levels will depend on circumstances; for example the trust will have a low tolerance to taking risks which may impact on patient or staff safety, but a greater appetite for opportunity risks such as major service developments which present significant challenges, but will ultimately bring benefits to the organisation. Expressing risk appetite can therefore enable an organisation to take decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board.

10. Risk Identification and Assessment

Risks can be identified proactively, or reactively – see examples in the table below:

Proactive risk identification	**Reactive risk identification**
Annual planning / objective setting	Review of cases where failure of controls has resulted in avoidable harm: incidents, complaints, claims
Self-assessment against Risk Management Framework	External health economy decisions / impact of commissioners' or other trusts' decisions
Impact assessments of proposed service developments and CIP measures	Response to external recommendations
Risk assessments conducted within the Trust	Audits; either clinical or internal/external audits

Assessing the Risk

A risk matrix is used to evaluate the risks so that there is an understanding of the risk exposure faced, which in turn influences the level of risk treatment that should be applied to manage/reduce/prevent that risk from occurring.

Risk scores are assessed using a 5 x 5 matrix (appendix 1 and 2). Three scores are assessed:

- **Initial risk score** – where we are at now without any controls in place
- **Residual risk score** – the score once controls are in place
- **Target risk score –** the score that could be achieved if additional controls were implemented or further assurance available

11. Glossary of Terms

Risk: the possibility of harm/damage occurring

Risk Assessment: a systematic process of evaluating the potential risks that may be involved in a projected activity or undertaking

Target risk score: is the score that can be reasonably achieved if additional controls were implemented or further assurance available.

Residual risk score: the residual risk left after putting controls in place to avoid harm/loss as far as is reasonably practicable

Open risk: A risk assessment that has demonstrated a gap between the residual risk score and the target risk score. In WHH, this will have an action plan to reduce the risk to the target score.

Significant risk: a risk scoring ≥ 15 (5 x 5 severity / likelihood matrix)

Strategic risk: a risk that may affect achievement of the Trust's objectives (and is therefore included on the strategic risk register). The ownership and accountability for strategic risks is assigned to the relevant executive director, though responsibility for managing a risk may be delegated. Many, but not all, strategic risks will be Trust-wide.

Risk appetite: the level of a risk that an organisation is prepared to seek, accept or tolerate. The appropriate level will depend on the nature of the work undertaken and the objectives pursued. For example, where patient safety is critical the appetite will be lower than for an innovative project - where it might be accepted that short-term failure could pave the way to longer-term success.

Risk tolerance: an organisation's readiness to bear risks in order to achieve its objectives. Sometimes risk tolerance is limited by legal or regulatory requirements.

12. Training Needs Analysis

Staff Role	Training Requirement	Frequency	Training Delivery Method
Executives Non-Executives	Senior Risk Management Training DATIX Risk Training	One off training	Class room
Deputy Directors Associate Directors Clinical Directors	Senior Risk Management Training DATIX Risk Training	One off training	Class room
CBU Managers Heads of Service	Senior Risk Management Training DATIX Risk Training	One off training	Class room
Lead Nurse Matron Department Manager	Risk Management Training DATIX Risk Training Integrated Risk Tool	One off training	Class room
All Staff	Risk Assessment Training	One of training	Class room

Appendix 1

Each risk is assessed by multiplying the scores for severity of harm and the likelihood of that level of harm occurring. This calculation will produce the **Risk Score.**

	Severity	Likelihood
5	Death or multiple permanent injuries or irreversible health effects; or totally unacceptable level or quality of treatment / service; *or* gross failure of patient safety; or de-authorisation *or* suspension of registration / prosecution; *or* prolonged national adverse media coverage*; or* total loss of public confidence; or loss of >1% of budget; or permanent loss of service or facility.	Almost Certain Poor control Daily
4	Major injury or harm leading to long-term or permanent incapacity / disability requiring extensive rehabilitation / increase in length of hospital stay by >15 days; or non-compliance with national standards with significant risk to patients if unresolved; or red formal complaint or multiple complaints; or uncertain delivery of key objective / service due to lack of staff; or unsafe staffing level or competence (5-14 days); or multiple breeches in statutory duty; or national media coverage with <3 days service well below reasonable public expectation; *or* loss of 0.5 to 1% of budget;	Likely Weak control Weekly
3	**Moderate harm** – Short-term harm e.g.# wrist, ankle / un-expected return to theatre / increase in length of hospital stay by approx 4-14 day; or RIDDOR / agency reportable incident - 8 days or more off work; or treatment or service has significantly reduced effectiveness; or amber formal complaint; or repeated failure to meet internal standards; or unsafe staffing level or competence (1-5 days); or single breech in statutory duty; or local media coverage/ medium-term reduction in public confidence; or loss / interruption of service >1 day or *or* loss of 0.25 to 0.5% of budget;	Possible Adequate control Monthly
2	**Minor harm** – required extra observation or minor intervention; increase in length of stay approx 1-3 days; *or* loss of 0.1 to 0.25% of budget; *or* overall treatment or service sub-optimal; *or* green formal complaint; or ongoing low staffing levels: or local media coverage; or loss / interruption of up to 24 hours	Unlikely Good control Annually
1	**Negligible / no harm:** 0 - £50K loss; *or* peripheral element of treatment or service suboptimal; *or* short-term staffing level (< 1 day); *or* minimal impact / breach of guidance; *or* service disruption up to 8 hours; *or* potential for public concern; *or* schedule slippage; *or* loss of service < 8 hours	Extremely rare Strong control < annually

X	LIKELIHOOD					
SEVERITY		1	2	3	4	5
	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Severity score: 1 represents negligible harm; 5 represents catastrophic harm / loss. Each level of severity looks at the extent of injury to persons, the level of financial loss or the damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting levels.

Likelihood score: 1 represents an extremely rare probability of occurrence; 5 represents an almost certain likelihood of [re]occurrence.

Differing Risk Scenarios

In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur.

E.g. death from a medication error is extremely rare, but minor or moderate harm is more common and may therefore have a higher residual risk. Whichever way the residual risk score is determined; it is the **highest residual risk score** that must be recorded on the risk register.

Appendix 2 Detailed Risk Grading Table

Severity (consequence)					
Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Patient / staff / public harm	No harm, requiring no or only minimal intervention or treatment. No time off work	Minor injury or illness, patient required extra observation or minor intervention. (E.g. bruising skin tear, psychological harm due to delayed surgery) Increase in length of hospital stay by approx 1-3 days Staff first aid / minor treatment. Requiring time off work for 0-7 days	Short-term harm e.g.# wrist, ankle, symphysis pubis or un-expected return to theatre. Increase in length of hospital stay by approx 4-14 days RIDDOR / agency reportable incident Requiring time off work for 8 days or more An event which impacts on a small number of patients	Major injury or harm leading to long-term or permanent incapacity / disability requiring extensive rehabilitation Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Requiring time off work for >6 months / permanently unable to work	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint / inquiry	Overall treatment or service suboptimal Green formal complaint Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Amber formal complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if not acted on	Non-compliance with national standards with significant risk to patients if unresolved Red formal complaint or multiple complaints / independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Inquest / ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Ongoing low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff / capacity Unsafe staffing level or competence (1-5 days) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (5-14 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations / improvement notice	Multiple breeches in statutory duty Enforcement action Improvement notices Low performance rating	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating

Severity (consequence)					
Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
				Critical report	Severely critical report
Adverse publicity / reputation	Adverse rumours Potential for public concern	Local media coverage: short-term reduction in public confidence Elements of public expectation not being met	Local media coverage: medium-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation Prolonged loss of public confidence	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the house) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5 – 9.9% over project budget Moderate schedule slippage	10 – 25 % over project budget Major schedule slippage Key objectives not met	>25 % over project budget Severe schedule slippage / abandonment Key objectives not met
Finance	Negligible loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective / Loss of 0.5–1.0 per cent of budget Purchasers failing to pay on time	Non-delivery of key objective / Loss of >1 per cent of budget Failure to meet specification / slippage Loss of contract / payment by results
Litigation	No risk / minor, out-of-court settlement	Claim less than £10,000	Claim(s) between £10,000 and £100,000	Claim(s) between £100,000 and £1 million	Claim(s) >£1 million
Service / business interruption	Loss / interruption of < 8 hour s	Loss / interruption of up to 24 hours	Loss / interruption of >1 day	Loss / interruption of >1 week	Permanent loss of service or facility
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 2 Risk Management Action Plan

Lead: Helen Wynn, Head of Safety and Risk

Progress Monitoring	
	Action Complete
	Action on Target
	Action is delayed but activity is being taken. Does not need to be escalated
	Action overdue and matter needs to be escalated.

Task	**Owner**	**Start Date**	**Date Due for Completion**	**Completion Date**	**Comments**
Review of Risk Management Strategy	Director of Governance & Quality Head of Safety and Risk	May 2019	May 2019	May 2019	
Review of Risk Assessment Policy	Head of Safety and Risk	July 2019	July 2019	July 2019	
Further embed the integrated risk tool across the Trust and review effectiveness	Head of Safety and Risk	June 2019	March 2020	Ongoing	
Audit of the integrated risk tool	Head of Safety and Risk	Oct 2019	Nov 2019	On track	

Task	Owner	Start Date	Date Due for Completion	Completion Date	Comments
Ensure there is a weekly updates of risk registers	Head of Safety and Risk /CBU leads	June 2019	March 2020	Ongoing	
Create guidance book for risk registers	Head of Safety and Risk	June 2019	November 2019	On track	
Training programme for Risk Management further rolled out	Director of Governance & Quality Head of Safety and Risk	June 2019	March 2020	On track	
Training programme for Risk Assessment further rolled out	Head of Safety and Risk	June 2019	March 2020	On track	
Risk Management Annual Report	Director of Governance & Quality Head of Safety and Risk	May 2019	May 2019	May 2019	
Ensure capital programme aligns to the risk management processes within the Trust	Head of Safety and Risk	June 2019	March 2020	Ongoing	
Ensure quality impact assessment process aligns to the risk management processes within the Trust	Head of Safety and Risk	June 2019	March 2020	On track	
Ensure NICE guidance aligns to the risk management processes within the Trust	Head of Safety and Risk	June 2019	March 2020	On track	
Corporate Risk Registers developed with appropriate reporting in place	Head of Safety and Risk	June 2019	September 2019	September 2019	
Further alerts to be set up on DATIX so managers	Head of Safety and Risk	June 2019	March 2020	On track	

Task	Owner	Start Date	Date Due for Completion	Completion Date	Comments
are aware of any new risks					
Working with the Board and Good Governance Institute to develop a Risk Appetite Framework	Head of Corporate Affairs	June 2019	March 2010	On track	

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 4

Equality Impact Assessment (EIA)		
Initial assessment	Yes/No	Comments
• Age • Disability - learning disabilities, physical disability, sensory impairment and mental health problems • Gender reassignment • Race • Religion or belief • Sex • Sexual orientation including lesbian, gay and bisexual people • Marriage and civil partnership • Pregnancy and maternity	No No No No No No No No No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	No	
Is the impact of the document likely to be negative? • If so can the impact be avoided? • What alternatives are there to achieving the document without the impact? • Can we reduce the impact by taking different action?	No	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the Human Resource Department together with any suggestions as to the action required to avoid /reduce this impact. For advice in respect of answering the above questions, please contact the Human Resource		

Department.		
Was a full impact assessment required?	N/A	
What is the level of impact?	N/A	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/99**
SUBJECT:	**Director of Infection Prevention and Control Annual Report**
DATE OF MEETING:	25 September 2019
AUTHOR(S):	Lesley McKay Associate Director of Infection Prevention and Control
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future
	SO3: We will .. Work in partnership to design and provide high quality, financially sustainable services
EXECUTIVE SUMMARY (KEY ISSUES):	This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2018 to March 2019 financial year. • Improvements were noted in compliance with the Code of Practice on Prevention of Healthcare Associated Infections from upgrades to patient care environments and Outpatient waiting areas • Overall attendance at infection control mandatory training ≥ 90% • There was a slight reduction in planned audit activity due to short period of reduced staffing. The Nursing Team has been restructured and an Audit and Surveillance Nurse post created • All policies/guidelines are in date (23 documents reviewed) • 27 C. difficile cases (increase by 3 cases and 1 case over threshold). The CCG review panel concluded 17 of these cases were unavoidable • 2 MRSA bacteraemia cases (increase by 1 cases). Both cases were avoidable and occurred as a result a delay in sampling or reporting of results and not poor patient care • 48 E. coli bacteraemia cases (increase by 12 cases) and 14 Klebsiella bacteraemia cases (increase by 2 cases) • 14 MSSA bacteraemia cases (decrease by 2 cases) • 5 Pseudomonas cases (decrease by 1 case) Discussion with Care Quality Commission inspector highlighted the

	national challenge with reduction of Gram Negative Bacteraemia. End of year data showed 67 Trusts with an increase in case and 9 Trusts with no change in case numbers out of 147 organisations. Action plans, which focus on learning from incidents, are in place to manage and monitor these infections. Due to the rise in E. coli bacteraemia cases, a 5% reduction target has been set as a priority in the Quality Strategy for 2019/20. The low incidence of surgical site infection in mandatory Orthopaedic surveillance has been maintained. Surveillance of surgical site infection in breast surgery identified a low infection rate which was comparable with the national rate for this procedure. Antimicrobial Stewardship has been strengthened with the appointment of an additional Consultant Medical Microbiologist and an increase in ward round activity. Point prevalence audits show 90% compliance with the Trust formulary. The Trust is sharing the notable approach used with other Trusts. The Trust scored above national average in the Patient Led Assessments of the Care Environment (PLACE) reports on both sites for cleanliness, condition and maintenance. During the Care Quality Commission inspection, positive comments were made by inspectors on the cleanliness of the hospital. Good progress was made against the Infection Prevention and Control Strategy. This is scheduled for revision this year. This report builds on previous annual reports submitted to the Board to give a whole year account of infection prevention and control activity.

PURPOSE: (please select as appropriate)	Information √	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to receive and note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**		Quality Assurance Committee	
	Agenda Ref.		QAC/19/09/145	
	Date of meeting		03.09.2019	
	Summary of Outcome		Noted and supported	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Trust Board

SUBJECT	Infection Prevention and Control	AGENDA REF:	BM/19/09/XXX

1. BACKGROUND/CONTEXT

EXECUTIVE SUMMARY

Organisation

Warrington and Halton Hospitals NHS Foundation Trust is a secondary care organisation providing healthcare services across the towns of Warrington, Runcorn, Widnes and surrounding areas. The Trust has 3 hospitals across two sites and operates within the mid-Mersey Health Economy. The Trust has approximately 540 inpatient beds, an annual budget in the region of £210 million, employs over 4,200 staff and delivers 500,000 individual appointments, procedures and inpatient stays.

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

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

Infection Prevention Annual Work Plan

This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for 2018/19 financial year. The Infection Prevention and Control Team worked towards delivery of the annual work plan. A period of reduced staffing had an impact on full achievement of the work plan in that the ward/department audit programme was not fully completed. A separate programme of high impact intervention audits continued and this provided assurance on compliance with clinical procedures.

A robust work plan (appendix 1) has been devised for the 2019/20 financial year. The work plan includes attendance at other committees to ensure integration of infection prevention and control across the organisation; compliance with all mandatory surveillance requirements; monitoring of environmental cleanliness standards; audits of practice/policies; policy/guideline reviews and a programme of education and awareness raising events.

The work plan will link to the Infection Prevention and Control Strategy which is being revised in 2019 and progress will be monitored by the Infection Prevention and Control Sub-Committee.

Code of Practice on Prevention of Healthcare Associated Infections

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

- 7 are fully compliant

- 3 have minor non-compliances

The minor non compliances relate to old Estate i.e. lower number of side room facilities than current recommendations, lower ratio of hand washing sinks to patient number than current guidance. Surveillance systems to detect infections electronically are under review.

Healthcare Associated Infections

There are 3 healthcare associated infection reduction action plans, linked to mandatory reporting requirements which were reviewed on a quarterly basis. Progress has been made and results compared to the previous financial year are detailed below.

- *Staphylococcus aureus* (Meticillin resistant/Meticillin sensitive) bacteraemia reduction
  - 2 hospital onset MRSA bacteraemia case - increase by 1 case
  - 15 hospital onset MSSA bacteraemia cases – decrease by 2 cases

- Gram Negative Bloodstream Infection (GNBSI) reduction
  - 48 hospital onset cases of Escherichia coli (E. coli) – increase by 12 cases
  - 14 hospital onset cases of Klebsiella spp. – increase by 2 cases
  - 5 hospital onset cases of Pseudomonas aeruginosa – decrease by 1 case

With the exception of E. coli, there were reductions or minimal increases in bloodstream infection case numbers. Nationally reported data shows E. coli bloodstream infections continue to increase. A revised national timescale for the targets to reduce these infections was published in the Tackling Antimicrobial Resistance 5 year plan (January 2019). This publication recommends a systematic approach to preventing infections and delivering a 25% reduction by 2021-2022 and 50% by 2023-2024.

Due to concerns identified with rising numbers of hospital onset E. coli bloodstream infections, an internal reduction target of 5% has been set as a priority in the Quality Strategy for 2019/2020. There is an internal working group that meets monthly to drive care improvements to support reductions in hospital onset cases. Work is also in place with partners across the health economy.

- Clostridium difficile
  - 27 hospital onset cases - increase by 3 cases

All cases underwent root cause analysis and were secondarily reviewed by the Clinical Commissioning Group (CCG) review panel. The CCG review panel concluded 17 of the cases were unavoidable; 2 were not concluded and 8 cases were avoidable.

Actions in place to reduce the risk of Clostridium difficile focus on hand hygiene, environmental cleanliness and antimicrobial stewardship. Antimicrobial stewardship has been further strengthened with the appointment of an additional Consultant Medical Microbiologist.

In the annual Patient Led Assessment of the Care Environment (PLACE), the Trust scored above national average at both sites for cleanliness, condition, appearance and maintenance. A vast amount of activity to improve the Trust estate has been undertaken. Completed actions include: some ward redecoration, conversion of ward areas to create additional storage, relocation of the Coronary Care Unit and Cardiology ward to one location, conversion of the former Coronary Care Unit to an Emergency Department Assessment Area, removal of carpets from outpatient clinic waiting areas on the Halton site and replacement of corridor flooring also at Halton.

This report builds on previous annual reports submitted to the Board to give a whole year account of infection prevention and control activity.

Kimberley Salmon-Jamieson
Chief Nurse
Director of Infection Prevention and Control (DIPC)
July 2019

Acknowledgements

Marcia Anthony	Facilities Manager
Natalie Crosby	Matron Intensive care
Julie McGreal	Facilities Manager
Lesley McKay	Associate Director of Infection Prevention and Control
Dr Zaman Qazzafi	Consultant Medical Microbiologist
Olwyn Wainwright	Surgical Care Practitioner MSK Clinical Business Unit
Jacqui Ward	Lead Pharmacist in Antimicrobial Stewardship

2. KEY ELEMENTS

Description of Infection Control Arrangements

Infection Prevention and Control Team

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

- Consultant Medical Microbiologists:-
  - Dr Zaman Qazzafi (Deputy DIPC and from October 2018 Infection Control Doctor)
  - Dr Thamara Nawimana /Infection Control Doctor – (until September 2018)
  - Dr Toong Chin (from February 2019)
  - Dr Janet Purcell (from February 2019)

- Associate Director of Infection Prevention and Control:-
  - Lesley McKay

- Infection Prevention and Control Nurses:-
  - Charlene Liptrot
  - Helen McLaren (until November 2018)
  - Katherine Summers (from January 2019)

- Lead Pharmacist in Antimicrobial Stewardship
  - Jacqui Ward

- Infection Control Administrator:-
  - Amanda Millington

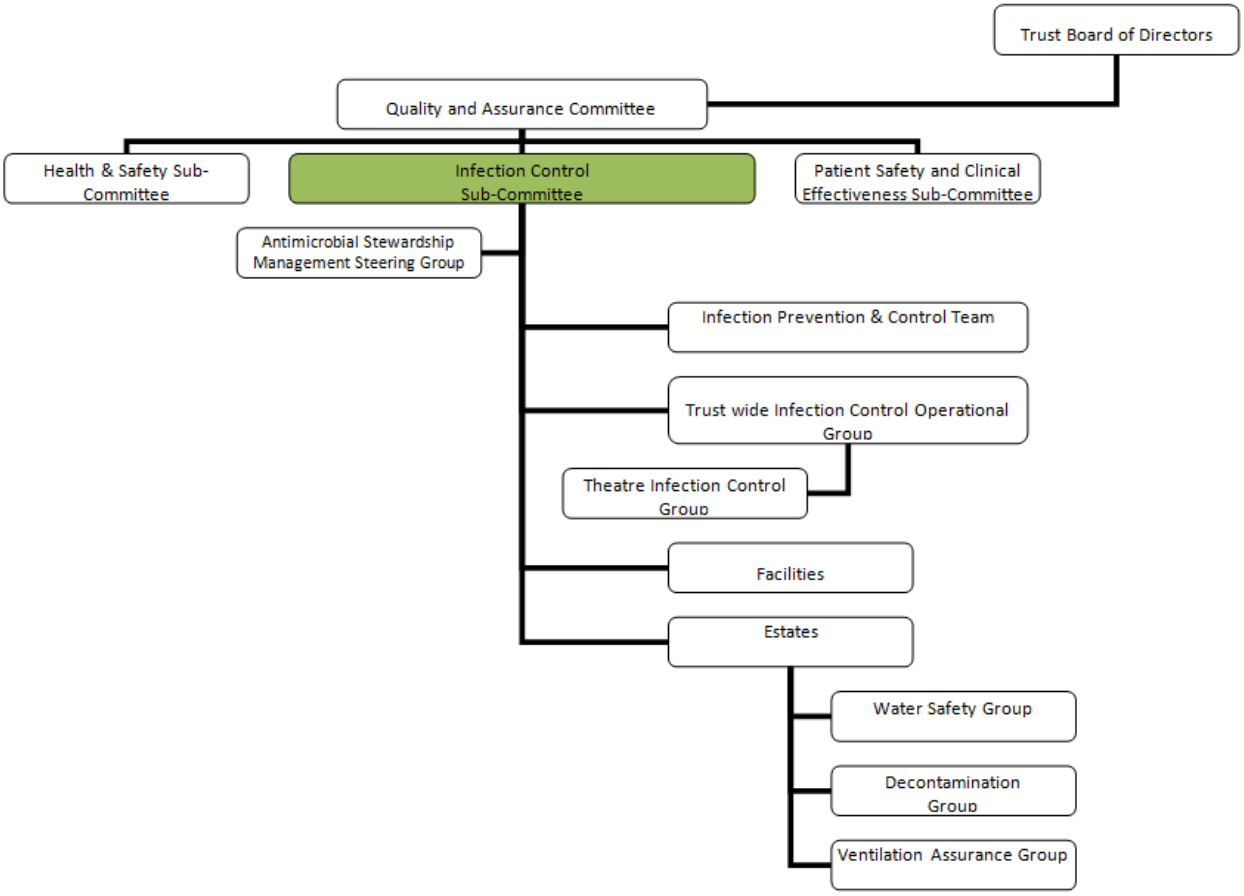
- Operational Estates Manager
  - Darren Wardley

Infection Control Sub-Committee

The Infection Control Sub-Committee is chaired by the Deputy DIPC/Infection Control Doctor/ Consultant Medical Microbiologist. The committee meets bimonthly. Membership comprises of the Infection Prevention and Control Team, Lead Nurses from each Clinical Business Unit, Estates and Facilities Managers, Lead Allied Health Professional and the Workplace Health and Wellbeing Manager.

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

Figure 1 Reporting Line to Trust Board



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

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

DIPC Reports to Trust Board

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

- April 2018
- June 2018 (Annual Report on previous years activity)
- August 2018
- October 2018
- February 2019

Annual work plan

The Infection Prevention and Control Team work plan was developed to give assurance that each element of the Code of Practice for prevention of healthcare associated infections (HCAIs), which

underpins the Health and Social Care Act (2008) is adhered to and that appropriate evidence of compliance is available.

This work plan is underpinned by action plans for key performance indicators/mandatory healthcare associated infections and a programme of audit that provides evidence of policy/guideline implementation and compliance. There was a reduction in planned audit activity due to a short period of reduced team staffing. At ward/department level high impact intervention and hand hygiene audits were carried out as planned.

The Lead Nurses/Matrons/ Lead Allied health Professional for each CBU submit reports at each Infection Control Sub-Committee meeting as a standing agenda item. This allows the Infection Control Sub-Committee to give assurance to the Quality and Assurance Committee and Trust Board that compliance with the Code of practice is maintained and that there is a programme of continued improvement. The work plan has been revised for 2019/20 (appendix 1).

Health and Social Care Act (2008) compliance assessment

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

The Care Quality Commission (CQC) uses this code to judge registered provider compliance with the cleanliness and infection control requirement set out in the regulations. Improvements were noted in the numbers of staff attending mandatory training (greater than 90%) during the financial year.

Compliance with the Code of Practice at the end of March 2019 and areas requiring further action are detailed in table 1.

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

Criterion	Assessment	Action required/in progress
1. *Systems to manage and monitor the prevention and control of infection*	*Partially compliant*	*Appointment of a Pathology Department IT manager. Purchase of surveillance software.*
2. *Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.*	*Partially compliant*	*Upgrades to some hand washing sinks required (design and location).*
3. *Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance*	*Compliant*	*Implementation of electronic prescribing planned during 2019.*
4. *Provide suitable accurate information on infections to service users and their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion*	*Compliant*	
5. *Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people*	*Compliant*	
6. *Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection*	*Compliant*	
7. *Provide or secure adequate isolation facilities*	*Partially compliant*	*Continuous liaison with the Patient Flow Team to optimise use of side rooms for appropriate patient isolation*
8. *Secure adequate access to laboratory support as appropriate*	*Compliant*	
9. *Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.*	*Compliant*	
10. *Providers have a system in place to manage the occupational health needs of staff in relation to infection*	*Compliant*	

Healthcare Associated Infection Statistics

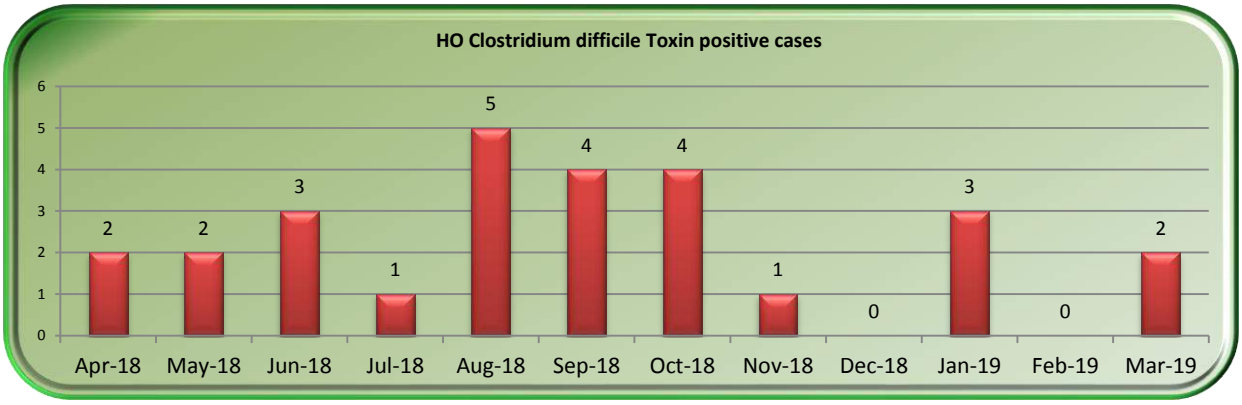
The Trust participates in the mandatory reporting of healthcare associated infections (HCAIs). There are 3 HCAI reduction action plans, linked to mandatory reporting requirements which were reviewed on a quarterly basis. Post infection reviews/root cause analysis investigations are completed. These reports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

Clostridium difficile

The Clostridium difficile objective for the 2018/19 financial year was 26 or less hospital onset cases. The Trust reported 65 Clostridium difficile toxin positive cases (38 community onset; 27 hospital onset). There was an increase of 3 hospital onset cases compared to the previous financial year and the Trust

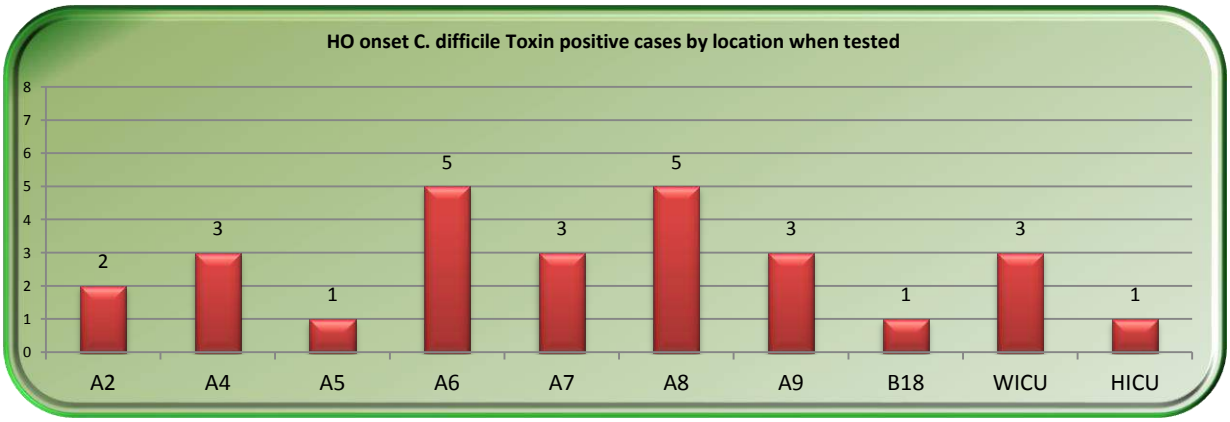
was 1 case over threshold. The number of hospital onset cases reported by month is displayed in figure 2.

Figure 2 Hospital onset (HO) Clostridium difficile cases by month 2018/19



The distribution of the hospital apportioned cases by location when the sample was taken is displayed in figure 3.

Figure 3 HO Clostridium difficile <u>toxin positive</u> cases by location when tested



The location the specimens were obtained from is not necessarily where the infection was acquired as patients may have been on the ward/department for less than 48 hours when tested.

All cases underwent root cause analysis. The investigations were completed by Ward Managers or Matrons with input from the patients' consultants. Completed investigations were reviewed internally and forwarded to the CCG for review. This resulted in 17 cases being assessed as unavoidable (and removed from those counted for contractual purposes), 2 cases were undetermined and 8 cases considered avoidable infections.

Figure 4 depicts the Clostridium difficile toxin positive case review outcomes by month. The undetermined cases are thought to be incidental results, where based on blood test results, the patients were not thought to have active C. difficile infection. There is an action plan in place linked to learning from these incidents that sets out the work required to reduce the risks of Clostridium difficile infection.

Figure 4 Outcome of CCG review panel decisions by month

2108/19	A	M	J	J	A	S	O	N	D	J	F	M	Total
Total HO C difficile	2	2	3	1	5	4	4	1	0	3	0	2	**27**
Not due to lapse in care	2	2	3	1	2	4	1	1	0	0	0	1	**17**
Due to lapses in care	0	0	0	0	2	0	2	0	0	3	0	1	**8**
Undetermined	0	0	0	0	1	0	1	0	0	0	0	0	**2**

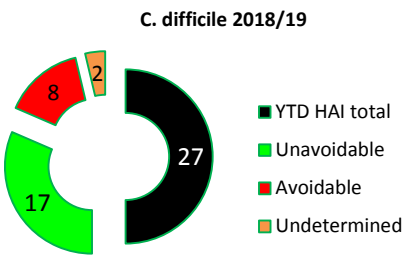
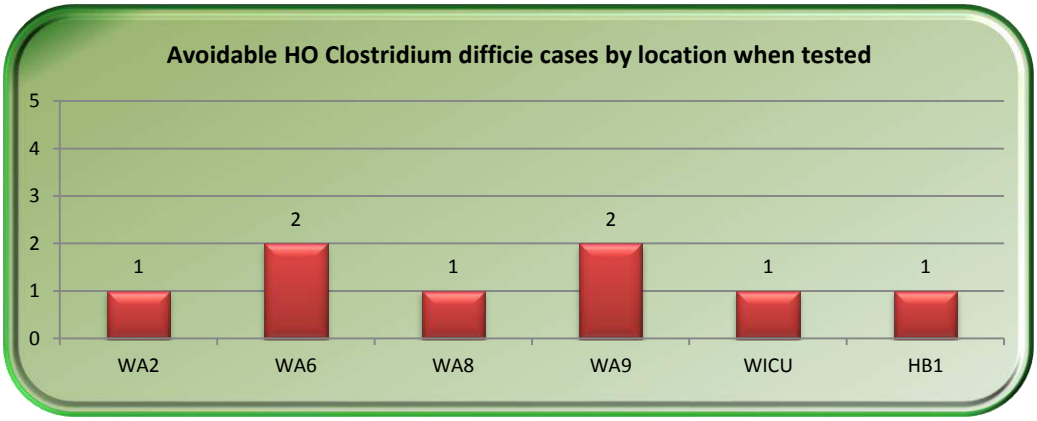


Figure 5 provides adjusted data on the 8 cases attributed to the Trust following decisions taken by the CCG review panel.

Figure 5 Avoidable Hospital onset (HO) Clostridium difficile <u>toxin positive</u> cases by location



The avoidable cases related to choice of antibiotic prescribing and there were some missed sampling opportunities for one of the cases. Other areas for care improvement emerging from the case reviews include:-

- microbiological samples are not being received in the laboratory that would support presumptive diagnoses/rationale for antibiotics
- stool output not always documented
- isolation not always carried out timely

The Chief Nurse/DIPC met with the Clinical Director for Digestive Disease to discuss antibiotic prescribing concerns across surgical specialities.

A number of stewardship initiatives are being implemented. These include additional training for nursing staff to support challenge on antibiotic choice, ward based pharmacist support and strengthening inclusion of junior doctors on antibiotic ward rounds. An additional Consultant Microbiologist has been appointed.

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

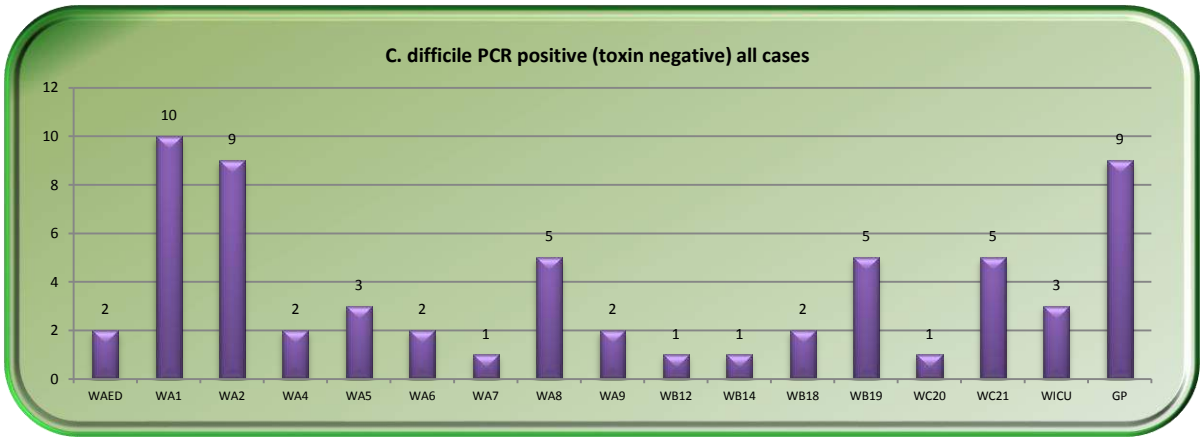
Clostridium difficile (toxin negative/PCR positive)

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

The Infection Prevention and Control Team conduct local surveillance on the patients who are Clostridium difficile PCR positive without the presence of toxins. These patients are at a higher risk of developing Clostridum difficile infection than non-colonised patients. Inpatients falling into this category are reviewed by the Infection Prevention and Control Team. Patients exhibiting symptoms are nursed in isolation and treatment advice is provided.

Figure 6 demonstrates the results for all patients (no apportionment) who were Clostridium difficile toxin negative/PCR positive and at the time of testing.

Figure 6 Clostridium difficile PCR positive/toxin negative cases (all) by location when tested



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

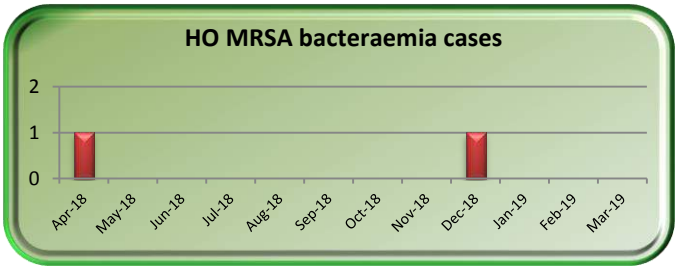
- Surveillance of cases/monitoring for increased incidences in defined locations
- Antimicrobial Management Steering Group – Stewardship
- Hand hygiene awareness raising events
- Ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment
- Weekly multi-disciplinary team review of patients with *Clostridium difficile*
- Promoting improvements to standards of environmental hygiene
- Use of hydrogen peroxide vapour for environmental decontamination

Next year's Clostridium difficile objective has been revised and the threshold increased to 44 cases. The apportionment algorithm has changed (reduction in one day from admission i.e. samples taken from 3rd day of admission onwards will be apportioned to the Trust; previously this was from 4th day). Any cases arising within 28 days of a patient discharged will also be apportioned to the Trust and will be classified as a community onset/healthcare associated case.

Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia

The Trust reported two cases of MRSA bacteraemia (both hospital onset). Both cases underwent a post infection review.

Figure 7 Hospital onset (HO) MRSA bacteraemia case



Case 1 occurred on ward A7 in April 2018 and findings suggested the patient was admitted with this infection, which was undetected due to a delay in blood culture sampling. A comprehensive incident investigation has been completed. Additional training has taken place with the Emergency Department to support timely blood culture sampling. The Urgent and Emergency Care CBU are reporting 71% of staff are trained in this clinical skill, which should support timely sampling.

Case 2 occurred on ward A4 in December 2018 and findings showed a laboratory system issue whereby the positive MRSA screen was not reported timely, resulting in a delay in prescribing skin suppression treatment. The Microbiology Laboratory Manager has implemented an additional step in the result validation process to ensure timely reporting to the Infection Prevention and Control Nurses and provided further training to laboratory staff.

Both these incidents were related to delays in either sampling or reporting of results and were not associated with poor patient care. The Trust continues to have a zero tolerance approach to avoidable MRSA bacteraemia cases.

MRSA screening

The Trust continues to provide MRSA screening for patients in line with the Department of Health guidance. Approximately 26, 500 patients were screened for MRSA This figure is consistent with previous years. Work is in progress with the data warehouse team to provide a more robust screening compliance report against the MRSA policy screening requirements.

Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia

The Trust reported 48 cases of MSSA bacteraemia (33 community onset and 15 hospital onset). This was a decrease of 2 hospital onset cases compared to the previous financial year. The Department of Health has not set targets for the reduction of MSSA bacteraemia.

Figure 8 shows the cases of MSSA bacteraemia identified within the Trust by month.

Figure 8 MSSA bacteraemia cases by month

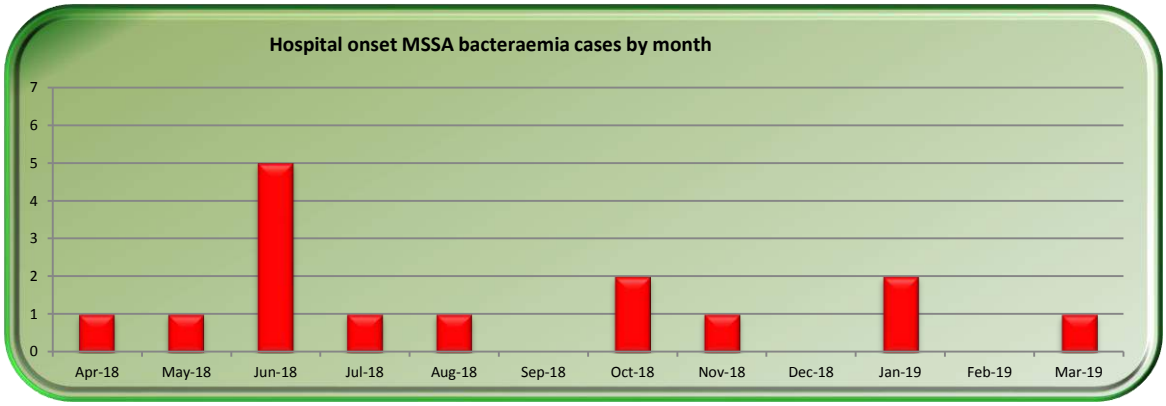
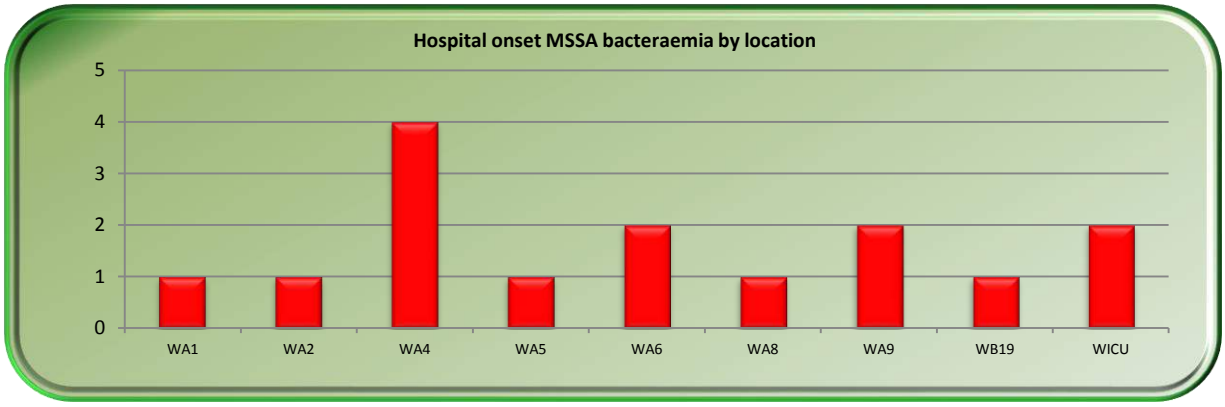


Figure 9 shows the patients location at the time the specimen was obtained.

Figure 9 MSSA bacteraemia cases by location detected



The post infection reviews identified a number of different sources for infection including intravenous device, respiratory tract infection, urinary tract infection and skin and soft tissue infection. Common themes emerged from the post infection review meetings including timely blood culture sampling on admission and monitoring of invasive devices. Work is in progress with AED to promote timely blood culture sampling on admission and improvements have been noted. There is an action plan in place linked to learning from these incidents that sets out the work required to reduce the risks of MRSA/MSSA bacteraemia cases.

Gram Negative Bloodstream Infection (GNBSI)

In 2017, the Department of Health introduced a target to reduce gram negative bloodstream infections (E. coli; Klebsiella spp. and Pseudomonas aeruginosa) by 50% by 2021. This target was set against baseline data from the 2016 calendar year. This was a health economy target and a 10% reduction target was set for E. coli bloodstream infections, linked to the Clinical Commissioning Group (CCG) Quality Premium. Nationally very few CCGs saw reductions in cases. Published data shows that of the 206 CCGs, 176 failed to meet the initial 10% E. coli reduction target.

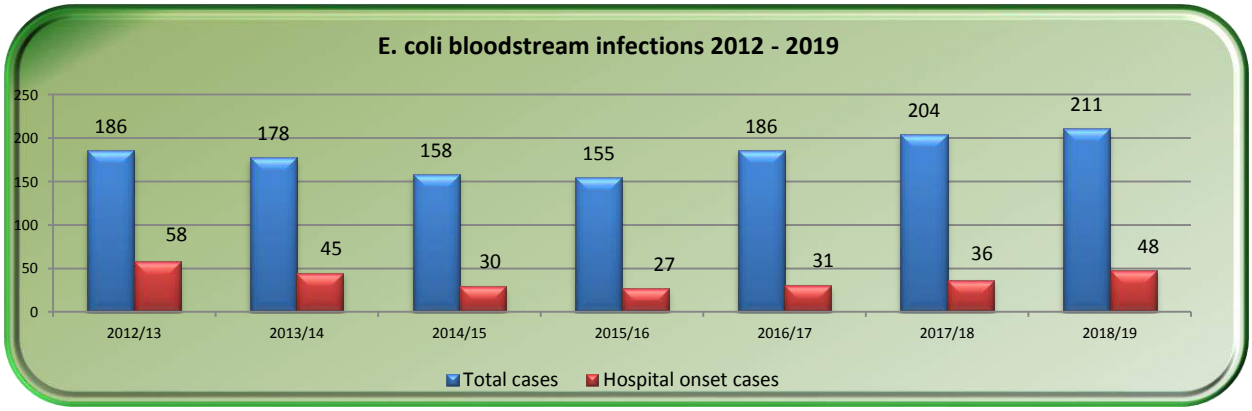
A revised target was published in 'Tackling Antimicrobial Resistance 2019-2024 – five-year national action plan' (January 2019). This document details a 25% reduction should be delivered by 2021 with the full 50% reduction by 2023-2024. NHS Improvement has also advised there is a plan to introduce individual provider Trust reduction objectives, however the date for this is not yet known.

Mandatory reporting of E. coli bloodstream infections commenced in June 2011. For the baseline year (2016) the reduction target is set against, the Trust reported a total of 181 E. coli bloodstream infections and 36 of these were hospital onset cases.

E. coli bacteraemia

In order to show whole year figures for comparison, data is shown in figure 10 from April 2012.

Figure 10 E. coli bacteraemia April 2012 – March 2019

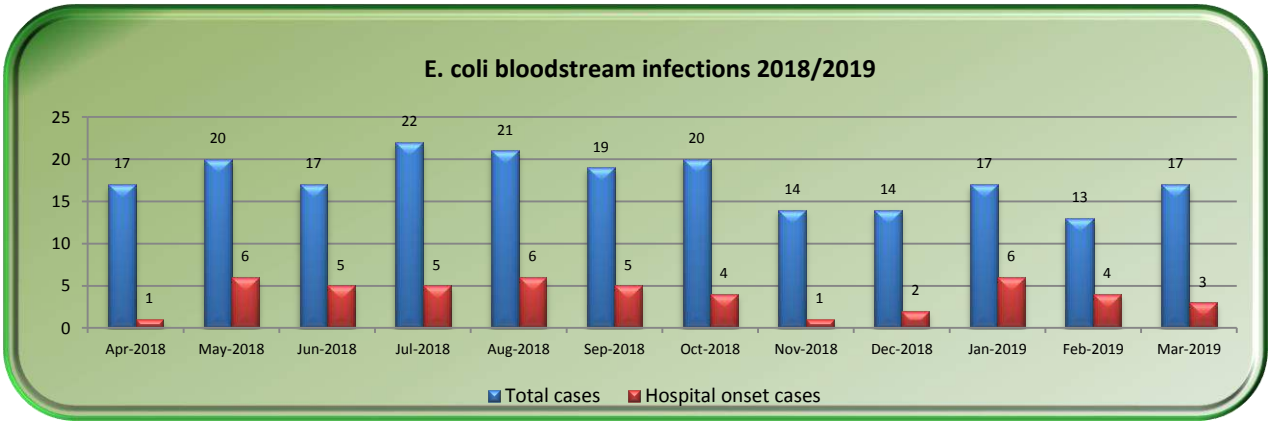


During in 2018/19 financial year the Trust reported a total of 211 E. coli bloodstream infections, 48 of these were hospital onset cases.

There was an overall increase in cases across the health economy and an increase of 12 hospital onset cases compared to the previous financial year.

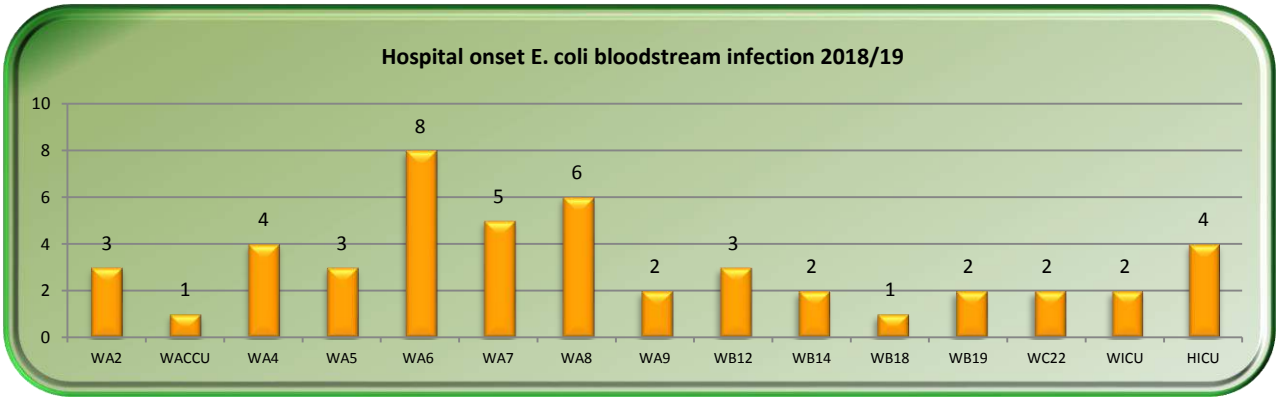
Figure 11 displays the total number of cases reported each month against the number of hospital onset cases during the financial year.

Figure 11 E. coli bacteraemia cases 2018/19



The hospital onset E. coli bacteraemia cases by ward when specimen was taken are shown in figure 12.

Figure 12 Hospital onset E.coli bacteraemia cases by ward location when tested



Of the 48 hospital onset cases the likely primary focus was assessed as being associated with:-

- urinary tract - 30 cases
- unknown source 8
- respiratory tract - 5 cases
- hepatobiliary 4 cases
- gastrointestinal (not hepatobiliary) - 1 case

All cases underwent root cause analysis. The investigations were completed by Ward Managers or Matrons with input from the patients' consultants. Completed investigations identified a number of opportunities for care improvement. These included: insertion and care of urinary catheters, timely blood culture sampling on admission and antibiotic treatment choice for urinary tract infection.

The Trust's urinary catheterisation rate is above the national average according to Safety Thermometer data. Daily reviews of continuing indication are being completed by Matrons to support timely removal.

Reporting of Klebsiella spp. and Pseudomonas aeruginosa bloodstream infections was made mandatory from April 2017.

Klebsiella spp. bloodstream infection

Figure 13 displays the total number of cases and the number of hospital onset cases reported each month during the 2018/19 financial year.

Figure 13 Klebsiella spp. bacteraemia cases 2018/19

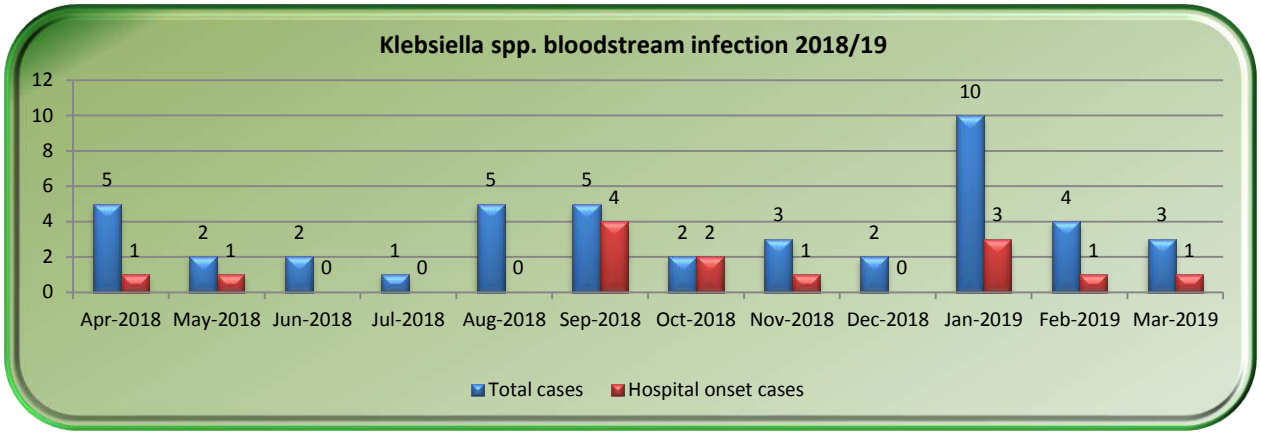
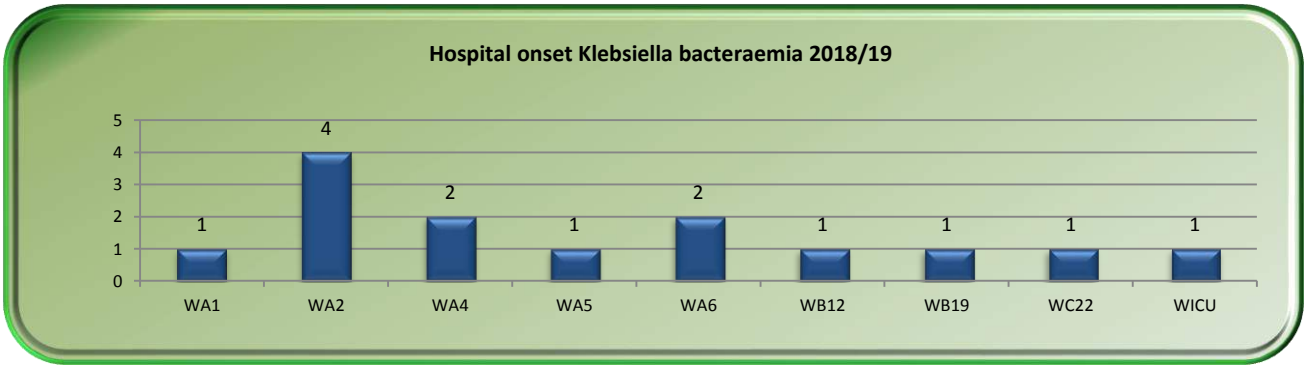


Figure 14 show Hospital onset Klebsiella bacteraemia cases by ward location when tested.

Figure 14 Klebsiella bacteraemia cases by ward location when tested



Pseudomonas aeruginosa bacteraemia

Figure 15 displays the total number of cases and the number of hospital onset cases reported each month during the 2018/19 financial year.

Figure 15 Pseudomonas aeruginosa bacteraemia cases 2018/19

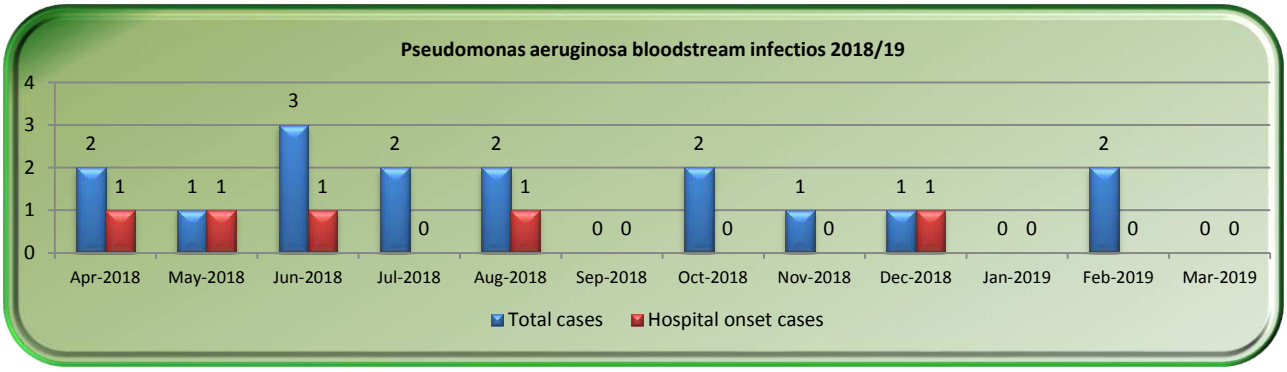
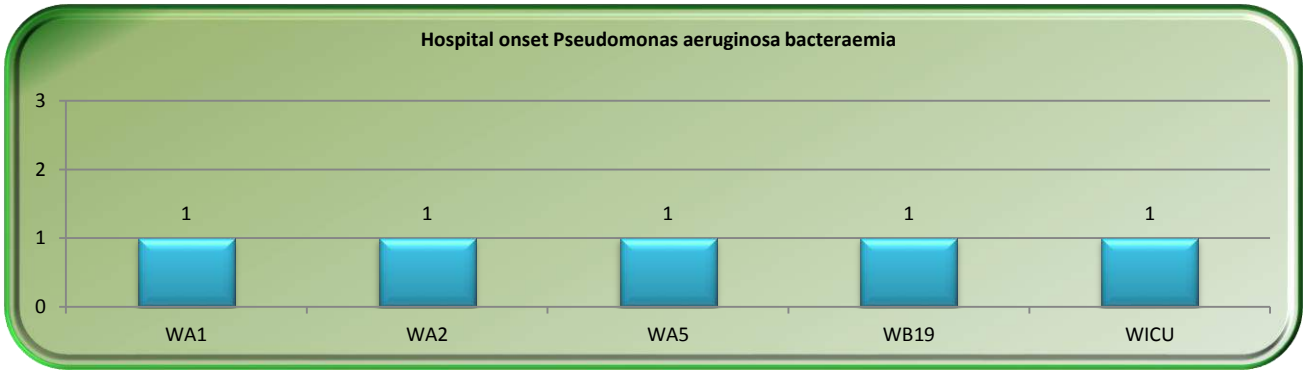


Figure 16 show Hospital onset Pseudomonas aeruginosa bacteraemia cases by ward location when tested.

Figure 16 Pseudomonas aeruginosa bacteraemia cases by ward loaction when tested



Additional activity is planned to tackle the GNBSI position including a further audit of the cases to determine additional learning. A masterclass is being delivered to Ward Managers, Matrons and Lead Nurses on completion of post infection reviews.

Information on all mandatory reported healthcare associated infections is circulated weekly with up to date information on cases and learning from reviews. Dashboards are circulated monthly after data validation.

A GNBSI reduction action group has been set up which meets monthly. A Driver Diagram and action plan have been developed with agreed tests of change. Focus of activity includes:-

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

- Grand Round presentation
- Highlight required actions at medical cabinet
- Education on the UTI pathway via computer desktops

Incidents/outbreak reports

Influenza

The Trust saw high numbers of patients admitted with influenza over the winter months (>150 cases). A background rise of influenza both in the Northwest and nationally was noted. In-house testing supported management of suspected cases. Workplace Health and Wellbeing vaccinated over 87% of frontline staff, which was the 2nd highest uptake across Cheshire and Merseyside.

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

Clostridium difficile periods of increased incidence

The Infection Prevention and Control Team have a robust system for monitoring Clostridium difficile and detecting periods of increased incidence (PII). A PII is defined as two or more new cases (occurring after 48 hours post admission, not relapses) in a 28-day period in a defined location.

During the reporting period 2 periods of increased incidence occurred.

- A8 – ribotyping was different therefore this was a cluster of cases
- ICU – 2 cases. Only 1 ribotyping result was available. This was concluded as a case cluster as the cases occurred in 2 distinctly separate geographical area of the unit

Viral gastroenteritis (Norovirus)

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

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

Closure of beds, bays and wards places significant pressure on operational teams. There has not been any hesitation in accepting the Infection Prevention and Control Team's recommendations on bed closures, which has substantially enhanced the overall management of the outbreaks. Table 2 provides details of the number of reported incidents by month, degree of closure and test results.

Table 2 Viral gastroenteritis incidents

Month	Year	No of wards affected	Closure	Causative organism(s)
Apr	2018	0		Not applicable
May	2018	0		Not applicable
Jun	2018	0		Not applicable
Jul	2018	0		Not applicable
Aug	2018	0		Not applicable
Sep	2018	0		Not applicable
Oct	2018	1	Partial	Norovirus
Nov	2018	0		Not applicable
Dec	2018	4	3 Partial 1 Full	Norovirus
Jan	2019	0		Not applicable
Feb	2019	1	Partial	Norovirus
Mar	2019	5	3 Partial 2 Full	Norovirus

The Infection Prevention and Control Team take a pragmatic and escalatory approach to diarrhea and vomiting outbreak management as detailed in national guidance documents. This involves closing affected bays and escalating to full ward closures only when appropriate. During the year norovirus was detected on 11 occasions.

Decontamination Incidents

Three incidents were reported relating to concerns about decontamination of surgical instruments. All incidents were fully investigated and concluded as no harm to patients. Additional inspections were undertaken of the decontamination facility and assurance on performance standards was provided.

Carbapenemase Producing Enterobacteriaceae screening

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

The Infection Prevention and Control Team implemented national guidance to isolate and conduct CPE screening for all patients admitted by inter hospital transfer. During the reporting period just over 1000 patients were screened for CPE carriage with 1 positive case identified. The Infection Prevention and Control Nurses visit wards daily to support staff with high standards of practice to prevent transmission.

Vancomycin Resistant Enterococci (VRE)

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

- VRE detected on rectal screening for 125 patients
- VRE detected in 116 clinical specimens (some patients may have more than 1 clinical site specimen)
  - 2 blood culture specimens
  - 67 urine specimens
  - 11 abscess/wound/pus/tissue swabs

- 1 ear swab

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

Orthopaedic surgical site infection surveillance

The Trust conducts continuous surveillance on both total hip and knee surgery. This goes further than the mandatory surveillance period of 3 months.

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

The surveillance data demonstrates there were 5 reported cases of surgical site infection (4 associated with hip surgery and 2 associated with knee surgery). Due to the nature of implant surgery infections can manifest themselves beyond this surveillance period.

Table 3 Hip Surgery surveillance April 2018 – March 2019

Type of Surgery	Number of surveillance forms completed (is previous year)	No. of SSI's detected during initial surveillance	Type of SSI Organisms identified
Cemented Uncemented Reverse hybrid Hybrid Revision Resurfacing Bilateral	132 (110) 12 (14) 96 (94) 81 (59) 9 (13) 6 (0) 4 (4)	3 (9)	1 hybrid THR Superficial Stitch Abscess 1 revision THR Superficial incisional infection E coli 1 THR superficial 1 THR Superficial incisional with Staphylococcus aureus
	312 (318)		

Table 4 Knee surgery surveillance

Type of Surgery	Number of surveillance forms completed (is previous year)	No. of SSI's detected during initial surveillance	Type of SSI Organisms identified
Cemented Unicompartmental Revision Bilateral	293 (387) 26 (29) 16 (12) 8 (6)	2 (0)	1 TKR patient recorded only 1 TKR joint space deep infection requiring 2 stage revision surgery Staphylococcus Epidermidis
Total	334 (437)		

The surveillance information collected during 2018/19 indicates Orthopaedic joint replacement infections have remained minimal and reduced from 9 cases 2017/2018 to 5 cases in 2018/19.

Breast surgery Surgical Site Infection Surveillance

The Trust participated in collecting data for a 3 month period (July – September) on breast surgery. During the data collection period 76 procedures were monitored including conducting a post discharge questionnaire at 30 days. Total number of surgical site infections identified was 1 (1.3% surgical site infection rate). This is comparable with nationally reported data where infection rate without post discharge questionnaire is 2.1% and with post discharge questionnaire 1.2%.

The Infection Prevention and Control Nursing team has been restructured and an Audit and Surveillance Nurse post created. This will provide the resources required to conduct other categories of surveillance for surgical site infection.

Hand Hygiene and Aseptic Protocols

Audits of compliance with the Hand Hygiene Policy are undertaken weekly at ward and department level. An average of 88% of clinical areas was audited with an average compliance rate for the year of 98%. Percentage of audits completed and overall results are detailed in table 5.

Table 5 Trust wide hand hygiene audit results

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
% areas audited	79%	99%	96%	86%	86%	83%	96%	87%	81%	80%	89%	99%
Compliance	99%	99%	99%	99%	98%	98%	98%	98%	97%	99%	98%	99%

National inpatient survey 2018

The Trust National Inpatient Survey 2018 included a question on cleanliness. The trust scored 8.9/10 and is reported as about the same as other Trusts. This survey included a new question on hydration and whether patients felt they were given enough to drink. This question scored 8.9/10 and was rated as worse than other organisations. The nutrition and hydration strategy is being launched and there is a focus on patient hydration to support GNBSI reduction. Overall patients reported they had a good experience 8.1/10.

DECONTAMINATION

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

All surgical instruments are decontaminated off site by a company that provides decontamination services for several Trusts within the region. There is a programme of internal and external validation.

The Trust is compliant with Department of Health and NHS Estates guidance. The terms of reference have been revised and meetings have been re-established quarterly.

CLEANING SERVICES

MANAGEMENT ARRANGEMENTS

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

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

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

BUDGET ALLOCATION

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

CLEANING ARRANGEMENTS

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

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

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

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

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

MONITORING ARRANGEMENTS

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

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

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

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

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

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

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

Infection Control Operational Group

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

Terminal Cleaning

Terminal cleaning is carried out by the Task team on request by a Ward when there is an infection or when a patient has been discharged outside normal working domestic hours. In 2018/19 staff responded to 4,346 terminal clean requests.

Table 6 Terminal cleans

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

Table 7 Curtain changes

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

CLEANLINESS SCORES

The 2018/19 cleanliness monitoring scores for clinical areas were as follows:

- Warrington: 96%
- Halton: 98%

Table 8 Cleaning scores Warrington

WARRINGTON 2018/19	A	M	J	J	A	S	O	N	D	J	F	M
Cleanliness Statistics	**95%**	**96%**	**96%**	**97%**	**96%**	**95%**	**98%**	**95%**	**98%**	**97%**	**96%**	**97%**

Table 9 Cleaning scores Halton

HALTON 2018/19	A	M	J	J	A	S	O	N	D	J	F	M
Cleanliness Statistics	**97%**	**98%**	**97%**	**98%**	**98%**	**97%**	**98%**	**97%**	**98%**	**99%**	**98%**	**99%**

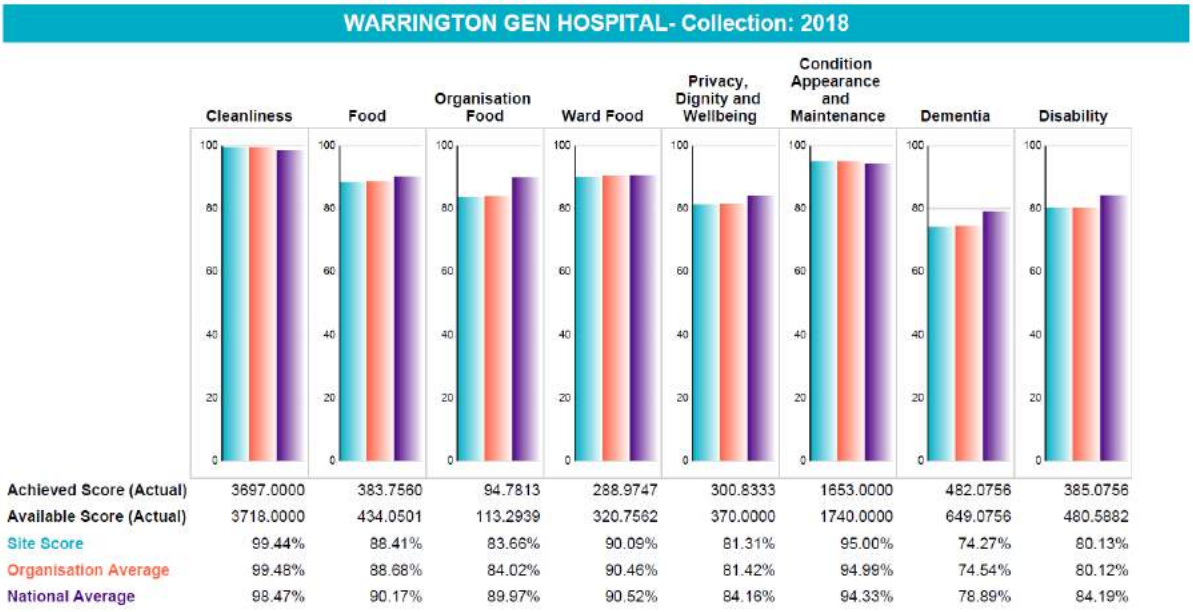
PLACE (Patient Led Assessments of the Care Environment)

In 2018 the PLACE assessments were carried out throughout the Trust by a team of patient assessors, Governors and representatives from Warrington and Halton Health Watch Organisations. This is facilitated and supported by representatives from the Trust. Results from the assessments are detailed below, along with National averages.

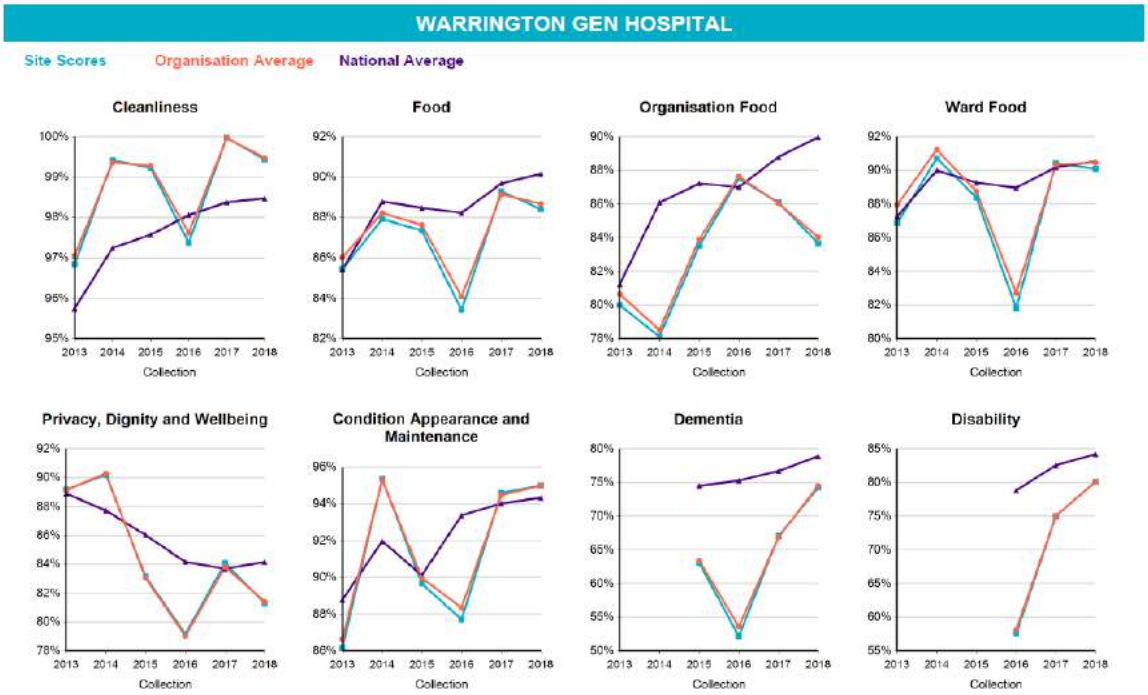
PLACE Comparison Scores (2013 – 2018)

The following graphs, produced by NHS Digital (Health and Social Care Information Centre), indicates comparison WHH Place from 2013 – 2018 for Warrington site:

Figure 17 PLACE Comparison Scores (2013 – 18) - Warrington

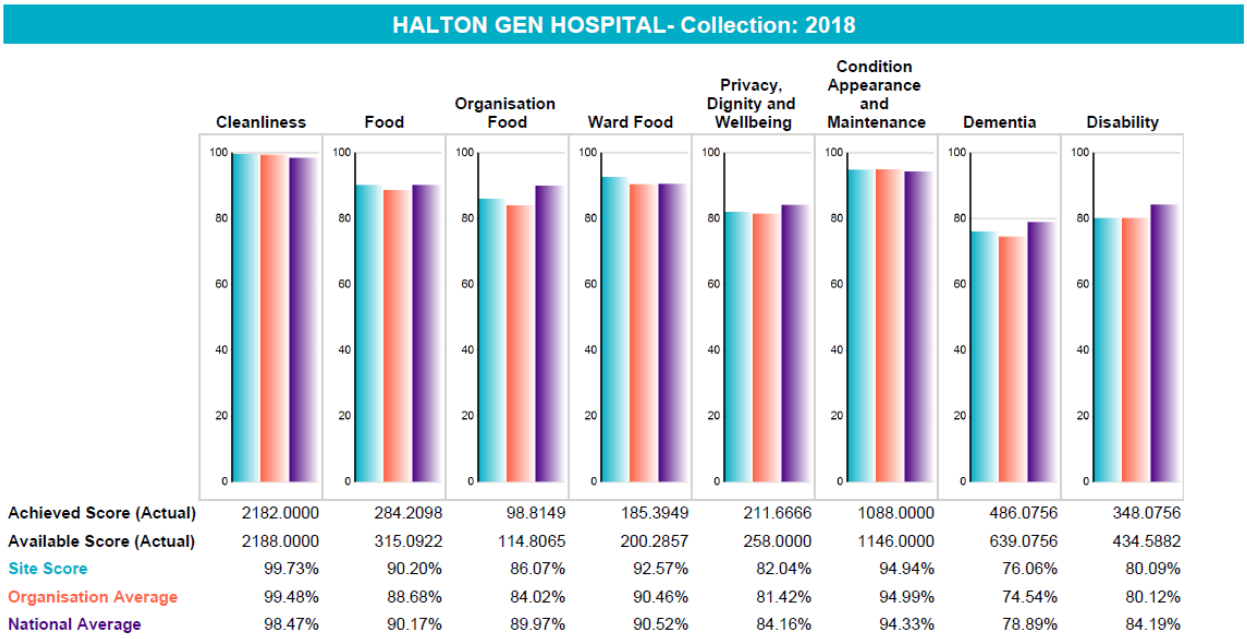


	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3697.0000	383.7560	94.7813	288.9747	300.8333	1653.0000	482.0756	385.0756
Available Score (Actual)	3718.0000	434.0501	113.2939	320.7562	370.0000	1740.0000	649.0756	480.5882
Site Score	99.44%	88.41%	83.66%	90.09%	81.31%	95.00%	74.27%	80.13%
Organisation Average	99.48%	88.68%	84.02%	90.46%	81.42%	94.99%	74.54%	80.12%
National Average	98.47%	90.17%	89.97%	90.52%	84.16%	94.33%	78.89%	84.19%

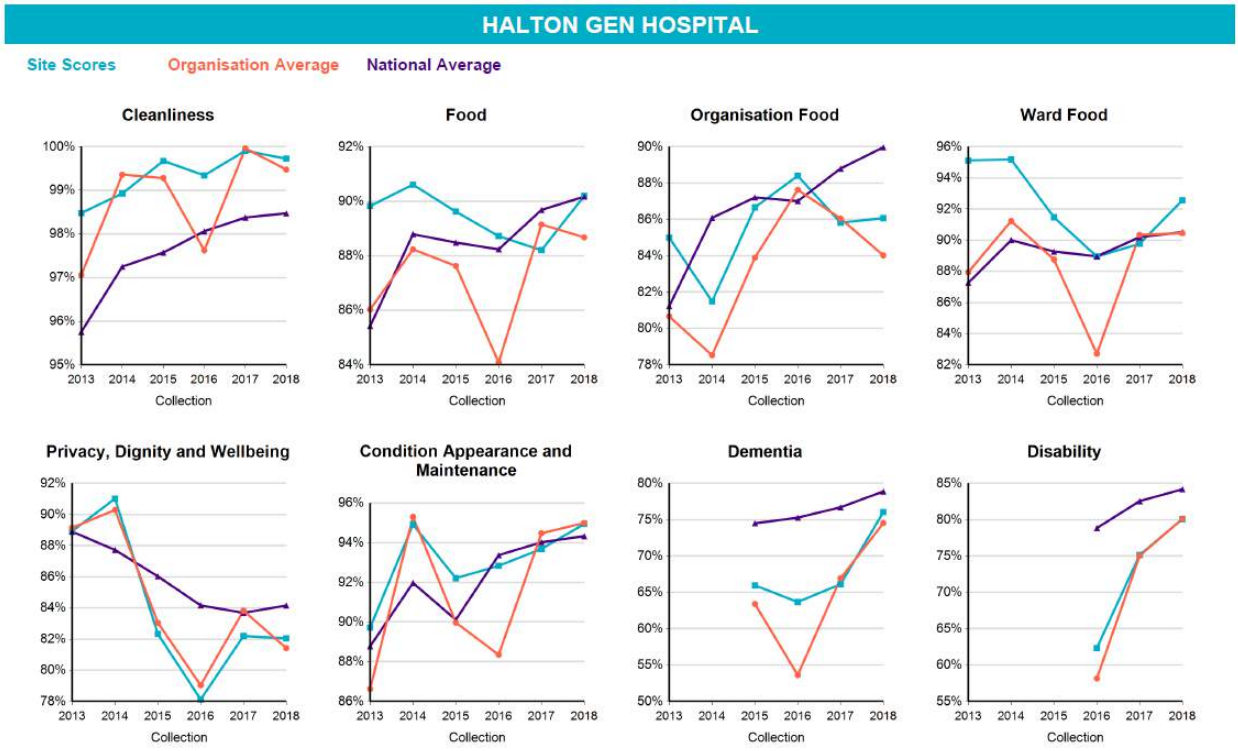


The following graph, produced by NHS Digital (Health and Social Care Information Centre), indicates comparison WHH Place scores from 2013 – 2018 for Halton site:

Figure 18 PLACE Comparison Scores (2013 – 2018) - Halton



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2182.0000	284.2098	98.8149	185.3949	211.6666	1088.0000	486.0756	348.0756
Available Score (Actual)	2188.0000	315.0922	114.8065	200.2857	258.0000	1146.0000	639.0756	434.5882
Site Score	99.73%	90.20%	86.07%	92.57%	82.04%	94.94%	76.06%	80.09%
Organisation Average	99.48%	88.68%	84.02%	90.46%	81.42%	94.99%	74.54%	80.12%
National Average	98.47%	90.17%	89.97%	90.52%	84.16%	94.33%	78.89%	84.19%



The Trust scored above national average at both sites for cleanliness, condition, appearance and maintenance and significantly above national average for food on the Halton site.

Following publication of the PLACE results, specific focus was given to the domains that have scored below the national average, with the aim to improve these scores by putting the following measures into place:

- Production of a PLACE Action Plan, circulated to Matrons to address and feedback
- Facilities to monitor progress and submit a monthly report to the Infection Control Sub-Committee
- PLACE issues that require funding, will be included on Risk Registers, including Capital Funding requests
- Monthly reporting and updates to the Patient Experience Group
- Estates and Facilities to work in liaison with the Dementia and Disability Trust Leads regarding Dementia and Disability standards

CORPORATE REPORTING

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

TRAINING

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

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

CLINICAL ACCESS/RESPONSIBILITY

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

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

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

INFECTION CONTROL AUDIT

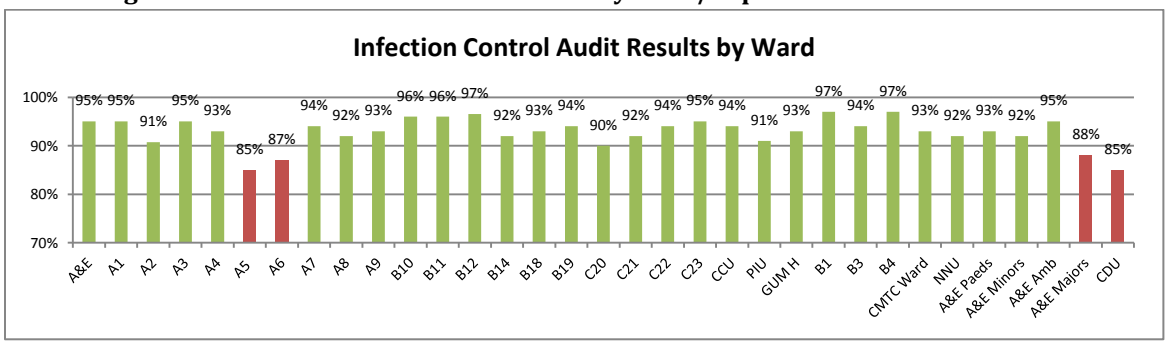
The aim of the audit programme is to measure compliance with Trust polices/guidelines and standards in the patient care environment. This audit programme contributes to providing assurance that infection risks are effectively managed within the Trust.

The audits are carried out by the Infection Prevention and Control Nurses using an approved Infection Prevention and Control audit tool. The audit tool has a total of 15 components however these are not all relevant in all areas of the Trust. A rolling programme of audit is in place to cover all in-patient areas. The audit plan was not fully completed due to a period of reduced staffing within the Infection prevention and Control Team. Additional audits are completed outside of the rolling programme when infection incidents occur.

Results

A total of 33 areas were audited. The majority of areas attained above 90% compliance. The exception to this was A5, A6, Emergency Department (Majors) and Clinical Decisions Unit. Results are shown in figure 19.

Figure 19 Infection Control audit results by ward/department



The total percentage compliance for each of the audit components is detailed in table 10.

Table 10 Audit Summary for each component

Element	Total
Environment	82%
Ward Kitchens	86%
Handling/Disposal of Linen	94%
Departmental Waste	97%
Safe Handling Disposal of Sharps	95%
Patient Equipment (General)	92%
Patient Equipment (Specialist)	95%
Personal Protective Equipment	91%
Short Term Catheter Management	97%
Enteral Feeding	86%
Care of Peripheral Intravenous Lines	95%
Isolation Precautions	99%
Hand Hygiene	94%
Overall Compliance	93%

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

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

Other areas of concern identified from the audits include:-

- Sharps disposal: 7 areas with less than 90% compliance
- Use of personal protective equipment: 8 areas with less than 90% compliance

Concerns have been discussed at the Infection Control Sub-Committee in relation to general ward environments and ward kitchens.

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

Areas that were audited have received their audit results to: confirm good practice and identify where improvement is needed to minimise infection risks and enhance the quality of the patient care environment. The success of the audit programme relies on having robust action plans that are followed through to completion to ensure improvement actions have been taken. A number of actions have been initiated include combined Matrons and Infection Prevention and Control Nurse Walkabouts to identify any problems.

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

Sharps audit

An external audit of compliance with good practice in relation to sharps management is conducted annually. The sharps bin supplier was invited (September 2018) into the Trust to conduct a Trust wide sharps safety audit. The object of the audit was to establish whether or not sharps are disposed of in a safe manner. The method used was to visit wards and departments and observe existing practices.

Results

One hundred and eleven (104) wards/departments were visited during the audit and four hundred and twenty five (425) sharps containers were reviewed. The sharps containers were mainly supplied by the company conducting the audit. The audit results showed:-

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

The audit recommendations included:-

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

Compared to the previous year's audit, there was an increase in sharps bins not being assembled and labelled correctly. The Health and Safety Team Produced a video on correct assembly of sharps bins. Education is also provided on correct assembly and labelling at mandatory training. Each area has received a copy of the audit and been asked to improve compliance where standards were not met. A repeat audit has been scheduled for May 2019 due to a decrease in some compliance standards.

High Impact Interventions

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

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

Antibiotic Prescribing

From 1st April 2018-31st March 2019, there were 59 joint Consultant Microbiologist and Antibiotic Pharmacist ward rounds carried out at Warrington hospital. The aim is to complete 2 ward rounds per week; other commitments permitting (Tuesday afternoon and Friday morning).

This year we saw a slight reduction in the number of ward rounds carried out when compared to the previous year when there were 66 joint Consultant Microbiologist and Antibiotic Pharmacist ward rounds carried out, however in September 2018 the Trust went from 2 whole time equivalent (WTE) Consultant Medical Microbiologists (CMM) to 1WTE which resulted in a drop in the number of weekly ward rounds carried out. The Trust has since recruited 2 Consultant Microbiologists who joined the Trust in February 2019, this recruitment has allowed us to increase the number of weekly ward rounds

back to 2 per week and it is expected that this additional cover will facilitate further improvements in patient care.

At the beginning of the year when we were carrying out 2 ward rounds per week - we used one of the ward rounds to look at patients on "target antibiotics". "Target antibiotics" are antibiotics that we have determined require closer monitoring than other antibiotics because they are either:

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

The "target antibiotics" within the Trust are:

- piperacillin/tazobactam (Tazocin®)
- meropenem
- ciprofloxacin
- teicoplanin
- cefuroxime
- co-amoxiclav
- levofloxacin.

The ward rounds are seen as a way of gaining assurance that the "target antibiotics" are being prescribed appropriately and that they are being reviewed in a timely manner and switched to narrower spectrum agents when culture and sensitivity results become available or it is clinically appropriate to do so.

With the exception of piperacillin/tazobactam (Tazocin®) these "target antibiotics" featured less frequently in previous versions of the Antibiotic Formulary than the current version. However in direct response to the National Tazocin® shortage (which originally started back in April 2017) and the other antibiotic stock shortages that followed, we were required to review the contents of our Antibiotic Formulary to try and reduce Tazocin® use and conserve supplies.

In addition the 2018/19 CQUIN required us to reduce Meropenem consumption and total antibiotic consumption (measured by defined daily doses (DDD's) so a new antibiotic formulary was launched across the Trust in June 2018 to help us achieve these CQUIN targets. Some of the "target antibiotics" now feature more frequently in the new antibiotic formulary, though they are restricted to specific patient groups (mainly patients <50 years of age) and consequently use of these antibiotics has increased appropriately.

The focus of the second weekly ward round for the past 12 months has been helping the Trust achieve the CQUIN targets. The original Anti-microbial Resistance (AMR) CQUIN was launched by NHS England in 2016. Reducing AMR has become a National target because AMR has risen alarmingly over the last 40 years and it is thought that inappropriate and overuse of antimicrobials is a key driver. The fact that

very few new antimicrobials have come onto the market in recent years coupled with an increase in total antibiotic prescribing across England, led NHS England to set Trusts the following targets:

- reducing consumption of piperacillin/tazobactam (Tazocin®)
- reducing consumption of meropenem
- reducing overall consumption of antibiotics (measured by a reduction in total DDDs)

The CQUIN was updated for 2018/19 and the requirement for Trusts to reduce Tazocin® consumption was removed. However the continued shortage meant that the Trust still needed to ensure that Tazocin® was being prescribed appropriately in order to conserve supplies for those most in need and therefore the ward round still targeted Tazocin® prescribing.

These CQUIN targets and shortages have meant that extra emphasis and resources have been placed on reviewing patients prescribed these 2 antibiotics and we have used the second ward round to review these patients.

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

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

Table 11 Total Number of Antibiotics Reviewed

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

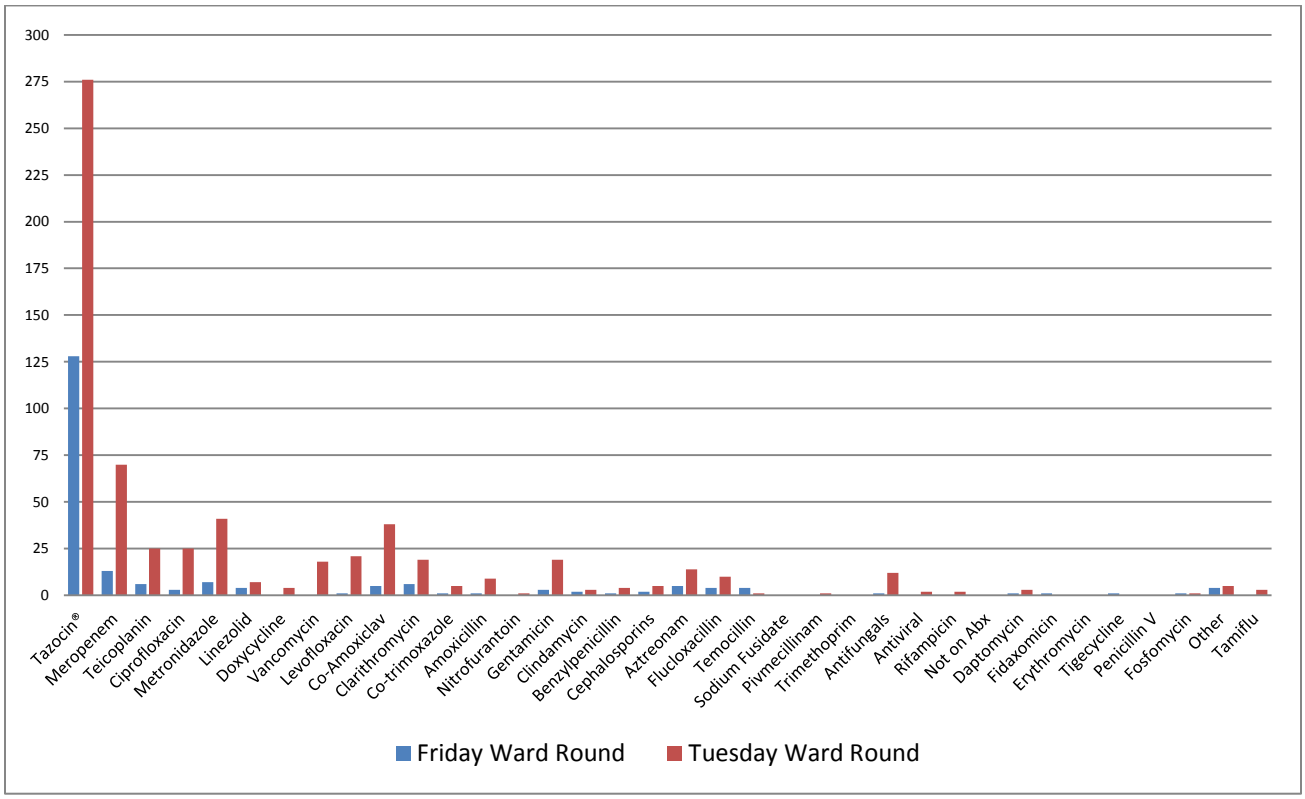
A total of 667 patients and 828 antimicrobials were reviewed between April 2018 and March 2019. 591 antibiotics were reviewed on the Tuesday “target” ward round and 237 were reviewed on the Friday ward round. As mentioned previously there was a reduction in CMM to 1 WTE in September 2018 and

the Friday ward round ceased. This accounts for the difference in review numbers across the 2 ward rounds.

Summary of Antibiotics Reviewed

Figure 20 shows which antibiotics were reviewed on the ward rounds. 72.7% of the antimicrobials which were reviewed were "target antibiotics," which is an increase on the previous year's results (67.5%). This percentage increase reflects the extra effort that went in to reviewing those patients prescribed piperacillin/tazobactam (Tazocin®) and meropenem in order to help the Trust try and achieve the % reduction in use of these antibiotics required by the AMR CQUIN and manage the National Tazocin® shortage. These 2 antibiotics alone made up 57.3% of all the antibiotics reviewed on the ward rounds.

Figure 20 Summary of antibiotics reviewed



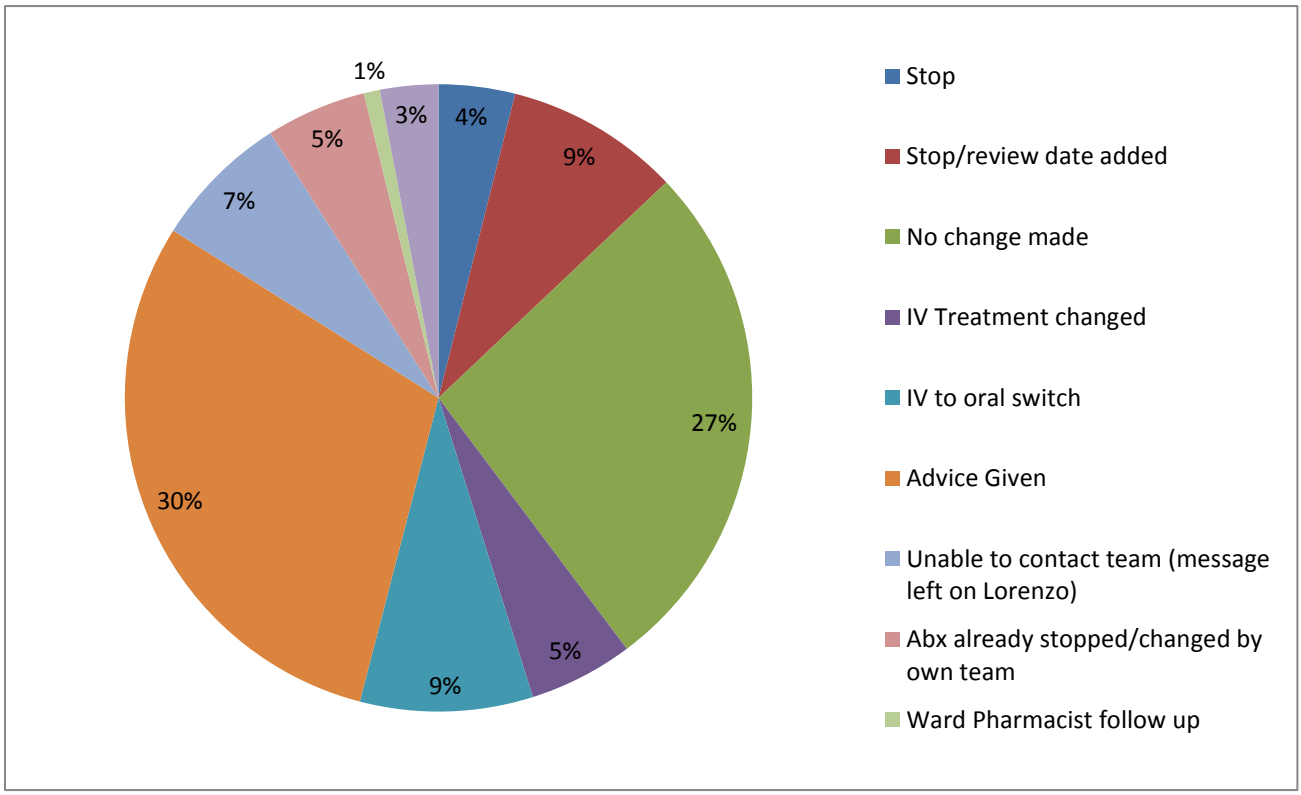
Summary of Ward Round Interventions

Of the antibiotics reviewed, we were able to stop 4% of antibiotics on the ward round and a stop/review date was added to a further 9% of reviewed prescriptions. 14% of antibiotics were changed to a more appropriate antibiotic – this could be a change in IV antibiotic regimen or an IV to oral step down. Changes were only made if the team looking after the patient could be contacted and the proposed changes were discussed and agreed.

Advice was given in a further 30% of cases; this may include changes to therapy if the patient deteriorates on current therapy or oral stepdown options when the patient is clinically well enough.

Figure 21 summarises the outcome of the antibiotic reviews in more detail.

Figure 21 – Summary Outcome of Antibiotic Reviews



Summary of Piperacillin/tazobactam (Tazocin®) and Meropenem Reviews

Focus went into reviewing these 2 key antibiotics to help the Trust try and achieve the % reduction in use required by the National AMR CQUIN and manage the National stock shortage of Tazocin®.

A total of 404 piperacillin/tazobactam (Tazocin®) prescriptions and 83 Meropenem prescriptions were reviewed over the 12 month period. Following the ward round review we were able to stop or change treatment for 18% (76) of piperacillin/tazobactam (Tazocin®) prescriptions and 8% (7) of Meropenem prescriptions. Stop or review dates were added to a further 36 (9%) piperacillin/tazobactam (Tazocin®) prescriptions and 22 (26.5%) Meropenem prescriptions.

Benefits of the ward round

The joint Consultant Microbiologist and Antibiotic Pharmacist ward rounds are beneficial because they provide a good educational opportunity for the junior doctors. The Consultant Microbiologists and Pharmacist use the ward rounds to educate the junior doctors on AMR, what they can do as individuals to influence and slow down progression of AMR and promote prescribing as per the Trusts antibiotic formulary. The ward rounds also provide an opportunity to educate doctors on the importance of timely microbiological sampling. Junior doctors are encouraged to ask questions and are informed of the reasons for suggesting changes to antimicrobial therapy which develops their knowledge of microbiology.

Prior to each ward round a review each patient's recent microbiology samples is undertaken to see if any organisms have been isolated which will allow us to narrow down the spectrum of activity of antimicrobial cover. The Ward Round also looks for any history of multi-drug resistant organisms which would influence prescribing decisions and ensure that patients are switched in a timely manner to the most appropriate antibiotic therapy and therefore exposure to fewer days of unnecessary broad spectrum antimicrobial cover. This in turn improves patient safety because if patients are exposed to fewer days of unnecessary broad spectrum antimicrobial therapy then the risk of the patient going on to develop *clostridium difficile* infection is reduced. The ward rounds also have other patient safety benefits; review of patients with complex histories who specifically need input from a Consultant Microbiologist i.e. patients with infective endocarditis and patients who are prescribed antibiotics with a narrow therapeutic window, providing specific advice on dosage adjustment and duration of treatment.

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

Future developments

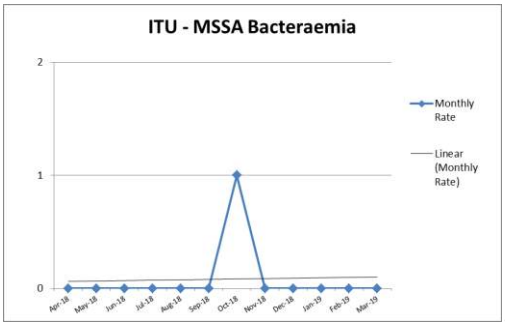
The number of weekly antimicrobial ward rounds could be increased so that more patients are reviewed; the feasibility of this is currently being looked into following the appointment of 2 new Consultant Microbiologists.

It is thought that more regular teaching and feedback to prescribing teams would drive further improvements in antimicrobial stewardship within the Trust, again this is being considered.

Critical Care Surveillance

The Critical Care unit conducts enhanced surveillance of bloodstream infections and ventilator associated pneumonias. During 2018/19 Meticillin sensitive Staphylococcus (MSSA) bacteraemia cases were monitored and one case was observed in October.

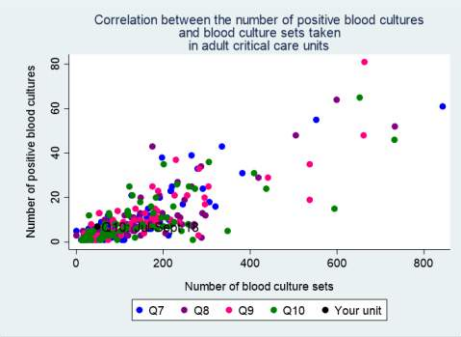
Figure 22 MSSA bacteraemia case



The Trust has registered with the Infections in Critical Care Quality Improvement Programme (ICCQIP) and surveillance extended to include all blood culture results. Data is published on correlation of numbers of positive blood culture sets and blood cultures sets taken. It is too early to draw any

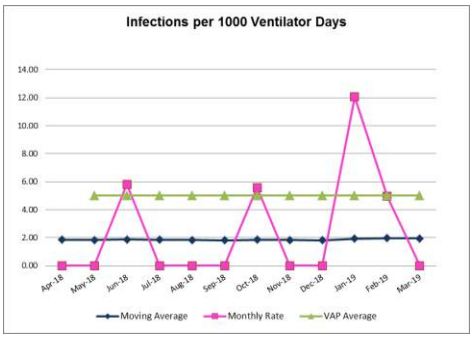
comparisons with data nationally as the Trust registered part way through the year. Data is shown in figure 23.

Figure 23 ICCQIP data



The Critical Care Unit also collates data on ventilator associated pneumonias (VAP). This facilitates identification of trends of bacterial pneumonia in ICU patients who are mechanically ventilated. Data for the 2018/19 year is displayed in figure 24. The unit is currently planning to move to the use of tracheal tubes with subglottic suction ports in a bid to further reduce the incidence of VAP:

Figure 24 VAP data



TARGETS AND OUTCOMES

Activities

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

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

Updated policies and guidelines

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

- Cleaning Standards Policy
- Group A Streptococcus Policy
- Aseptic non-touch technique
- Personal protective equipment guidelines
- Pest control policy
- Waste management policy
- Peripheral cannulation guidelines
- Peripheral insertion of midline catheters
- Hand hygiene policy
- Infection control policy
- Mandatory reporting of HCAIs
- Terminal cleaning guidelines
- Standard precautions guidelines
- SOP for single patient testing for viral gastroenteritis
- Operational Policy for the *C. difficile* Cohort Ward
- Chickenpox/Shingles Guidelines
- Viral Gastroenteritis Guidelines
- Pandemic Influenza Plan
- *C. difficile* Guidelines
- Notification of Communicable Diseases Policy
- Contractors information leaflet
- Water Safety Group Terms of Reference
- Viral Haemorrhagic Fevers Policy
- Isolation of Immunosuppressed Patients Guidelines
- Ward Closure Guidelines
- Major Outbreak of Infection Guidelines
- Waste Segregation, handling and disposal at ward/departmental level guidelines
- Blood Culture Sampling Policy
- Deceased Patient Infection Control Guidelines
- Influenza Guidelines
- Isolation Policy
- Spillage Guidelines

Information leaflets

- Viral gastroenteritis patient information leaflet
- C. difficile
- Vancomycin resistant Enterococci

Other documents

- Clostridium difficile – toolkit for case investigation
- MSSA bacteraemia - post infection review toolkit
- MRSA bacteraemia - post infection review toolkit
- Gram Negative Bacteraemia post infection review toolkit
- Assurance framework – Infection Prevention and Control Team reporting structure
- Terms of reference - Infection Control Sub-Committee
- Infection Control Sub-Committee Work Plan 2018/19

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

Contribution to other initiatives

Capital Projects

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

Estates projects

- Relocation of C21/CCU into a combined Acute Cardiac Care Unit
- Set up of a temporary ward for seasonal pressures

Group documents

- Terms of Reference Decontamination Group
- Terms of Reference Infection Control Sub-Committee
- Terms of Reference Ventilation Assurance Group

External groups

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

- North West Boroughs Partnership Mental Health Trust Infection Control Committee
- 3 Boroughs Public Health Infection Control Committee
- Public Health Forum (Public Health England)
- Health Protection Forum – Warrington Borough Council
- Multi-agency C difficile Review meeting

External reviews

- Dynamic mattress decontamination facility
- Waste reprocessing facility Duty of Care inspection

TRAINING ACTIVITIES

The Infection Prevention and Control Team continue to provide a structured annual programme of education. This includes an Infection Control E-Learning package for clinical staff. Overall attendance at

mandatory infection prevention and control training was 90% across the Trust at the end of the financial year.

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

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

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

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

Medical Students

- Infection Prevention and Control
- Various infection/microbiology topics

Consultant Mandatory Infection Prevention and Control Training

Ad hoc clinical based teaching

Single point lessons in response to incidents on:-

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

Training attended/ provided by Infection Prevention and Control Team Members

Dr Zaman Qazzafi - Consultant Microbiologist

Apr 18 - Mar 19	Grand Round presentations
21-24 April 2018	ECCMID (European Congress of Clinical Microbiology & Infectious Diseases)
26 June 2018	Management of CPEs and Gram negative Infections: presented at Regional Microbiology meeting
3 July 2018	DIPC Development programme: Taking surveillance forwards: making the most of your data
30 July 2018	Teaching Elderly care medical staff – AMR: Tackling antibmicrobial resistance
Feb 2019	Antimicrobial Stewardship: Systems and Processes for Effective Antimicrobial Medicine Use – NICE Guidelines (NG 15): An audit on compliance assessment

Dr Thamara Nawimana – Consultant Microbiologist/Infection Control Doctor

21/06/18	Optimising Antibiotics Lecture
26/06/18	CPE Management Lecture
1/7/19	GNBSI reduction Grand Round

Lesley McKay – Associate Director for Infection Prevention and Control

01/05/18	GNBSI – Ensuring Board assurance Against National Standards
03/07/18	DIPC development day
July – September	Quality Improvement Practitioner training (4 days)
30/10/18 – 02/11/18	Ventilation in Healthcare premises
17/01/19	NW Infection Prevention Conference

E. coli bacteraemia collaborative (Health economy group) meetings

Helen McLaren – Infection Prevention and Control Nurse

23/04/19	Presentation Skills Training
15/04/18	Creating a Patient Safety Culture
04/06/18	PDR and Coaching Conversations
20/06/18	Managing Performance and Organisational Change

28/06/18	Managing Sickness

Charlene Liptrot – Infection Prevention and Control Nurse

04/2018	Practical teaching skills
06/2018	Public Health England Visit
05/2018	Safety Culture Event
05/2018	Community Infection Control Team Visit
03/2019	Surgical Site Infection Training Day

Kathryn Summers – Infection Prevention and Control Nurse

03/2019	Surgical Site Infection Training Day

Jacqui Ward – Antibiotics Pharmacist

Quarterly	North West Antimicrobial Pharmacist Group educational session

CONCLUSION

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

This has been another challenging year for the Infection Prevention and Control Team due to the noted increase in influenza cases and reduction in team staffing. It is to their great credit that these issues have been managed alongside a proactive agenda to address Clostridium difficile and bloodstream infections from MRSA/MSSA and E.coli. Concurrently they have maintained attention to a demanding audit, education and training and surveillance work plan.

Assurance on the prevention and control of infections is provided by a matrix approach of updating policies in light of best practice/legislation; robust and regular auditing of policies and practice; spot checks and self-assessment. Although there was a reduction in auditing there was an increased focus to areas where risks were identified, which was appropriate for immediate patient safety concerns. Compliance with the Health and Social Care Act (2008) Code of practice has improved with work undertaken to improve patient care environments.

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

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

To note the revised mandatory reporting requirement and additional actions required.

4. IMPACT ON QPS?

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

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

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

5. MEASUREMENTS/EVALUATIONS

Monitor:-
Progress against the Infection Control Sub-Committee work plan

- Healthcare associated infection surveillance data
- Progress against action plans
    - *Staphylococcus aureus* bacteraemia reduction (MRSA/MSSA)
    - Clostridium difficile infection reduction
    - Gram Negative bloodstream infection reduction
- Redevelopment of the Infection Prevention and Control Strategy for the next 3 years
- Education and training compliance figures
- Audit findings and non-compliance actions
- Progress with policy revisions

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

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

6. TRAJECTORIES/OBJECTIVES AGREED

Nationally set Clostridium difficile threshold of 44 cases

Zero tolerance to avoidable MRSA bacteraemia cases

Quality Priority 5% reduction target for Gram Negative Bloodstream Infections (GNBSI)

National CQUIN for:-

- Management of lower urinary tract infections in older people
- Antibiotic prophylaxis in colorectal surgery

7. MONITORING/REPORTING ROUTES

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

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

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

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

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

8. TIMELINES

Financial year 2018/19

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

To Trust Board is asked to receive and note the report.

Kimberley Salmon-Jamieson
Chief Nurse
Director of Infection Prevention and Control (DIPC)
July 2019

Appendix 1 ANNUAL WORK PROGRAMME 2019/20

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

GOVERNANCE													
	Target date	**Leads**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Monitor action plan following external review	3 /annum	ADIPC												
Review of ICSC Terms of Reference	Annual	Deputy DIPC												
Review of IPCT infrastructure	Annual	ADIPC												
DIPC annual report	Annual	ADIPC												
Quarterly reports to Quality and Assurance Committee	Quarterly	ADIPC												
Quarterly DIPC reports to Trust Board	Quarterly	ADIPC												
Risk register review	Monthly	ADIPC												
Assurance Framework monthly submission to CCG	Monthly	ADIPC												
HLBP submission to PSCE; QA; and H and S committees	Bimonthly	ADIPC												
RCAs/PIR of HCAI incidents: Monitoring of associated action plans linked to CBU Governance Frameworks and demonstration of learning	Per case	LNs												
Review of action plans for HCAI reduction C. difficile and Staphylococcus aureus bacteraemia cases	3/annum	LNs												
Submission of C. difficile RCA findings to the CCG panel for review to assess for lapses in care	Quarterly	LNs / ADIPC												
Review of revised C. difficile Objective for 2019/20	Annual	ADIPC												
IPCT team building session	Sep 2019	ADIPC												
Review of progress against this work plan and the IC strategy	Bimonthly	ADIPC												
Provision of commentary for Trust Quality Account	Monthly	ADIPC												
Code of Practice for prevention of HCAIs – compliance assessment	Biannual	ADIPC												
Review of HCAI reduction action plans GNBSI	3 / annum	ADIPC												
Revise investigation toolkit for GNBSI	June 2019	ADIPC												
Revise toolkit for investigation of MSSA bloodstream infections	June 2019	ADIPC												
Revise toolkit for investigation of Clostridium difficile cases	June 2019	ADIPC												
Other Committee attendance/Group provision														
Antimicrobial Stewardship Group Meetings	Quarterly	AMSG Lead CMM												
Bed meetings	Daily	IPCNs												
CCG CDT review panel meetings	Quarterly	ADIPC												
CDT MDT	Weekly	IPCNs												
Decontamination Group	Bimonthly	ICD / ADIPC												
Event planning group	Monthly	ADIPC												
GNBSI operational group – external	Quarterly	CCG												
GNBSI operational group – internal	Monthly	Deputy DIPC												
HCAI Network PHE	Quarterly	IPCNs												
Health and Safety Sub-committee	Bimonthly	ADIPC												
Health Protection Forum WBC	Quarterly	IPCNs												

	Target date	Lead	A	M	J	J	A	S	O	N	D	J	F	M
ICSC	Bimonthly	IPCT												
Submit HCAI data to Communications team	Monthly	ADIPC												
Annual review of ToRs for IC Operational Group	Annual	Deputy DIPC/ADIPC												
Action plan for next financial year	Annual	ADIPC												
ICU/IPCT meetings	TBC	Deputy DIPC												
Incident meetings	As required	IPCT												
IPCT meetings	Fortnightly	IPCT												
IPS meetings	Biannual	IPCNs												
Medical Devices group	Bimonthly													
Nursing & Midwifery Forum	Monthly	ADIPC												
Nutritional steering group	Monthly	CL												
NWB ICC	TBC	Deputy DIPC												
Operational IC & Environment Group	Monthly	ADIPC												
Patient Safety and Clinical Effectiveness Committee	Bimonthly	ADIPC												
PIR Staphylococcus aureus bacteraemia meetings	Each case	ADIPC												
Quality and Assurance Committee	Bimonthly	ADIPC/DIPC												
Safer sharps group meeting	Monthly	CL												
Theatre IC group	Monthly	KS												
Water safety group	Quarterly	ICD / ADIPC												
Workplace Health & Wellbeing Meetings	Biannual	TBC												
Ventilation Assurance Group														
Surveillance														
Compliance with mandatory reporting of MRSA; MSSA; C. difficile; GNBSIs (E. coli, Klebsiella and Pseudomonas)	Monthly	IPCNs/ ADIPC												
Mandatory reporting data validation and timely sign off	Monthly	ADIPC												
MSK compliance with Mandatory orthopaedic surveillance	Quarterly	LN MSK												
Zero tolerance to MRSA bacteraemia cases	Monthly	ALL												
CPE admission screening	Monthly	IPCNs												
SSSI	Quarterly	LN DD												
HCAI surveillance reports – weekly to Chief Nurse, Associate Chief Nurses, Lead Nurses and Matrons	Weekly	IPCNs												
Surveillance of HAI alert organisms (MRSA, VRE, CDT etc.)	Daily	IPCNs												
HCAI reporting for Trust dashboards with commentary	Monthly	ADIPC												
HCAI reporting to ICSC dashboards	Bimonthly	ADIPC												
Pseudomonas surveillance in Augmented care area (ICU and NNU)	Fortnightly	IPCNs												
VRE surveillance	Fortnightly	IPCNs												
Complete Quarterly Mandatory Laboratory returns and submit to PHE	Quarterly	Deputy DIPC												
Antibiotic ward rounds daily on ICU and ward B18	Daily	CMMs												
Antibiotic ward rounds and MDT ward B18	Weekly	CMMs												

	Target date	Lead	A	M	J	J	A	S	O	N	D	J	F	M
Environmental Cleanliness monitoring														
Environmental cleanliness monitoring	Monthly	Facilities Manager												
Participate in PLACE assessments	TBC	IPCNs/ LNs												
Matron and IPC Walkabouts	Monthly	Matrons /IPCNs												
Estates PAM assessment	Annual	ADE												
Legionella Assessments and compass flushing reports	TBC	ADE												
Monitor progress with carpet removal and dishwasher installation	Bimonthly	Deputy DIPC												
Isolation facilities audit – side room use	Annual	IPCNs												
Audit														
Audit Programme (IPC led) against standard precautions with reporting to ICSC	Annual	IPCNs												
Hand hygiene audits	Weekly	LNs												
MRSA pre-operative screening audit	Quarterly	LN DD												
MRSA screening compliance audits	Monthly	IPCNS												
Support areas requiring improvements identified on the Quality Metrics programme	Monthly	IPCNs												
Policy /Guideline Leaflet reviews														
Multidrug resistant Organism Guidelines	May 2019	ADIPC												
PPE	Sep 19	IPCN												
Audit timetable for Infection Control Policies and Guidelines	Jul 2019	Deputy DIPC/ABP												
Decontamination Policy	Jul 2019	Facilities Manager												
Mattress inspection & cleaning SOP	July 2019	ADIPC												
Meningitis	Jul 2019	ICD/ ADIPC												
HCAI investigation Sop	Jul 2019	ADIPC												
Scabies Guidelines	Oct 2019	ADIPC												
Legionella Policy	Nov 2019	ADE												
Laundry Policy	Dec 2019	FM												
Reactive and Planned Preventative Maintenance Policy	Dec 2019	ADE												
Uniform and Workwear Policy	Jan 2020	ADIPC												
CJD Instrument Handling	Jan 2020	ADIPC												
CJD Nursing Management	Jan 2020	LN Sp. Medicine												
Specimen handling	Jan 2020	ADIPC												
Tuberculosis	Jan 2020	ADIPC												
Awareness raising events														
Placement of hand hygiene sanitiser dispensers at main entrances	Apr 2019	IPCNS												
GNBSI and ANTT	May 2019	IPCNS												
Uniform and workwear promotion	Apr 2019	All												

	Target date	Lead	A	M	J	J	A	S	O	N	D	J	F	M
October IC week – Topic Boards	Oct 2019	IPCNs												
Trust wide Safety Brief – IPC promotion	Oct 2019	ADIPC												
November World Antibiotic Awareness Week	Nov 2019	IPCNs												
Seasonal flu campaign with WHWB	Dec 2019	WHWB												
Education														
Provide Mandatory training for IPC supporting areas with low compliance figures	Monthly	IPCNS												
Revise E-Learning package for IPC Clinical staff	May 2019	ADIPC												
Participate in CLiPs training	Monthly	IPCNS												
Participate in Preceptorship training	Monthly	IPCNS												
Launch ANTT E-Learning package and develop competency assessment framework and annual updates	May 2019	ADIPC												
Present GNBSI reduction and UTI pathway to N&M forum	Jun 2018	IPCT												
Provide single point lesson training in response to incidents	As required	IPCNS												
Revision and standardisation of Blood Culture training PowerPoint	Apr 2019	IPCT												
Mandatory training sessions as per timetable	Mar 2020	IPCNs												

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/100**			
SUBJECT:	**Council of Governors Terms of Reference**			
DATE OF MEETING:	25 September 2019			
AUTHOR(S):	John Culshaw, Head of Corporate Affairs			
EXECUTIVE DIRECTOR SPONSOR:	Mel Pickup, Chief Executive			
LINK TO STRATEGIC OBJECTIVES:	All			
	Choose an item.			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	The Board is asked ratify the Council of Governors Terms of Reference, approved by the Council of Governors on 13 August 2019. There have been no amendments to those previously approved by the Board and Council of Governors in 2018.			
PURPOSE: (please select as appropriate)	Information	Approval √	To note	Decision
RECOMMENDATION:	To ratify the Council of Governors Terms of Reference			
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors		
	Agenda Ref.	COG/19/09/55		
	Date of meeting	13 August 2019		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

Council of Governors

AGENDA REFERENCE:	**COG/19/08/55**			
SUBJECT:	**Council of Governors Terms of Reference**			
DATE OF MEETING:	13th August 2019			
ACTION REQUIRED	**Approval**			
AUTHOR(S):	John Culshaw, Head of Corporate Affairs			
EXECUTIVE SPONSOR	Mel Pickup, Chief Executive			
LINK TO STRATEGIC OBJECTIVES:	All			
	Choose an item.			
	Choose an item.			
EXECUTIVE SUMMARY	The Council of Governors is asked to review to and approve the Committee Terms of Reference. There have been no amendments to those previously approved by the Council of Governors in 2018.			
PURPOSE*: (please select as appropriate*	Information	Approval ✓	To note	Decision
RECOMMENDATIONS	That the Council of Governors approves the Terms of Reference			
PREVIOUSLY CONSIDERED BY	**Committee** Choose an item.			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: (if relevant)	None			

TERMS OF REFERENCE OF THE COUNCIL OF GOVERNORS

COUNCIL OF GOVERNORS (COG)

Approved by the Council of Governors on 13 August 2019

Council of Governors - Terms of Reference

1. PURPOSE

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

2. GENERAL DUTIES

The general duties of the Council of Governors are:

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

3. STANDING

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

4. MEMBERSHIP

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

5. QUORUM

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

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

6. COUNCIL OF GOVERNORS COMMITTEES

The Council of Governors will establish the following committees:

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

7. THE ROLE OF THE COUNCIL OF GOVERNORS

Non-Executive Directors; Chief Executive and the Auditors

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

Constitution and Compliance

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

Governors

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

Strategy, Planning, Reorganisations

- Provide feedback on the development of the strategic direction of the Trust to the Board of Directors as appropriate.

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

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

Representing Members and the Public

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

Holding the Non-Executive Directors to Account

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

Some of the following may support this process and dialogue:

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

8. COLLECTIVE EVALUATION OF PERFORMANCE

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

9. FREQUENCY OF MEETINGS

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

10. MINUTES

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

11. REVIEW

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

TERMS OF REFERENCE REVISION TRACKER

Name of Committee	Council of Governors
Version	V3
Implementation Date	
Review Date	August 2020
Approved By	Council Of Governors 13 August 2019

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

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved By**

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/101**			
SUBJECT:	**Charitable Funds Committee Cycle of Business 2019-21**			
DATE OF MEETING:	25 September 2019			
AUTHOR(S):	Pat McLaren, Director of Community Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	The Charitable Funds Committee has delegated authority from the Trust Board (the Corporate Trustee) to govern WHH Charity. In discharging its duties the CFC presents the attached Cycle of Business to the Corporate Trustee for approval.			
PURPOSE: (please select as appropriate)	Information	Approval X	To note	Decision
RECOMMENDATION:	For approval as attached			
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee		
	Agenda Ref.	**CCF/19/09/34**		
	Date of meeting	12th September 2019		
	Summary of Outcome	Approved Cycle for period noted.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

CHARITABLE FUNDS COMMITTEE CYCLE OF BUSINESS 2019-2021									
	Exec Lead	**Sept 2019**	**Dec 2019**		**March 2020**	**June 2020**	**Sept 2020**	**Dec 2020**	**Mar 2021**
INTRODUCTION & ADMINISTRATION									
Apologies for Absence	Chair	X	X		X	X	X	X	X
Declarations of Interest	Chair	X	X		X	X	X	X	X
Minutes of the Last Meeting	Chair	X	X		X	X	X	X	X
Matters Arising+ Action Log	Chair	X	X		X	X	X	X	X
Rolling attendance	Chair	X	X		X	X	X	X	X
FUNDRAISING									
Fundraising Report + Workplan	Director of Community Engagement	X	X		X	X	X	X	X
Charitable Funds Strategy	Director of Community Engagement	X	X				X		
FINANCE									
Finance Report	Director of Finance + Commercial Development	X	X		X	X	X	X	X
Bid applications	Director of Community Engagement	X	X		X	X	X	X	X
Investment Strategy/update	Director of Finance + Commercial Development				X				X
Annual Review of Reserves Policy	Head of Financial Services					X			X
GOVERNANCE & COMPLIANCE									
Terms of Reference (due Sept 2021)	Chair/Director of Community Engagement								
Cycle of Business	Chair/Director of Community Engagement	X					X		
Charities Commission Checklist	Director of Community Engagement	X			X		X		X
Charity Risk Register	Director of Community Engagement	X	X		X	X	X	X	X
Annual Report and Accounts	Director of Finance + Commercial Development		X				X		
Committee Chair's Annual Report to Board	Chair					X			
Annual Review of Bid Approval process	Director of Finance + Commercial Development					X			
CLOSING									
Key issues to the Board	Chair	X	X		X	X	X	X	X
Any Other Business	Chair	X	X		X	X	X	X	X