We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 25 May 2022
10.00am-12.30pm
Via MS Teams

SUPPLEMENTARY PACK

FOR APPROVAL

BM/22/05/64 – Code of Governance Compliance
BM/22/05/65 – Terms of Reference

- Strategic People Committee
- Clinical Oversight Recovery Committee
- Finance & Sustainability Committee

BM/22/05/66 – Cycle of Business - Clinical Recovery Oversight Committee
BM/22/05/67 – Policies including; Social Media & Media Policy & Accessible Information Policy
BM/22/05/68 – Quality Account
BM/22/05/69 – Finance & Sustainability Committee Annual Report

FOR ASSURANCE

BM/22/05/70 – Infection & Prevention Control
BM/22/05/71 – Infection & Prevention Control Board Assurance Framework
BM/22/05/72 – Learning from Experience Report Q4
BM/22/05/73 – Digital Board Reports – April & May 2022
BM/22/05/74 – Learning from Deaths Review Q4
BM/22/05/75 – PPP&I Strategy
BM/22/05/76 – Patient Experience Strategy
BM/22/05/77 - Quality Strategy Annual Update
BM/22/05/78 – IPC Strategy
BM/22/05/79 – Guardian of Safe Working Report Q4

Warrington and Halton Teaching Hospitals NHS Foundation Trust

SUPPLEMENTARY AGENDA

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 25 May 2022, 10.00am – 12.30pm
Via MS Teams

FOR APPROVAL						
BM/22/05/64 **PAGE 4**		Code of Governance Compliance & Compliance with Licence Annual Return – Completion of Cos7	***For approval***	n/a	***Report***	John Culshaw, Trust Secretary
BM/22/05/65 **PAGE 6**		Terms of Reference Strategic People Committee Clinical Recovery Oversight Committee & Finance & Sustainability Committee	***For approval***	Committee: Finance & Sustainability Committee/Strategic People Committee/Clinical Recovery Oversight Committee Date of Meeting: 19.05.22/ 18.05.22 & 17.05.22 Agenda Ref: FSC/22/05/75/SPC/22/05/50 & CROC/22/05/52 Outcome: Supported for approval	***Report***	John Culshaw Trust Secretary
BM/22/05/66 **PAGE 25**		Cycle of Business Clinical Recovery Oversight Committee	***For approval***	Committee: Clinical Recovery Oversight Committee Date of Meeting:17/05/22 Agenda Ref: CROC/22/05/52 Outcome: Supported	***Paper***	John Culshaw Trust Secretary
BM/22/05/67 **PAGE 27** **PAGE 54**		Policies • Social Media Policy • Accessible Information Policy	***For approval***	n/a	***Paper***	Pat McLaren, Director of Comms & Engagement
BM/22/05/68 **PAGE 75**		Quality Account	***For approval***	Committee: Quality Assurance Committee Date of Meeting:3 May 2022 Agenda Ref: QAC/22/05/116 Outcome: Approved	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/69 **PAGE 163**		Finance & Sustainability Committee Annual Report	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 19 May 2022 Agenda Ref: FSC/22/05/93 Outcome: To note for assurance	***Report***	Terry Atherton, Committee Chair

TO NOTE FOR ASSURANCE						
BM/22/05/70 **PAGE 173**		Infection Prevention and Control (DIPC) Q4	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting:3 May 2022 Agenda Ref: QAC/22/05/126 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/71 **PAGE 197**		Infection Prevention and Control - Board Assurance Framework	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting:3 May 2022 Agenda Ref: QAC/22/05/127 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO

BM/22/05/72 **PAGE 249**		Learning from Experience Report Q4	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 3 May 2022 Agenda Ref: QAC/22/05/124 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/73 **PAGE 277**		Digital Board Report	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 20.04.22/19.05.22 Agenda Ref: FSC/22/04/65 & FSC/22/05/84 Outcome: Noted for assurance	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/22/05/74 **PAGE 288**		Learning from Deaths Review Q4 Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 3 May 2022 Agenda Ref: QAC/22/05/131 Outcome: Noted for Assurance	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/22/05/75 **PAGE 306**		Working with People and Communities Strategy	***For approval***	Committee: Council of Governors Date of Meeting: 12 May 2022 Agenda Ref: COG/22/05/34	***Paper***	Pat McLaren, Director of Communications & Engagement
BM/22/05/76 **PAGE 328**		Patient Experience Strategy	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 5 April 2022 Agenda Ref: QAC/22/04/91 Outcome: Noted for Assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/77 **PAGE 342**		Quality Strategy Annual Update	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 1 March 2022 Agenda Ref: QAC/22/03/67 Outcome: Noted for Assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/78 **PAGE 369**		IPC Strategy	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 3 May 2022 Agenda Ref: QAC/22/05/118 Outcome: Approval	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/05/79 **PAGE 384**		Guardian of Safe Working Q4 Report, Safe Working Hours Jnr Doctors in Training	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 18 May 2022 Agenda Ref: SPC/22/05/58 Outcome: Noted for Assurance		Paul Fitzsimmons, Executive Medical Director
CLOSING						
BM/22/05/80		Any other business		Steve McGuirk, Chair		
Date of next meeting – Wednesday 27 July 2022						

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/65**			
SUBJECT:	**Declarations required by General Condition 6 (G6(3)) and Continuity of Service Condition 7 (CoS7) of the NHS Provider Licence**			
DATE OF MEETING:	25th May 2022			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Self-Certification for the items is attached and the Board is asked to approve compliance with NHS Conditions G6 and CoS7			
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2021/22

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust recorded an adjusted surplus of £0.2m which is slightly better than the breakeven plan. This adjusted surplus is the value which NHSE/I monitors the Trust against and was achieved.
The annual capital programme was £19.2m and the actual spend for the year was £19.15m, delivering an underspend of £0.05m.
Public Dividend Capital (PDC) of £33.7m was provided in March 2021 to support the Trust in continuing to pay creditors promptly in line with guidance. The cash balance at the end of the year was £44.7m which will be utilised to fund the annual leave accrual, new EPCMS and delayed capital creditors.
There were no failures in financial governance during the year. The Finance and Sustainability Committee reviewed and scrutinised the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. Furthermore, the Board reviewed the position and challenged forecast outturns and mitigations on regular basis.
Capital has been monitored through the year via Capital Planning Group and Finance and Sustainability Committee, with particular focus on schemes over £0.5m.
Over the last 12 months the Trust has continued to have regular meetings with NHSE/I where the financial position, forecast and capital have been discussed, reviewed, and challenged.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Steve McGuirk	**Name**	Simon Constable
Capacity	Chair	**Capacity**	Chief Executive
Date	25th May 2022	**Date**	25th May 2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/66**			
SUBJECT:	**Terms of Reference:** - **Finance & Sustainability Committee (FSC)** - **Strategic People Committee (SPC)** - **Clinical Recovery Oversight Committee (CROC)**			
DATE OF MEETING:	25th May 2022			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The proposed amended Terms of Reference for the Finance & Sustainability Committee, Strategic People Committee and Clinical Recovery Oversight Committee are attached for consideration and approval.			
PURPOSE: ***(please select as appropriate)***	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the ToR for the above Committees.			
PREVIOUSLY CONSIDERED BY:	**Finance & Sustainability Committee**	Agenda Ref: FSC/22/05/76 Date of meeting: 19th May 2022 Summary of Outcome: **Approved**		
	Strategic People Committee	Agenda Ref: SPC/22/05/50 Date of meeting: 18th May 2022 Summary of Outcome: **Approved**		
	Clinical Recovery Oversight Committee	Agenda Ref: CROC/22/05/52 Date of meeting: 17th May 2022 Summary of Outcome **Approved**		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

TERMS OF REFERENCE
STRATEGIC PEOPLE COMMITTEE

1. PURPOSE

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

Linked to the Trust's Strategic Objective 2: *We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future* the Committee will ensure that there are arrangements in place to enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all.

The Strategic People Committee will seek assurance on the:

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

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

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

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

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly.

3. MEMBERSHIP

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

- Non-Executive Director (Chair)

- Non-Executive Director (Deputy Chair)
- Chief People Officer
- Deputy Chief People Officer
- Chief Operating Officer
- Executive Medical Director
- Chief Nurse & Deputy Chief Executive
- Director of Strategy & Partnerships
- Chief Finance Officer & Deputy Chief Executive
- Director of Communications & Engagement

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

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

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

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

4. QUORUM

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

5. AUTHORITY

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

6. REPORTING

~~**Governance**~~

The Strategic People Committee will have the following reporting responsibilities:

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

- The minutes of the Committee meetings will be formally recorded.

- The Chair of the Committee will provide a written Committee Assurance report to the Board bi-monthly following each meeting to draw to the attention of the Board and Audit Committee any issues that require disclosure to it or require executive action.

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

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

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

Duties – advisory:

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

Duties – monitoring:

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

Duties of members:

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

Sub-Committees (Groups):

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

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

8. ATTENDANCE

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

9. ADMINISTRATIVE ARRANGEMENTS

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

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

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

Papers are to be submitted in the following format:

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

10. REVIEW / EFFECTIVENESS

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

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	STRATEGIC PEOPLE COMMITTEE
Version:	V6.2
Implementation Date:	July 2021
Review Date:	12 months from approval
Approved by:	Draft v3 approved by TRUST BOARD (July 2018) Draft v4 – to be presented to September TRUST BOARD Draft v5 - to be presented to May 2019 Trust Board Draft V6 – approved by SPC 18 March 2020 to Trust Board 25 March 2020 and approved Draft V6.1- approved by SPC 18.11.2020, Trust Board 25.11.2020 V6.2 SPC 21.07.2021, Trust Board 28.07.2021
Approval Date:	19 September 2018 – SPC V4 approved 26 September 2018 – Trust Board V5 approved 20 March 2019 – SPC V6 approved 18 March 2020 at SPC and Trust Board 25 March 2020 V6.1- approved by SPC 18.11.2020, Trust Board 25.11.2020 V6.2 approved by SPC 21.07.2021, Trust Board 28.07.2021

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

	membership rather than full membership 3. **Duties & Responsibilities** – Section on Decision Making. Clarity on SPC role to assure actions taken to recruit and retain our workforce Section on Monitoring. Scope of Employee Relations Case Report clarified and to be included in workplan 4. **Subcommittees** – to include Triangulation Group		
20 March 2019	**Section 3 – Membership**	Updated attendee titles	
20 March 2019	**Section 7 – Duties + Responsibilities**	Triangulation Group removed	
18 March 2020	**Section 3 – Membership**	Updated attendee titles	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 10 – Administrative Arrangements**	Updated submission of papers timeframe	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 3 - Membership**	Removal of reference to Head of HR Strategic Projects	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 4 - Quorum**	To amend in line with other assurance committees	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 8 - Attendance**	To insert the term 'nominated' before deputy	V6 SPC 18.03.2020 Trust Board 25.03.2020
22 July 2020	**Section 3 – Membership**	Updated Executive Director titles, Deputy HRD&OD and attendee titles	V6.1 SPC 22 July 2020
18 November 2020	**Section 7 – Duties & Responsibilities**	**Added** Equality Diversity & Inclusion Sub Committee	V6.1 SPC 18.11.2020 Trust Board 25.11.2020
14 July 2021	**Section 7 – Duties & Responsibilities**	Added Workforce Recovery Steering Group – meeting monthly	V6.2 SPC 22.07.2021 Trust Board 28.07.2021
14 July 2021	**Section 7 – Duties & Responsibilities**	Amended Equality Diversity & Inclusion Sub Committee to Workforce Equality Diversity & Inclusion Sub Committee	V6.2 SPC 22.07.2021 Trust Board 28.07.2021
TBC	**Sections 1 – Purpose**	Updated the description of the purpose of the	TBC

		Committee to include reference to equity for all	
TBC	**Section 6 - Reporting**	Updated reporting arrangements to the Trust Board	TBC
TBC	**Section 7 – Duties & Responsibilities**	Added Medical Education Quality Sub-Committee	TBC

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
	Version 5 replaced with Version 6	SPC 18.03.2020 and Trust Board 25.03.2020
	Version 6 replaced with Version 6.1	V6.1 SPC 18.11.2020 Trust Board 25.11.2020
	Version 6.1 replaced with Version 6.2	V6.2 SPC 21.07.201 Trust Board 28.07.2021
	Version 6.2 replaced with Version 6.3	TBC

TERMS OF REFERENCE

CLINICAL RECOVERY OVERSIGHT COMMITTEE

1. PURPOSE

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

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

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

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

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

and to review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.

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

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly

3. QUORUM

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

4. MEMBERSHIP

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

Core Members

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

Attendees

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

Observers

- **Public Governor**

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

5. AUTHORITY

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

6. REPORTING

The Committee will have the following reporting responsibilities:

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

The following groups will report into the Committee:

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

7. DUTIES & RESPONSIBILITIES

To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.

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

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

8. ATTENDANCE

A record of attendance will be kept; attendance of 75% per year is expected

Executive members unable to attend must send a deputy who is able to make decisions on their behalf.

Other Executive Directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Officers who are unable to attend a meeting of the Group may appoint a deputy who will attend. It is the responsibility of the core member to inform the Chair of the Group if they are unable to attend and who will attend as their deputy.

9. ADMINISTRATIVE ARRANGEMENTS

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

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

Papers are to be submitted in the following format:

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

10. REVIEW / EFFECTIVENESS

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

The Cycle of Business will be reviewed by the Group every 6 months.

TERMS OF REFERENCE REVISION TRACKER

Name of Group:	Clinical Services Recovery Oversight Committee
Version:	1
Implementation Date:	October 2021
Review Date:	12 months from approval
Approved by:	Finance & Sustainability Committee 24.03.2021 Trust Board 31.05.2021
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
25th May 2021	**4 - Membership**	Addition of Associate Director of Planned Care to the membership	**Trust Board**
12th October 2021	**2 – Frequency of meetings**	Change to monthly meetings due to assurances and governance in place.	**Trust Board**
17th May 2022	**Section 1 – Purpose**	**To include oversight of the Corporate Performance report previously received by the Finance & Sustainability Committee**	
17th May 2022	**Section 7 – Duties & Responsibilities**	**To include oversight of the Corporate Performance report previously received by the Finance & Sustainability Committee**	

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

FINANCE & SUSTAINABILITY COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

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

2. AUTHORITY

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

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

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

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

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

4. DUTIES & RESPONSIBILITIES

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

Finance and performance

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

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

Strategy, planning and development

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

5. MEMBERSHIP

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

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

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

6. CORE ATTENDEES

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

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

- Deputy Chief Finance Officer
- Director of Strategy & Partnerships (when required)
- Trust Secretary

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

7. QUORUM

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

8. FREQUENCY OF MEETINGS

Meetings shall be held on a monthly basis.

9. REPORTING GROUPS

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

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

The following groups will report directly to the Committee:

- Capital Planning Group
- Finance and Resources Group
- Digital Board
- Medical Staffing Review Group
- Strategy & A Greener WHH Sub-Committee
- GIRFT / Clinical Productivity Oversight Group

10. ADMINISTRATIVE ARRANGEMENTS

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

11. REVIEW / EFFECTIVENESS

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

Date: September 2021

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Finance and Sustainability Committee
Version:	**V8 DRAFT**
Implementation Date:	September 2021
Review Date:	May 2022
Approved by:	Finance & Sustainability Committee
Approval Date:	XX.xx.xxx

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

		Remove IM&T Steering Cttee, Lorenzo Project Group, IM Governance and Records	
22nd November 2017	**Section 4 Duties and Responsibilities** **Section 9 Reporting Groups**	- To monitor compliance with NHSI requirements relating to pay policies - To review and monitor the Trust's overall pay bill - To monitor all elements of the Board Assurance Framework that relate to the work of this Committee To include: reports on premium pay spend	
21st March 2018	**Core Attendees**	Addition of Medical Director	Trust Board 29.5.2019
19th September 2018	**Core Attendees**	Remove Director of Transformation	Trust Board 29.5.2019
20 March 2019	**Section 6: Core Attendees**	Remove Medical Director Add Head of Corporate Affairs	Trust Board 29.5.2019
20 March 2019	**Section 9: Reporting**	Add Financial Resources Group Remove Out Patient Turnaround Remove ICIC	Trust Board 29.5.2019
18 March 2020	**Section 6: Core Attendees**	ADD Medical Director Amend Title of Head of Corporate Affairs to read Trust Secretary Amend title of Deputy director of Finance Strategy to read Deputy Director of Finance & Commercial Development ADD Director of Strategy (when required)	FSC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 9: Reporting**	Remove Urgent & Emergency Care Improvement Committee	FSC 18.03.2020 Trust Board 25.03.2020
23rd September 2020	**Section 4 Duties and Responsibilities**	Addition of reports from Digital Services	FSC 23.09.2020 Trust Board 25.11.2020
23rd September 2020	**Section 6: Core Attendees**	Amend the titles of three Directors Add Chief Information Officer	FSC 23.09.2020 Trust Board 25.11.2020
23rd September 2020	**Section 9: Reporting**	Add Digital Board	FSC 23.09.2020 Trust Board 25.11.2020
22rd September 2021	**Section 6: Core Attendees** **Section 9: Reporting**	Amend title of Deputy Director of Finance & Commercial Development and Delete post of Chief Information Officer **Add Medical Staffing Review Group and Strategy & Sustainability Review Group**	FSC 22.09.2020 Trust Board 24.11.2020
November 2021	**Section 9: Reporting**	Add Medical Staffing Review Group Add Strategy & a Greener WHH Sub-Committee	FSC – Chair's Actions
May 2022	**Section 9: Reporting**	Add GIRFT / Clinical Productivity Oversight	

		Group	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
20 March 2020	**V5 to be replaced by V6**	FSC 18.03.2020
23 September 2020	**V6 to be replaced by V7**	FSC 23.09.2020
22 September 2020	**V7 to be replaced by V8**	FSC 22.09.2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/66**			
SUBJECT:	**Clinical Recovery Oversight Committee (CROC) Cycle of Business 2022-2023**			
DATE OF MEETING:	25th May 2022			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The Cycle of Business for the Clinical Recovery Oversight Committee (CROC) is attached for consideration and approval.			
PURPOSE: *(please select as appropriate)*	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2021-2022 Cycle of Business for Clinical Recovery Oversight Committee			
PREVIOUSLY CONSIDERED BY:	**Committee**	Clinical Recovery Oversight Committee		
	Agenda Ref	CROC/22/04/46		
	Date of meeting	26th April 2022		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Clinical Recovery Oversight Committee Cycle of Business 2022-23

		2022									2023		
Agenda Item	**Executive Lead**	**26.04.21**	**17.05.22**	**21.06.22**	**19.07.22**	**16.08.22**	**20.09.22**	**18.10.22**	**15.11.22**	**20.12.22**	**17.01.23**	**14.02.23**	**21.03.23**
INTRODUCTION & ADMINISTRATION													
Apologies for Absence	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the last meeting	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters Arising and Action Log	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rolling attendance log and cycle of business	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GOVERNANCE & COMPLIANCE													
Committee Terms of Reference – to review in six months	**Trust Sec**	✓						✓					
Committee Cycle of Business – to review in six months	**Trust Sec**	✓						✓					
Minutes/High Level Briefing from Thursday meeting of Clinical Services Oversight Group	**Assurance**		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Committee Effectiveness Review – six months	**Chair/Trust Sec**		✓						✓				
Committee Effectiveness Review – annual	**Chair/Trust Sec**												
Risk Register – every other meeting	**Trust Sec**		✓		✓		✓		✓		✓		✓
PERFORMANCE													
Corporate Performance Report	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Harm Profile Update	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review of Waiting Lists and Clinical Harm Review report	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Waiting List update: RTT; Priority Code Waiting Times; Cancer; Diagnostics.	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outpatients Deep Dive	**Chief Operating Officer**							✓					
PLANNING													
Clinical Prioritisation & Scheduling Standard Operating Procedure (SOP) – for information	**Chief Operating Officer**	✓											
Speciality Overview	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Access to Recovery Fund – monthly update	**Deputy Director Finance & CD**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
TO NOTE FOR ASSURANCE													
Cheshire & Merseyside Elective Restoration update	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CLOSING													
Key issues to the Board	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Any Other Business	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Next Meeting Date & Time	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/67**	
SUBJECT:	**Media and Social Media Policy v5**	
DATE OF MEETING:	25th May 2022	
AUTHOR(S):	James Bates, Interim Head of Communications	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Media and Social Media policy outlines the role of the Communications Team in supporting staff across the Trust in informing, involving, engaging, supporting and protecting patients, staff, public and other stakeholders when they have contact with the media or use social media in a work and personal capacity. The policy provides clear guidance on procedures to follow when using social media and also approached by the media. The key elements of this policy include contacting the Communications Team for management, support and guidance on: • media enquiries • Requests for interviews, filming and photography • Guidance on Social media usage and blogs • Internal incidents/major incidents support and management • Complaints, litigation cases and internal investigations The Media and Social Media Policy 2020-22 has been refreshed with some changes: 1. Updated to provide guidance on using cropped images in social media 2. Reference to the Accessible Information Standard 3. Updated guidance on consent for filming and photography, with particular reference to unconscious patients and best practice in terms of securing advance consent.	

PURPOSE: ***(please select as appropriate)***	Information	Approval x	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the media and social media policy v5 for 2022-25			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

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NHS
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Media and Social Media Policy v5			
Lead executive	Pat McLaren (Director of Communications and Engagement)		
Author's details	Gina Coldrick, Communications and Engagement Specialist		
Type of document	Policy		
Target audience	Trust-wide		
Document purpose	Information for all staff on working with media and using social media		
Approving meeting	Strategic People Committee		
Implementation date	Wednesday, 25 May 2022	Review date	24 May 2025
WHH Documents to be read in conjunction with			
	• IM&T Acceptable Use Policy • Managing Celebrity, VIP and Media Visits Policy • Disciplinary Policy • Accessible Information Policy		
Document change history			
What is different?	• Addition of Social Media Guidance • Reference to Cyber Security • Updated to new template		
Appendices/electronic forms	Consent form Social Media Guide		
What is the impact of change?	None		
Training requirements	None		
Keywords	Media, Photography, Filming, Publicity		
Taxonomy	**Type**	**Policy Category Non-Clinical**	**Policy Category Clinical**
	Non-Clinical	Communications	Choose an item.

Do not retain a paper version of this document, always view policy / guidance documents from the desktop icon on your computer.

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MEDIA AND SOCIAL MEDIA POLICY v5

Contents

Executive Summary

This policy has been produced by the Trust's Communications and Engagement service, whose mission is to: Inform, Involve, Engage, Support and Protect the wide range of patients, staff, public and other stakeholders with whom the Trust interacts as part of its business.

So that relationships with media are successful it is vital that Trust communications and messages are accurate, concise, consistent, clear and unambiguous. To this end, all WHH staff and volunteers are required to comply with this policy.

Successful deployment of the Trust's strategy requires us to create opportunities for involvement and engagement with our stakeholders. Good relationships with the media is essential to enable the Trust to promote and protect its reputation and to be seen as an organisation that conducts business in an open, honest and accountable way.

In addition to being responsible for deploying the Trust's Engagement Strategy the Communications and Engagement Team is responsible for:

- Providing 24-hour communications support for emergency situations
- Ensuring that statements and quotes which are sent to media in response to reactive (unplanned) and proactive (planned) enquiries are approved by any patients quoted, the member of staff concerned, his/her line manager and where appropriate the relevant Executive Director. If a patient is unable to give consent, then consent should be sought from a parent or legal guardian
- Identifying appropriate spokespeople for quotes and interviews and issuing responses to media which meet deadlines
- Protecting patient confidentiality at all times ensuring compliance with the Caldicott Report (1997) and the Data Protection Act (2018)
- Accompanying reporters, photographers and camera crews when on hospital grounds
- Providing advice and support to any staff or patients who are responding to a media enquiry or wish to initiate a story themselves (a good news story) and may need help with a press release, for instance
- Monitoring all media (and social media) coverage and preparing an Engagement dashboard for the Council of Governors and Trust Board.
- Supporting staff to promote their work, developments or progress through the use of on-line media such as social, website or extranet as well as traditional media

NOTE – The Communications Team subscribes to a media monitoring service which name-checks the organisation's name or its hospitals or services – this is to enable us to react appropriately. Copyright laws prevent the distribution of photocopied articles from the press and therefore we are unable to photocopy, scan or circulate any such articles.

Purpose and Scope

The aim of this policy is:

- To build trust and confidence with all of our stakeholders and raise public confidence in the NHS.
- To support WHH staff and patients when they have any contact with the media which includes television, radio, print and online (also known as digital or social media)
- To raise local and national awareness of the Trust in terms of its name, role, ambition, progress and positioning
- To be recognised as the acute healthcare provider of choice by our patient populations, staff and stakeholders; and a trustworthy, caring and open organisation which provides outstanding safe, quality care
- To be recognised as an organisation that values and invests in its staff and volunteers and the role they play
- To be recognised as a regional and national centre of excellence in selected specialties, research and development and teaching and education in healthcare.

This policy covers:

- All Staff including honorary staff and all volunteers that are normally based at the Trust
- The use of Trust services, facilities and grounds such as for filming and interviews with staff and volunteers;
- The involvement of patients with the media and the obtaining of their consent interviews and photography
- The use of the Trust's name as an employer or venue by Staff, Volunteers and Honorary staff

Duties and Responsibilities

Role	Responsibilities
Chief Executive	It is the responsibility of the Chief Executive to ensure systems and processes are in place to monitor and implement this procedural document.
Delegated Executive Lead	The Director of Community Engagement has been delegated by the Chief Executive to take the Executive ownership for this procedural document
Senior Clinicians and Managers	Senior Clinicians and Managers are responsible for the provision of managerial and professional clinical advice to their teams on patient safety issues, and to ensure the provision of services and care is consistent and equitable care relating to this procedural document.

Policy Details

Contacting the communications Team

The Communications Team is the first point of contact for **all media enquiries**, including both proactive (planned) and reactive (unplanned) enquiries.

Should journalists approach WHH staff, volunteers or honorary staff members directly on any issue that relates to the Trust, its staff or patients, or to ask for an opinion or comment from an expert on a medical issue, they should be referred to the Communications Team before responding:

- **During office hours:** Communications Portakabin, Kendrick Wing, Warrington Hospital, Lovely Lane, Warrington, WA5 1QG tel: 2873 email whh.communications@nhs.net

  During normal working hours (9am-5pm), Monday to Friday (with the exception of Bank Holidays and other public holidays) all media enquiries should be referred to the Communications Team so that the enquiry can be logged and dealt with appropriately. All media enquiries should be referred to the Communications Team during normal office hours on 01925 662873. Outside of these hours urgent media enquiries will be dealt with by the on-call Director of Community Engagement.

- **On-call (out-of-hours) Communications:** via switchboard
  If media contact the Trust out-of-hours (evenings, weekends or Bank Holidays) the Switchboard (01925 635911) will refer the call to the on-call Director of Community Engagement or nominated deputy.

  Non-urgent out-of-hours media enquiries should be dealt with as above. The on-call communications officer will make a decision whether to deal with the enquiry out-of-hours or pick up during normal office hours depending on the nature of the enquiry.

Incidents or Accidents

As a part of the Trust's standard incident reporting processes, staff are asked to inform the Communications Team if they know of an incident or event that has happened which may result in any publicity and where the Trust may need to respond. The Communications Team will endeavor to keep staff informed about key media coverage that affects the Trust and also ensure stakeholders are fully briefed about any media enquiries/ activity that could have an impact on them (or their members) directly or affect the reputation of the Trust.

We will attempt to resolve any issues regarding how a story has been published by dealing first with the journalist concerned, and only where this has failed by formally complaining to the editor. We reserve the right to approach the Independent Press Standards Organisation (IPSO) where local efforts at resolution have failed.

Nominated Spokespeople

Only nominated spokespeople are permitted to speak to or contact the media on the Trust's behalf. The Communications Team will decide who is the most appropriate spokesperson and will arrange statements and interviews as appropriate. Nominated spokespeople about reactive issues are usually the Chief Executive, executive directors, senior clinicians or a member of staff who is an expert in their field.

Staff, including honorary staff or volunteers are NOT authorised to speak to the media without the express permission or at the request of the Trust via the Communications Team.

Media statements are official responses from the Trust to negative or controversial media enquiries. Media statements are written by the Communications Team on behalf of the Trust and approved by the relevant director.

Patient Condition Checks

The police and media most often request patient condition checks from the Trust, usually for patients who have been admitted to hospital after incidents such as a road traffic accident, violent attack or house fire etc. There are also occasions where a celebrity/VIP has been admitted after an illness/accident. In all cases, the protocol outlined below should be followed.

During normal working hours (9am-5pm), Monday to Friday, **all** media condition checks should be referred to the Communications Team on ext 2873. The Communications Team will contact the relevant ward/unit to get the information. Consent to provide this information will be sought by the Communications Team from the patient or from their next-of- kin/parent/legal guardian, via ward manager or nurse-in-charge.

Only basic information will be provided about the patient's condition, such as 'critical', 'stable', 'comfortable', 'improving' or 'patient has been discharged'. If the patient has passed away, this information will only be shared once relatives have been notified and their permission obtained to share information. Before giving out **any** information to the Communications Team, the ward manager or nurse-in-charge must seek consent from the patient or the next- of-kin.

Occasionally journalists may try to contact wards/units directly for condition checks. If this happens, the ward should forward requests to the Communications Team so that the enquiry can be logged and handled appropriately. Managing patient condition checks in this way minimises the risks to individual members of staff being placed in what can be difficult situations and/or compromising patient confidentiality

As with other routine media enquiries, requests for condition checks from media out-of-hours should be referred to the on-call communications officer. Requests for condition checks from Police out-of-hours should

be referred to the senior manager on call (SMOC).

Providing information about patients on remand

Occasionally the Trust may receive enquiries from media requesting details (either condition checks or other information) about a prisoner who is receiving medical care. For security reasons, it is important that no identification information relating to prisoners or prison staff is disclosed by anybody except the Prison Service.

Proactive Media

One of the key roles of the WHH Communications Team is to maximise publicity for good news stories, provide necessary information to the media and identify suitable members of staff and where appropriate patients for interviews. The Communications Team relies on staff to let the team know about any good news stories in their directorate that would be suitable to send to the media. If in doubt about the appeal of a story, please do check with the Communications Team. Ideas for positive stories include:

- New services, procedures or ways of working
- Award wins/shortlisting
- Improvements to services
- Research projects
- Personal achievements
- Positive patient experiences or feedback
- Anything unusual or out of the ordinary

Press releases are the main way in which good news stories are highlighted to the media. This includes stories on staff awards/achievements, fundraising events for WHH, opening of new medical equipment/department, and ground-breaking developments in treatment/techniques and breakthroughs in medical research.

The Communications Team is responsible for writing press releases on behalf of WHH staff and can advise when the best time to send out is and to which media depending on the nature of the story to ensure maximum publicity is gained. If an external agency, such as a supplier, wishes to issue a press release that involves the Trust or a part of the Trust, this press release must be submitted to the Communications Team for approval (who will seek input from Procurement) prior to being issued.

The Communications Team is responsible for managing all VIP/celebrity visits to the Trust, for example: Royal visits, MPs, celebrities and sports people. Staff intending to arrange such a visit should contact the Communications Team in the first instance so that the necessary guidance can be given – note that all such visits are governed by the Celebrity, VIP and Media Visits policy to ensure that the safety of our patients is protected at all times. A log of such visits is maintained by the Communications Team and submitted annually to the Strategic People Committee for assurance purposes.

Clinical, Scientific, Technical or other work-related publications

The involvement of WHH clinicians and other staff, some of whom are nationally renowned in their field of expertise, is encouraged by the Trust. Enquiries for contributions should be notified to the Communications Team so that staff can be supported.

It is recognised that clinicians must prioritise their clinical commitments (patient care), but it is important that all staff respond as quickly as possible to media enquiries when asked. This will ensure media reports relating to WHH are accurate, balanced and give an opportunity for the Trust to respond and rebut if required. It is suggested that any member of staff who has submitted a paper to a medical, scientific or management (specialist) journal which is likely to be published may wish to inform the Communications Team. If it is thought that that the article would be of interest to wider media, the Team can advise on how this can be achieved. A database of contacts for local, regional, national media and trade press is held and will be able to target the most suitable audience for such stories.

It is also possible that the publication of articles in specialist journals could prompt media enquiries on both a local and national level. By informing the Communications Team of the content of the article and when it is likely to be published in advance, the team can plan for any follow-up enquiries and be prepared for wider interest in the article. A proof reading and graphic design service is available for external publications, such as journals and articles for other specialist publications.

Requests for Interviews, Filming and Photography

Requests for interviews, filming and photographs can be received as a result of both proactive press releases and in reaction to an unplanned story. **All** requests for interviews, filming and photography should be forwarded so that a member of the Communications team can give approval for this to go ahead and provide any necessary advice to staff/patients taking part.

Staff should be alert to approaches for an interview/comment in the event of reporters posing as others (undercover reporter) who are looking for a story. All requests for comments/interviews should be referred to the Communications Team who will offer the relevant advice. Media representatives usually have identification (for example ID badge). However, they should never be left unaccompanied when on Trust premises. If any media representatives or film crews are seen on site and are unaccompanied, please inform the Communications Team (ex 2873) or contact Security ext 5233.

All requests from media for filming or photography on hospital grounds must be approved and led by the Communications Team who will be present to oversee the filming or photography.

The Communications Team will ensure that **prior written consent** is obtained from any patients involved in interviews/filming/photography (Appendix A) and a record of this consent will be kept in the Communications office. When a member of the Communications Team is not present during filming/photography sessions, the manager assisting should forward the consent form to the communications team so that the forms can be kept securely. Photography/film consent forms are available from the Communications Team on ext 2873 or on the extranet in the Communications workspace https://extranet.whh.nhs.uk/workspaces/communications/documents .

Verbal consent is accepted by the Communications Team by staff taking part in media interviews, filming or photography. It is not necessary for staff to complete consent forms.

Before any filming or photography takes place on Trust grounds, all patients and staff using the area must be asked for their consent. Accidental recording of people in the background who have not given consent must be avoided. If patients or staff do not wish to be included, the angle of the filming/photography or the location may need to be changed. Media crews and photographers who do not respect patients' and staff wishes will be asked to stop filming/photographing and leave the premises. **Consent needs to be obtained from everyone in shot – even if they are just in the background. If patients are unable to give consent due to incapacity for any reason, and their relative/carer is unable to do this for them then no photography/filming is permitted under any circumstance.**

Interviews with Patients and/or Relatives

All requests for interviews with patients should be directed to the Communications Team during normal working hours (Monday to Friday, 9am-5pm). The Communications Team will give permission for the interview to go ahead on hospital grounds only if:

- Appropriate written consent is obtained from the patient or a legal guardian/parent

for children under the age of 16 (Appendix A).

- The consultant/nurse-in-charge/ward manager agrees that the patient is medically fit enough to be interviewed and that it is appropriate to do the interview in hospital and is unlikely to cause any disturbance to other patients on the ward or interfere with the work of other staff on the ward.

Urgent requests from media for interviews with patients that are received out-of-hours should be referred to the on-call Director of Community Engagement via switchboard. Non-urgent requests from media for interviews with patients received out-of- hours should be referred to the Communications Team (via e-mail or a message left on voicemail at 01925 662873) and will be dealt with during normal office hours.

Unauthorised filming and photographs

Trust premises including car parks and grounds are private property and the confidentiality of patients using our services is paramount. As a result, any unauthorised filming, photography or audio recording will be stopped and anyone taking part in this activity may be escorted from trust premises.

Staff should never take photographs on the ward/patient facing areas without consent from other staff members and written consent from patients as described above.

Patient and visitor filming, photography and audio recording

To protect confidentiality, patients and visitors must not take pictures or video of other patients, visitors or trust staff without their permission. Trust staff should challenge anyone believed to be taking pictures, video or personal details of other patients, visitors or trust staff without their permission. In the first instance, staff should ask that the individual/s concerned delete any photos/videos taken and remove them from social media and/or websites if relevant. If patients or visitors do not comply with this request, they may ultimately be asked to leave in appropriate circumstances, as their behaviour could constitute 'causing nuisance or disturbance on NHS premises' as per Section 119 of the Criminal Justice and Immigration Act 2008.

It may also be appropriate to report activity of this nature to the police in certain circumstances, for example if it suspected that images or videos of a voyeuristic nature are being recorded or if the material posted is of a significantly offensive or threatening nature (as outlined in the Communications Act 2003). Please raise a Datix in these situations as well as notifying Security and the Communications Team

Requests from the Police

When the police are looking for help from the public to progress a criminal investigation (for instance if they are appealing for witnesses to come forward), they might make a request to allow the media to be allowed to speak and film a patient in hospital. The police will usually have spoken to the patient in

advance to get the necessary consent. The Communications Team will speak to the ward manager/nurse-in-charge on the ward/unit concerned to check that the patient is happy to go ahead with the interview and has given the necessary consent to the police. We will make every effort to assist the police with such requests.

Request for Opinion

Local media regularly contact the Trust and ask for a comment from experts at WHH in response to issues raised by national media. The Communications Team will decide whether it is in the Trust's best interest to make a public comment on a national issue and will notify NHS England/Improvement's regional team as well as our Commissioners and any other appropriate partner.

Social Media and Blogs

Responsibility for protecting and promoting privacy and dignity of patients and their families does not lie with one individual or group, but with all staff and volunteers. Staff must always be aware of actual and potential clinical risks of discussing patient care or other confidential information in public.

No information which may identify patients, or staff in a negative way, or otherwise bring the Trust into disrepute is permitted to be discussed.

Where staff wish to use social media to express opinions that may not be those of the organisation, they should ensure that they do not identify themselves as Trust employees and furthermore state that their views are their own.

For more information on Social Media use please see the appendices.

Incidents

Internal incidents

An internal incident is an incident which presents a significant risk to patients, staff and the public or which has the potential to significantly disrupt or harm the reputation of the Trust. Internal incidents include such events as a power failure, fire, IT server or network outage, extreme demand for our services – anything where there could be an immediate disruption to services may prompt the use of the Internal Incident Plan.

As with major incidents, internal incidents could attract significant media interest. The role of the Communications Team in the case of an internal incident is to work with the 1st on-call manager. In the event of an internal incident occurring outside of normal working hours, the Director of Community Engagement will be contacted via the hospital switchboard.

Major incidents

A major incident will attract immediate and probably large-scale media interest, potentially on a national or even international scale depending on the nature of the incident or emergency the hospital is dealing with.
Dealing effectively with the media is therefore critical to the effective handling of the major incident. This is especially important as the public will turn to the media immediately for information during such an incident. It is therefore essential that information given out to media is accurate, timely and delivered through easily accessible channels to prevent the media from going elsewhere for information which may be from a less reliable source.

All media enquiries in relation to a major incident will be dealt with by the Communications Team, in conjunction with the Trust's Major Incident Plan. In the event of a major incident outside of normal working hours, members of the Communications Team will be contacted via the hospital switchboard.

Complaints, litigation cases and internal investigations

The Communications Team responds to all media enquiries relating to complaints, litigation cases (including court cases and inquests) and internal and external investigations. Once the media enquiry has been received the Communications Team will ensure it is brought to the attention of the relevant director and a response will be formulated with the assistance of the Patient Experience Team, Legal and Human Resources departments. Communications will ensure the response for media (media statement) is signed off by those named above before issuing to the media.

Rights of Staff Side Representatives of Recognised Trade Unions or Staff Associations

This policy does not restrict the right of representatives of recognised trade unions or staff associations to express their views through or to the media directly. Representatives of recognised trade unions or staff associations are entitled to make comment on behalf of their staff association or trade union. They are not able to make comment on behalf of, or represent, Warrington and Halton Hospitals NHS Foundation Trust.

Communication of the Policy

The policy will be distributed to all staff as a link in an article in Trust's weekly bulletin. It will also be available via extranet and held in the policy database. All staff will be made aware of the policy as part of their induction.

Implementation and Monitoring

The Communications Team is responsible for ensuring this policy is circulated and monitored and for recommending updates when necessary. A record will be kept of incidents breaching this policy and recommendations/training offered to the relevant department/ward.

AUDIT of the DOCUMENTED PROCESS OF THE POLICY

Compliance with this procedure will be monitored by the Director of Community Engagement and Fundraising.

Monitoring will be on-going and will include compliance with procedures outlined within this procedure together with feedback from staff and those involved in the visit.

Protocol compliance will be measured by matching reported events against monthly media coverage. All records are to be retained by the Communications team.

Where risks are identified an action plan will be devised by the Communications and Engagement Specialist in conjunction with the Head of Security and any other relevant staff.

Minimum requirements	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
Compliance with the procedure	Monitor of Datix Incident log	Director Community Engagement and Fundraising	Ongoing	Director Community Engagement and Fundraising	Director Community Engagement and Fundraising	Strategic People Committee

Sources/ References

- Sir David Nicholson letter to all NHS organisations in light of the recent abuse allegations against Jimmy Savile DH Gateway number: 18350 13 November, 2012
- Care Quality Commission Essential Standards 2009 Outcomes 7 &10
- Independent Press Standards Organisation – Editors Code of Practice July 2019

Glossary of Terms

Sanctioned visitors - individuals or groups who are invited or who have approval to be on hospital premises for an official purpose or for the benefit of patients, staff, the Trust or the NHS. These may include:

- **Media** – journalists or other representatives of print or broadcast media organisations i.e. newspapers or television. This category will also include associated technical or creative people such as camera / sound crews, or photographers.
- **Public areas** - any location in the hospital that is accessible by the general public and does not have secure entry. These would include reception areas, catering and retail areas.
- **Clinical areas** - any area of the hospital in which clinical care is provided to inpatient or outpatients. This would include all wards, theatres, departments and clinics. It also includes any area associated with health care or the business of the Trust which has a secure door or requires a hospital pass or staff member to gain entry.
- **VIPs** - key stakeholders including Ministers, elected representatives, overseas dignitaries, members of the Royal Family.
- **Celebrities** - famous/high profile figure who might be well known to the public and therefore to patients and their families; also includes costumed characters as these would be well known to children and young people.

Associated Documents

- Consent to Treatment
- Assessment of Capacity
- Adult and Children Safeguarding procedures

Equality and Diversity Statement

All patients, employees and members of the public should be treated fairly and with respect, regardless of age, disability, gender, marital status, membership or non-membership of a trade union, race, religion, domestic circumstances, sexual orientation, ethnic or national origin, social & employment status, HIV status, or gender re-assignment.

All trust polices and trust wide procedures must comply with the relevant legislation (non-exhaustive list) where applicable:

- Equal Pay Act (1970 and amended 1983) Sex Discrimination Act (1975 amended 1986) Race Relations (Amendment) Act 2000 Disability Discrimination Act (1995) Employment Relations Act (1999) Rehabilitation of Offenders Act (1974) Human Rights Act (1998)
- Trade Union and Labour Relations (Consolidation) Act 1999 Code of Practice on Age Diversity in Employment (1999)
- Part Time Workers - Prevention of Less Favourable Treatment Regulations (2000)

- Civil Partnership Act 2004
- Fixed Term Employees - Prevention of Less Favourable Treatment Regulations (2001)
- Employment Equality (Sexual Orientation) Regulations 2003 Employment Equality (Religion or Belief) Regulations 2003 Employment Equality (Age) Regulations 2006
- Equality Act (Sexual Orientation) Regulations 2007

The Communications Team will endeavour to engage a range of media to target all groups, including minority and ethnic radio stations and television (broadcast media) and programmes aimed at particular segments (for example, older people). The team will take account of the range of media available to reach the community the Trust serves.

Equality Impact Assessment Statement

WHH is committed to ensuring that none of its policies, procedures, services, projects or functions discriminate unlawfully. In order to ensure this commitment all policies, procedures, services, projects or functions will undergo an Equality Impact Assessment.

Equality Impact Assessment (EIA)		
Initial assessment	Yes/No	Comments
• Race • Ethnic origins (including gypsies and travellers) • Nationality • Gender • Culture • Religion or belief • Sexual orientation including lesbian, gay and bisexual people • Age • Disability - learning disabilities, physical disability, sensory impairment and mental health problems	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?		
What is the level of impact?		

Appendix One Consent Form for Patients involved in photographs/filming

Name:

Location:

Reason for request:

Name of communications team lead:

1. Why we are asking you to take part in photography or filming

Warrington and Halton Hospitals NHS Foundation Trust works closely with the media and we often get requests to accommodate filming or recording on the hospital premises and sometimes requests to interview patients. We also like to use photographs of staff and patients for leaflets, our internet site, newsletters and other publications that can help promote NHS services to other people.

If we ask you if you mind taking part in a media or photo opportunity we are organising we always explain what is involved and make sure you are happy to take part. This consent form gives us a record of this.

As the patient, the decision on whether to take part or not is entirely yours. Please do not feel under any pressure to agree to take part if you don't want to and if you have any questions, please feel free to ask us.

Your help is much appreciated and will support our work in promoting the hospitals to the public in the future.

2. Please read the statement below and complete the following section

I agree to participate in the production of the above mentioned programme/publication, the nature of which has been fully explained to me and hereby give consent for the filming/recording/photographing of my interview, treatment or presence in the clinic/surgery/ward.

I understand that I will be contacted to give my consent if the material is to be used for a purpose other than that mentioned above.

Your name: _____

If not the patient, please state relationship, e.g. parent/guardian _____

Address: _____

Phone: _____ Email: _____

Signed: _____ Date: _____

Appendix Two - Guidance on Social Media and its use by Staff and Volunteers

Social media can take on many different forms, including Internet forums, weblogs, social blogs, micro blogging, wikis, podcasts, photographs or pictures, video, rating and social bookmarking.

74% of all adults that use the internet use social media, and the number is even higher with teenagers under 18. The major social media sites/platforms include Facebook, Twitter, Snapchat, Instagram, YouTube, LinkedIn, WhatsApp, Messenger, Viber. This list is not fully exhaustive as technology continues to move at pace and new sites and platforms emerge regularly.

Social media is an effective way for members of staff to celebrate their own, their team and the Trust's achievements and the Trust encourages colleagues to use social media in this way. However, in using social media, colleagues need to be careful not to do anything which brings the Trust into disrepute. The guidelines here set out how colleagues can avoid doing this.

Trust use of social media

The Trust uses social media as part of its communication strategy. The communications department is authorised to speak on behalf of the Trust and is responsible for managing the Trust's official sites, including Facebook, Twitter, Instagram and YouTube.

Warrington and Halton Teaching Hospitals NHS Foundation Trust's social media accounts:

- Facebook account: @WarringtonandHaltonHospitalsNhsFoundationTrust @warringtonmaternity @WHHCareers
- Twitter account: @whhnhs, @WHHCareers
- Instagram: @whhnhs

Social media, like other communication tools, is used to improve the public's understanding of the Trust and its work, promote health and services, and engage with the general public. When using social media sites, the communications department will, on behalf of the Trust, ensure that:

- Comments and posts reflect the Trust's vision and values
- Responses are respectful towards patients, members of the public and Trust staff
- Confidential or sensitive information about patients, staff or the organisation or offensive or derogatory posts are removed
- Defamatory comments about members of our staff should not be shared in any public forum. Legal advice will be sought and action taken where necessary.

Adhere to other Trust policies and procedures

Staff using social networking sites should always adhere to the Trust's vision and values, as well as codes of conduct and policies which are part of their professional and employment requirements.

Social Media, Cyber Security and Your Safety

Employees should be aware that social media sites are open to the public and may be considered public record. Employees should ensure that any reference made to the Trust, their colleagues, or working practices are professional, responsible and positive, whether posting from work or at home. To make sure you're safe on these sites, here are a few do-s and don'ts of social media to keep your information safe:

- Create a strong password you can remember and never tell anyone your password; not even a friend.
- Don't use the same password for every site.
- Always set your privacy settings. Avoid having a lot of information available to the public - make sure only your friends and family can see what you put online.
- Be vigilant. Always double check every link, attachment, download, email, or anything else sent to you. Even your best friend could have had their account hacked so make sure it really is them if the message seems suspicious.
- Don't ever put in more information about yourself than absolutely necessary and never complete "fun" surveys from unfamiliar sources; these can be used by hackers or scammers for malicious purposes including impersonating you.
- Don't forget to be aware of how much live information you're putting out there. Avoid showing off expensive purchases and telling the world you're going on holiday.
- Don't upload anything you wouldn't want everyone to see. It's a good rule to assume that anything you put up will be revealed to the internet at large at some point, whether through hack, leak, or privacy policy change.

How staff can use social media to promote their work

Staff are encouraged to use social media responsibly to raise awareness of the work they/their teams are doing. Social media is not just a way of reaching external audiences but of communicating with colleagues internally. Examples of social media use which colleagues can employ, are:

- Posting a small piece of text or photo about some work they are doing or a recent achievements
- Posting something about their team, or a photo of their team
- Liking or re-tweeting a post put up by the Trust's Communications Team
- If colleagues are uncertain about how best to use social media in their work, please contact the Communications department.

Staying Safe with Social Media

- Make it clear that the opinions you express are your own
- If a member of staff discloses that they work for the Trust or can be identified as an employee through association with other people, they should ensure their profile and related content is consistent with how the Trust would expect them to present themselves professionally
- Do not set up official Trust sites - All official social media channels are managed by the Communications Team. No other teams/staff within the Trust should set up corporate sites without the authorisation of the communications department. Staff should not set up sites that are made to resemble an official site.

Setting up a social media page for work

Please contact the Communications Team on whh.communications@nhs.net for support in setting up a department/team Facebook group or a Twitter account. Please note that the Communications Team will set up the Facebook group and be present within the group to monitor posts and provide support; each department/ team will need to provide at least two administrators for the group. These groups are a great way at communicating news, training and changes to policies that you are working on with your staff.

Communicate as yourself

If a member of staff associates themselves with Warrington and Halton Teaching Hospitals NHS Foundation Trust on their social media site, they are expected to post under their real name. This demonstrates openness, honesty and accountability.

Respect others

Posts must not contain anything contrary to the Trust's values and the Equality and Inclusion policy. Anything containing racist, sexist, homophobic, sexually explicit, threatening, abusive, disrespectful or other unlawful comments must not be published. Inappropriate comments relating to protected characteristics set out in current legislation, for example disability, should also not be posted.

Be aware of how online posts are, or can become, public

- When staff publish something on social media, they should assume it is in the public domain.
- Staff should be aware of privacy limitations when posting material. Even if something is initially shared with a limited group of followers or friends, it could still be copied and shared or published elsewhere.
- Staff should carefully consider what they want to say before they publish anything, and work on the basis that anything they write or post could be shared more widely without their knowledge or permission.
- Staff should configure their privacy settings and review them regularly because social media sites cannot guarantee confidentiality and often change settings once information is online – so it can be difficult to remove it

Get your facts right

- When posting information, staff must ensure it is factually correct. If they discover they have reported something incorrectly, they should amend it and make it clear they have done so
- Understand the implications of defamation
- Staff could face legal proceedings for posted comments aimed at named individuals or an organisation that are considered to harm reputation.

Respect copyright

- Staff may use the Trust logo and photos from the internet and intranet if they are posting to raise awareness, in a positive way, of their own work within the Trust. Staff should not use the Trust and NHS logo and photos from the internet or intranet sites for any other purposes as these are copyright protected

- Be careful when talking about work-related issues
- Staff should only share information about the Trust that is in the public domain, and should not add derogatory comments on these issues
- Staff must also respect patient confidentiality, and should not disclose information that could identify a patient in any way.
- Don't bring yourself or the Trust into disrepute
- Staff should not air grievances or publish anything that risks bringing the Trust into disrepute.
- Be careful about the use of photos
- Staff should think carefully before posting photos that relate to their work or photos in an identifiable work setting. Staff should not use a photo of themselves in uniform as their profile picture; this could give the impression that their site is an official site, there are implications for your professional bodies
- Staff must not post images, of any description, containing patients on personal social media accounts

Protect Our Patients

- Protect patient confidentiality - under no circumstances should anything be posted that identifies a patient.
- Staff should ensure they know Trust policy on patient confidentiality and follow it at all times. The DH guidance on patient confidentiality is contained in the publication "Confidentiality: NHS Code of Practice (Nov 2003)".This states that all NHS staff have a duty to keep confidential all information about patients, and to not disclose this information to anyone not involved directly in their care. It is a legal obligation derived from case law; a requirement within professional codes of conduct; and is included in NHS employment contracts as a specific requirement linked to disciplinary procedures.
- It is Trust policy to gain written consent from patients for all disclosures of identifiable information to the media and for publicity purposes. As well as names and other personal details, this includes the use of images of the patient undergoing treatment in a real life situation and where the patient is posing for a picture.
- Employees must not discuss patients, patients' relatives or any confidential information on social media sites.

Indirect breaches of confidentiality

- Nothing written by staff should comment on, or provide additional information about, cases already in the public eye – for example, any incident that has already been reported in the media.

Respect safeguarding issues

Posts made by staff must not encourage behaviour that could be linked to safeguarding issues, for example:

- Bullying
- Luring and exploitation
- Theft of personal information
- Encouraging self-harm or violence

- Glorifying activities such as excessive drinking or drug taking

Being harassed, bullied or victimised via a social networking site?

If staff believe they are being harassed, bullied or victimised as a result of another member of staff's post to an internet site, they can take action. Staff should access the Trust's Respect policy which outlines the informal and formal action that can be taken.

These kinds of posts may be investigated and result in disciplinary action

Help on Social Media Use

- Staff may use social media to raise awareness of their work, within working hours. Staff should not use social media for other purposes outside their allocated break times
- When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge
- use of social media can benefit patient care by:
  - engaging people in public health and policy discussions
  - establishing national and international professional networks
  - facilitating patients' access to information about health and services.

Maintaining boundaries

- Using social media also creates risks, particularly where social and professional boundaries become unclear. You must maintain a professional boundary between you and your patient
- If a patient contacts you about their care or other professional matters through your private profile, you should indicate that you cannot mix social and professional relationships and, where appropriate, direct them to your professional profile

Maintaining confidentiality

- Many clinical staff use professional social media sites that are not accessible to the public. Such sites can be useful places to find advice about current practice in specific circumstances. However, you must still be careful not to share identifiable information about patients
- Although individual pieces of information may not breach confidentiality on their own, the sum of published information online could be enough to identify a patient or someone close to them.
- You must not use publicly accessible social media to discuss individual patients or their care with those patients or anyone else.
- If you identify yourself as a clinician in publicly accessible social media, you should also identify yourself by name. Any material written by authors who represent themselves as clinicians is likely to be taken on trust and may reasonably be taken to represent the views of the profession more widely. You should also be aware that content uploaded anonymously can, in many cases, be traced back to its point of origin.

Adding Images to Social Media

When adding images to social media, it is important to check:

- There is no patient identifiable information in the background
  Or
- If an image has been screen shot and added to a word document, please check when saving as a jpeg to be uploaded on whichever social media platform that the image has not expanded to show the original full image it has been taken from. To check:

    - Right click on the image and click crop it will show the original document, if it shows a wider area, click on compress images and then tick ' cropped areas of pictures' this will remove it before saving as a jpeg to upload it to your social media platform. This is especially important if cropping down an image which shows patient identifiable information.

Additional reading:

An excellent resource has been produced by the Nursing and Midwifery Council *Guidance on using social media responsibly which can be accessed at this link:* https://www.nmc.org.uk/standards/guidance/social-media-guidance

Appendix Three – How to Guides

Your guide to setting up and using a STAFF Facebook group

Want to set up a group for your department/team?

Please contact the Communications Team to arrange this, the team will then work with you to set it up and arrange for the administrators to have editing rights. Your group will be a 'closed' group and will be listed as secret, so that it is not discoverable and only you can invite staff to the group.

Responsibility of the Communications Team

A member of the Communications Team will be a silent member of the group for occasional monitoring/mediating but at times may also post Trust wide information required to be cascaded to all staff.

Our social media code of conduct

We reserve the right to remove any comments which;

- Are considered likely to disrupt, provoke, attack or offend others
- Are racist, sexist, homophobic, sexually explicit, abusive or otherwise objectionable
- Contain swear words or other language likely to offend
- Break the law or condone or encourage unlawful activity. This includes breach of copyright, defamation and contempt of court.
- Advertise products or services for profit or gain
- Include contact details such as phone numbers, postal or email addresses
- Are negative remarks about named members of staff
- Could be considered as bullying or harassment
- Describe or encourage activities which could endanger the safety or wellbeing of others

Top posting tips

- Post regularly to engage with your staff/colleagues
- Keep your staff up to date with things happening in your department/service/ward
- Share ideas – bright spots etc.
- Don't feel you have to be online all the time
- If in doubt, ask; the Communications Team is here to support you.

Your guide to Twitter

Tweeting: A **Tweet** is a message posted on Twitter. It can contain text, photos, links to websites, articles and videos. It's up to you **what you tweet about** - it could be your journey to work, an achievement you're proud of or just a great view. You can also use Twitter to research a topic by tweeting a question.

Profile:

- **Your Twitter @username** (also known as your handle) is your unique identifier on Twitter. It can contain up to 15 characters.
- **Your profile photo** - choose one that visually represents you and fits well in a small space. This image isn't just on your profile page; it will be shown as the icon in every Tweet.
- **Your biography** gives you160 characters to tell people about you – your interests, job title etc. **REMEMBER to stay safe – if you want to identify as an NHS worker then please ensure you include a disclaimer 'All views are my own and not necessarily those of my employer'**
- **Timeline, Following & Followers:** Your **timeline** includes your tweets and those of the people and organisations you are following. From other NHS staff, to family, friends and celebrities; there are 305 million active users on Twitter for you to **follow**. Your **followers** are people who follow you – in effect your audience. They read your posts and may well like, comment on or share them.

Mentions and Direct Messages

- Include another @username in a Tweet (mention them) and bring your message to their attention. You could use it to ask a question, to thank them or simply to highlight their work.
- When someone follows you - if you follow them back you'll also be able to communicate directly with them via Direct Messaging. Using this, you'll be able to hold a private conversation over Twitter.

Like, Hashtag, Retweet & Trending:

- A 'like' is a simple way to acknowledge a Tweet. Tap the heart icon to like a Tweet and the author will see that you appreciate it.
- A hashtag is used during Twitter conversations to make it easier to find all content related to a given topic or story eg #NHS #floods etc.
- A retweet (RT) is to share or forward someone else's message on the Twitter. Hash-tagged words that become very popular Trend.

Top tweeting tips:

- Tweet regularly to keep your followers interested, Tweet pictures – people love to see where you are/what you've seen.
- Follow organisations and people that interest you.
- Take it slow and see how others use Twitter.
- Don't feel you have to be online all the time.
- If in doubt, ask; there's a lot of advice out there and people on Twitter will offer answers.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/67 ii**	
SUBJECT:	**Accessible Information and Communications Policy**	
DATE OF MEETING:	25th May 2022	
AUTHOR(S):	Alison Aspinall, Senior Communications and Involvement Manager	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	N/A	
EXECUTIVE SUMMARY *(KEY ISSUES):*	Effective information and communication are vital components of a 'patient centred NHS.' Many people who need to access WHH services may have difficulty understanding the information provided. This may be because they are blind, D/deaf, have a learning disability, or because they have limited or no English. It may be because they need support in terms of reading (limited literacy) or they have a condition which limits their ability to communicate (for example following a brain injury or a stroke). Children and young people have specific communication requirements too. It is important, therefore, that information is presented in an accessible way, and where appropriate in a range of languages and formats that are easily used and understood by the intended audience. **The Accessible Information Standard (AIS)** The AIS directs and defines a specific, consistent approach to Identifying, Recording, Flagging, Sharing and Meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a permanent or temporary disability, impairment or sensory loss. The Standard applies to all service providers across the NHS and adult social care system, and it specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and wellbeing. There are further implications under a number of constitutional and statutory standards including: The NHS Constitution, The Equality Act 2010 and the Health and Social Care Act 2012 as well as supporting the Trust's own People objective of supporting a diverse and inclusive workforce.	

<table>
<tr><td></td><td colspan="4">Purpose and Scope of the Acessible Information and Communication Policy

The scope of this policy relates to the Trust's arrangement of interpretation, translation, transcription and communication support. It also includes the accessibility of information, published documents and digital content.

It is intended to make staff aware of reasonable adjustments required to support patients' communication preferences and to signpost them to the resources available. It covers:
Communication, including methods available for people to contact the Trust and support for participation in face-to-face meetings and events.
Information, including all information published by the Trust whether as a hard copy or electronically, including the accessibility of documents and online content, and the availability of information in alternative formats and languages (i.e. alternatives to standard printed English).
Addressing communication needs, including arranging professional interpretation to support face-to-face discussion, use of communication aids and adapting behaviour to support effective communication with an individual or group.
Support for communication needs which relate to an impairment, sensory loss, disability, and / or because the individual does not speak or read English.
The accessibility of internal communications, information, engagement and consultation exercises for WHH staff.
The Policy has been developed by the Accessible Information and Communications Task and Finish Group to support compliance with the Accessible Information Standard.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval
X</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to approve the Accessible Information and Communications Policy</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">Choose an item.</td></tr>
</table>

Accessible Information and Communications Policy

Lead executive	Director of Communications and Engagement		
Author's details	Pat McLaren, Director of Communications and Engagement		
Type of document	Policy		
Target audience	WHH Staff who have a patient or service user contact role and / or responsibility for accessing or utilising patient / service user records, whether this is in a clinical or non-clinical capacity.		
Document purpose	This policy relates to Trust's arrangement of interpretation, translation, transcription and communication support. It also includes the accessibility of information, published documents and digital content. It is intended to make staff aware of reasonable adjustments required to support patients' communication preferences and to signpost them to the resources available.		
Ratification meeting	Quality Assurance Committee		
Approval meeting	Appropriate Governance meeting		
Implementation date	Wednesday, 01 June 2022	Review date	02 June 2025
WHH Documents to be read in conjunction with			
	Alerts Policy and Protocols Production of Patient Information Policy Interpretation and Translation Policy SOP The use of Fixed and Portable Hearing Loops		
Document change history			
Version	1.0		
What is different?			
Appendices/electronic forms	Health Passport/ This is Me Constitutional and Legal Implications EIDO		
What is the impact of change?			
Training requirements	• Awareness for all staff – particularly front-line staff • AIS training on E-learning Introduction and Towards Excellence		
Keywords	Accessible information, translation, interpretation, foreign language, EIDO, hearing impairment, visual impairment, D/deaf, blind, D/deaf-blind, learning disabilities		
Taxonomy	**Type**	**Policy Category Non-Clinical**	**Policy Category Clinical**
	Non-Clinical	Communications	Choose an item.

Contents

1. Flowchart of process

To add following approval

2. Executive Summary

Effective information and communication are vital components of a 'patient centred NHS.' Many people who need to access WHH services may have difficulty understanding the information provided. This may be because they are blind, D/deaf, have a learning disability, or because they have limited or no English. It may be because they need support in terms of reading (limited literacy) or they have a condition which limits their ability to communicate (for example following a brain injury or a stroke). Children and young people have specific communication requirements too.

It is important, therefore, that information is presented in an accessible way, and where appropriate in a range of languages and formats that are easily used and understood by the intended audience.

There are significant benefits for patients in providing accessible information and communication:

1. Improved health and wellbeing amongst patients in the key affected groups due to increased take-up of early intervention and prevention opportunities, ability to participate in decision-making and improved compliance with treatment and/or medical advice.
2. Improved patient safety due to ability to understand and follow information regarding care and treatment, including medicines management and pre- and post-operative advice.
3. Improvement in the effectiveness of clinical care due to addressing barriers to communication.
4. Improvement in patient experience and satisfaction, and reduction in complaints and litigation associated with failure to provide accessible information and communication support.
5. More appropriate use of services by patients in affected groups including increased use of primary/routine care and services and reduction in urgent and emergency care usage.

In providing accessible information WHH will help to improve access to services, promote social inclusion and enable people to make more informed choices about their care. For staff, the provision of accessible information will aid communication with patients, their carers and loved ones; support effective engagement activity, and support choice, personalisation and empowerment. It will also promote the effective and efficient use of resources.

The provision of accessible information can reduce inequalities and barriers to good health and the implementation of this policy will demonstrate that WHH is meeting its legal duties to reduce inequalities between patients in access to our services and in the outcomes achieved.

Providing accessible information can also be key to promoting a diverse workforce. It supports the Trust's ability to expand beyond the equality issues that are covered by law, including the Equality Act 2010, and build on proven approaches to equal opportunities, adding new impetus to the development of employment policies, practices and processes. This approach supports the creation of an inclusive environment in which enhanced contributions are

encouraged and welcomed from all employees, helping to build a workforce that is representative of the communities served by NHS England and supporting the reduction of health inequalities.

This policy will ensure that Warrington and Halton Teaching Hospitals has a clear, consistent, transparent and fair approach to the provision of accessible, inclusive information and communication support to all. The policy covers all of our operations including both internal and external communication and should be followed by all staff.

The Accessible Information Standard

The AIS directs and defines a specific, consistent approach to Identifying, Recording, Flagging, Sharing and Meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a permanent or temporary disability, impairment or sensory loss.

The Standard applies to all service providers across the NHS and adult social care system, and it specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and wellbeing.

There are further implications (see Appendices) under a number of constitutional and statutory standards including: The NHS Constitution, The Equality Act 2010 and the Health and Social Care Act 2012 as well as supporting the Trust's own People objective of supporting a diverse and inclusive workforce.

3. Purpose & Scope

This policy relates to Trust's arrangement of interpretation, translation, transcription and communication support. It also includes the accessibility of information, published documents and digital content. It is intended to make staff aware of reasonable adjustments required to support patients' communication preferences and to signpost them to the resources available.

3.1 Purpose and Scope

The scope of this policy relates to the Trust's arrangement of interpretation, translation, transcription and communication support. It also includes the accessibility of information, published documents and digital content. It aims to:

- describe accessible information and communication and why it is important;
- define the roles and responsibilities of NHS England staff with regards to accessible information and communication;
- provide advice about some of the more common information formats and communication support which may be needed;
- explain the policies and procedures associated with arranging and procuring interpretation, translation, transcription and other forms of communication support;
- signpost staff to additional sources of guidance and support.

The scope of this policy includes:

- **Communication**, including methods available for people to contact the Trust and support for participation in face-to-face meetings and events.
- **Information**, including all information published by the Trust whether as a hard copy or electronically, including the accessibility of documents and online content, and the availability of information in alternative formats and languages (i.e. alternatives to standard printed English).
- **Addressing communication needs**, including arranging professional interpretation to support face-to-face discussion, use of communication aids and adapting behaviour to support effective communication with an individual or group.
- **Support for communication needs** which relate to an impairment, sensory loss, disability, and / or because the individual does not speak or read English.
- **The accessibility of internal communications**, information, engagement and consultation exercises for WHH staff.

3.2 Target audiences

The following groups of patients/service users are most affected by the Standard:

- People who are blind or have some visual loss;
- People who are D/deaf or D/deaf or have some hearing loss;
- People who are D/deafblind;
- People who have a learning disability.

The following groups are also affected by the Standard:

- People with aphasia
- People with a mental health condition which affects their ability to communicate
- People with a progressive neurological condition such as dementia
- People with cognitive impairment
- People with autism
- All staff have a responsibility to make information and online content accessible and inclusive.

And:

Carers: A carer is a person who is either providing or intending to provide a substantial amount of unpaid care on a regular basis for someone who is disabled, ill or frail. A carer is usually a family member, friend or neighbour and does not include care workers. The main carer will be identified by the individual or the person's GP or key worker if the person lacks capacity to identify one themselves. The Accessible Information Standard includes within its scope the needs of a patient or service user's main carer, as well as other important or regular informal (unpaid) carers.

Parents: The legally recognised parent or guardian of an individual under 18 years of age or an individual with parental responsibility or delegated authority for a child.

4. Duties & Responsibilities

Role	Responsibilities
Chief Executive	To commit to implementation of the principles of the accessible information standard at WHH
Delegated Executive Lead	The Director of Communications and Engagement has a duty to launch and promote this policy and ensure that the required resources are made available.
Head of Patient Experience and Inclusion	The Head of Patient Experience is responsible for the provision of Interpretation and Translation services
Communications Team	The Communications Team is responsible for the production of accessible communications materials across all print and digital platforms, both internally and externally. It is also responsible for the provision of information in alternative formats on request and the promotion to patients and their carers of their rights under the Accessible Information Standard.
All Clinical Staff	All clinical staff have a responsibility to ask patients if they have any additional requirements and to place an alert on their electronic patient record using the Alerts and Protocols Policy
Learning and Development Team	Learning and Development Team have a responsibility to promote the e-learning resources available ('introduction' and 'towards excellence')
All Staff	All front-line staff are responsible for being aware of the communication requirements of the various patient groups described within the policy and how to signpost them for support

5. Policy Details

5.1 Basic Steps to Accessibility

To support patients to participate equitably and fully in their care there are five basic steps which staff need to be aware of and take action on to comply with the Accessible Information Standard:

1. **Ask:** identify/find out if an individual has any communication/information needs relating to a disability or sensory loss and if so, what they are.
2. **Record**: record those needs in a clear, unambiguous and standardised way in the electronic patient record.
3. **Alert/flag/highlight**: ensure that recorded needs are 'highly visible' whenever the individual's record is accessed, and prompt for action. See the Alerts Policy and Protocols Policy for details on placing alerts on patient records

4. **Share:** include information about individuals' information/communication needs as part of existing data sharing processes (and in line with existing information governance frameworks).
5. **Act:** take steps to ensure that individuals receive information, which they can access and understand, and receive communication support if they need it.

5.2 Communication Aids for Specific Needs

All patients should be able to be accompanied by a carer or advocate to support their interaction with our services or have access to professional communications support arranged and paid for by the Trust where this is needed to enable them to participate in their care or to communicate effectively when making an enquiry or complaint. In these instances, staff should arrange and book the translation, interpretation or transcription of information in advance of the patient's appointment. Note that additional time will be needed to conduct a conversation which is supported by an interpreter, and allowance should be made for this in the appointment time as necessary.

- **Individuals who have limited or no English**

  The Trust has a variety of services available to support interpretation. The primary interpretation services for foreign language are:

  1. **Language Line Solutions® -** 24/7 audio and video on-demand interpretation service available in over 200 languages (audio) and 40 languages (video). Please follow the link for more details on the extranet: https://extranet.whh.nhs.uk/workspaces/translation-services/language-line-solutions
  2. **The Big Word® -** this service provides telephone interpretation and pre-booked face to face interpretation. Please follow the link for more details on the extranet: https://extranet.whh.nhs.uk/workspaces/translation-services/get-foreign-language-interpreter

- **Individuals with a hearing impairment** or who use British Sign Language (BSL) or the D/deafblind manual alphabet.

  There are an estimated 11 million people with hearing loss across the UK. The 2013 Action on Hearing Loss report, Access all Areas? reported that 14% of people with hearing loss had missed an appointment due to not hearing their name being called in the waiting room.

  Patients with a hearing impairment visiting the Trust can be supported by:

  - **The Trust's suppliers for British Sign Language (BSL) - The D/deafness Resource Centre**. Staff can book an interpreter using this link: https://extranet.whh.nhs.uk/workspaces/translation-services/get-british-sign-language-interpreter-bsl
  - **Supporting lip reading:** A person who is D/deaf or has hearing loss may also need support to communicate because they Lip read – in which case the speaker should clearly address the person and face them whilst speaking, avoid touching or covering their mouth*, and ensure conversations are held in well-lit areas. Transparent face masks can aid communication for those who lip read and are available for those patients who meet the criteria in the Standard Operating Procedure for the use of

face masks in a hospital setting, including but not limited to those with hearing impairment or hearing loss.

- **Hearing Aids and Loops:** A person who is D/deaf or has hearing loss may also need support to communicate because they use a hearing aid – in which case a 'loop system' should be provided, and care should be taken to speak clearly. There are a number of fixed and portable hearing loops available across the Trust, staff should familiarise themselves with the location of devices and how to use them. It should be noted that not all hearing aids have the facility to connect with a hearing loop - in which case patients should be offered a portable hearing aid device (may be borrowed from welcome desks/have been deployed to key areas – see SOP *The use of Fixed and Portable Hearing Loops.*
- **Speech-to-text reporter:** many patients have applications on their personal devices which enable them to read what is being spoken to them. The Trust is also to provide this service, information is available from the Communications Team.

** Please see separate guidance for staff wearing surgical masks*

- **Individuals with a visual impairment**

The RNIB reports that there are over two million people in the UK are living with sight loss and nearly 0.5m people are registered as blind or partially sighted in the UK (i.e. 1 in 180 adults). It is estimated that 1 in 5 people aged 75 and over, and 1 in 2 people aged 90 and over are living with sight loss.

We can support visually impaired patients by providing:

- Large or giant print formats are available via the Patient Information database, if your service requires additional formats (including Braille or Moon) please contact the Communications Team or please follow this link on the Extranet for more information: https://extranet.whh.nhs.uk/workspaces/translation-services/requesting-documentation-braillleeasy-readforeign-language-forma

- Visually impaired patients may also wish to record their appointments and should be supported to do so using their own recording devices. Where a patient does not have a recording device please contact the Communications team where recordings can be made and provided on mpg files or on CDRom.

- **Individuals who are D/deaf/blind**

According to Sense, there are nearly 400K people who are D/deafblind in the UK. Of these, half are aged over 70. It is estimated that there will be 600K D/deafblind people in the UK by 2030 – 400K of which will be people aged over 70.

D/deafblind patients are accompanied by a specialist carer who will often use a communication method called Tadoma, in which the D/deafblind person places their thumb on the speaker's lips and their fingers along the jawline. The middle three fingers often fall along the speaker's cheeks with the little finger picking up the vibrations of the speaker's throat.

Braille is the only communication format for some people who are D/deafblind.

The Trust uses The Big Word to provide its accessibility translation, this includes Braille. More information can be found using this link: https://extranet.whh.nhs.uk/workspaces/translation-services/requesting-documentation-brailleeasy-readforeign-language-forma

- **Individuals with learning disabilities (or to use as appropriate)**

There are estimated to be nearly 1 million people in England with a learning disability, representing a huge potential for positive impact on length and quality of life. A patient who lives with a learning disability may need information which is usually provided in standard English provided in an alternative format such as 'easy read' or Makaton. Note that such patients may require support from a communication professional, for example an advocate or learning disability communication support worker and will usually be accompanied to their appointments.

It should be noted that the level of a person's learning disability will have a significant impact on their ability to communicate and therefore level of support needed. People with a mild or moderate learning disability may be living independently and need information in 'easy read' format and verbal information explained more slowly and simply. A person with a more severe or profound learning disability is likely to be supported by one or more carers and will need additional support to communicate, including using a communication tool or aid and / or being support by a communication support worker. People with a more severe learning disability may be more likely to communicate in non-verbal and non-traditional ways.

Information for patients with Learning disabilities is available in Easy Read formats and the Trust has access to Widgit software to aid in the production of easy read information. If your service requires Easy Read versions of information, please contact the Communications Team.

Support can be provided by the Trust Safeguarding Learning Disabilities Professional by emailing nch-tr.AdultSafeguarding@nhs.net or calling 01925 275553.

- **Individuals with Aphasia**

More than 350,000 people in the UK have aphasia, a disorder of language and communication.

Aphasia (sometimes also referred to as dysphasia) is an acquired, multi-modal language disorder resulting from neurological damage. It may affect a person's ability to talk, write and understand spoken and written language, leaving other cognitive abilities intact. However, in some cases cognitive difficulties can co-occur. All languages are similarly affected, including sign languages used by d/Deaf people. In some individuals, the ability to use non-linguistic communication such as gesture and drawing is also impaired.

Aphasia can vary in severity from mild word finding difficulties to not understanding any language. Therefore, knowing an individual's level of aphasia is essential to being able provide the appropriate resources.

More time should be allocated for any appointments with people with aphasia.

- **Individuals with a cognitive impairment**

  Individuals who have a cognitive impairment (eg stroke, acquired brain injury, brain tumours) may experience communication difficulties affecting memory, attention and concentration and reduced reasoning skills or slowed information processing. This can be helped by providing orientation material, ensuring the person knows who you are by wearing a name badge, providing information in written/pictured formats. It can be necessary to give the person extra time to respond.

5.3 Production of Patient Information

- **EIDO Resources**

  A wide range of resources are available from our provider EIDO, particularly for information about clinical procedures. These include Easy Read, Large and Giant Print formats, screen reader and are available in a wide range of foreign languages. The database can be accessed via the Extranet at this link: https://extranet.whh.nhs.uk/patient-information

- The production of patient information is guided by the policy which is available on the Policies database http://thehub/PP/Policies/Production%20of%20Patient%20Information%20Policy%20March%202020%20(2).docx. Where new material is produced the service should request any additional formats at time of ratification. All patient information is 'read' by an independent reading panel which is volunteer led and supported by a wide range of advocates.

5.4 Production of Trust publications

All Trust communications must be accessible and should include people accessing documentation on web and digital platforms where screen readers or text enlargement/adjustable contrast is used.

- All Trust corporate communications should include the 'accessible communication statement' in a prominent position, as follows:

  This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact the Communications Team on 01925 662710.

- All Trust publications should carry a QR code on the rear enabling users to scan the code and be taken directly to the relevant information on the Trust's website.

- All Trust publications should carry the alternative formats notice in the main languages:

Polish:	Niniejsza publikacja jest dostępna w alternatywnych językach lub formatach na życzenie
Punjabi:	ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਬੇਨਤੀ 'ਤੇ ਵਿਕਲਪਕ ਭਾਸ਼ਾਵਾਂ ਜਾਂ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਉਪਲਬਧ ਹੈ
Urdu:	یہ اشاعت درخواست پر متبادل زبانوں یا وضعوں میں دستیاب ہے
Bengali:	এই প্রকাশনাটি অনুরোধের ভিত্তিতে বিকল্প ভাষা বা বিন্যাসে উপলব্ধ
Gujurati:	આ પ્રકાશન વિનંતી પર વૈકલ્પિક ભાષાઓ અથવા ફોર્મેટમાં ઉપલબ્ધ છે
Arabic:	هذا المنشور متاح بلغات أو تنسيقات بديلة عند الطلب
French:	Cette publication est disponible dans d'autres langues ou formats sur demande
Cantonese:	本出版物可應要求以其他語言或格式提供
Portugese:	Esta publicação está disponível em idiomas ou formatos alternativos a pedido
Spanish:	Esta publicación está disponible en idiomas o formatos alternativos bajo petición

5.5 Additional information requests

DVD copies of British Sign Language (BSL) video files, CD copies of audio files, and paper copies of documents in standard English, easy read and community languages (where appropriate) should be made available and posted out as required.

5.6 Accessible Events

For advice about making events accessible and inclusive please contact the Communications Team.

5.7 Online content and digital media

Documents published by the Trust must be accessible and follow the guidance outlined here https://www.gov.uk/guidance/publishing-accessible-documents

6. Document monitoring

This document will be deployed according to the associated action plan and monitored through the Patient Experience Committee.

7. Glossary of Terms

- **Advocate:** a person who supports someone who may otherwise find it difficult to communicate or to express their point of view. Advocates can support people to make choices, ask questions and to say what they think.

- **Accessible information**: information which is able to be read or received and understood by the individual or group for which it is intended.
- **Alternative format:** information provided in an alternative to standard printed or handwritten English, for example audio, braille or large print.
- **Aphasia:** a condition that affects the brain and leads to problems using language correctly. People with aphasia find it difficult to choose the correct words and can make mistakes in the words they use. Aphasia affects speaking, writing, and understanding of spoken language.
- **Autism spectrum disorder** (ASD): a condition that affects social interaction, communication, interests and behaviour.
- **Braille:** a tactile reading format used by some people who are blind, D/deafblind or who have visual loss. Readers use their fingers to 'read' or identify raised dots representing letters and numbers. Although originally intended (and still used) for the purpose of information being documented on paper, braille can now be used as a digital aid to conversation, with some smartphones offering braille displays.
- **British Sign Language (BS**L): BSL is a visual-gestural language that is the first or preferred language of many people who are D/deaf and some people who are D/deafblind; it has its own grammar and principles, which differ from English.
- **BSL interpreter:** a person skilled in interpreting between BSL and English. A type of communication support which may be needed by a person who is D/deaf or D/deafblind.
- **BSL translator**: a person able to translate written or printed English into British Sign Language (BSL), to support face-to-face consideration of a document, or for recording for use in a BSL video for example for publication on a website.
- **D/deaf:** a person who identifies as being D/deaf with a lowercase d is indicating that they have a significant hearing impairment. Many people who are D/D/deaf have lost their hearing later in life and as such may be able to speak and / or read English to the same extent as a hearing person. A person who identifies as being D/deaf with an uppercase D is indicating that they are culturally D/deaf and belong to the D/deaf community. Most D/deaf people are sign language users who have been D/deaf all of their lives. For most D/deaf people, English is a second language and as such they may have a limited ability to read, write or speak English.
- **D/deafblind: D/deafblindness** is a combined hearing and sight loss that causes problems with mobility, communication and access to information.
- **Disability:** the Equality Act 2010 defines disability as follows, "A person has a disability for the purposes of the Act if he or she has a physical or mental impairment and the impairment has a substantial and long term adverse effect on his or her ability to carry out normal day to day activities."
- **Easy read:** written information in an 'easy read' format in which straightforward words and phrases are used supported by pictures, diagrams, symbols and / or photographs to aid understanding and to illustrate the text. The Trust has access to Widgit software to aid in the production of easier to read information.
- **Hearing loop**: a hearing loop or 'audio frequency induction loop system,' allows a hearing aid user to hear more clearly. It transmits sound in the form of a magnetic field that can be picked up directly by hearing aids switched to the loop (or T) setting. The magnetic field is provided by a cable that encloses, or is located close to, the intended listening position such as a reception desk. The loop system allows the sound of interest, for example a conversation with a receptionist, to be transmitted directly to the person using the hearing aid clearly and free of other background noise.
- **Large print:** printed information enlarged or otherwise reformatted to be provided in a larger font size. A form of accessible information or alternative format which may be needed by a person who is blind or has visual loss. Different font sizes are needed by different people. Note it is the font or word size which needs to be larger and not the paper size.

- **Learning disability:** this term is defined by the Department of Health in Valuing People (2001). People with learning disabilities have life-long development needs and have difficulty with certain cognitive skills, although this varies greatly among different individuals. Societal barriers continue to hinder the full and effective participation of people with learning disabilities on an equal basis with others.
- **Makaton:** a communication system using signs, symbols and speech. There are three levels of Makaton, used according to the individual's circumstances and abilities – functional, keyword and symbol reading. Makaton may be used by people with D/deafblindness or a learning disability.
- **Moon:** a tactile reading format made up of raised characters, based on the printed alphabet. Moon is similar to braille in that it is based on touch. Instead of raised dots, letters are represented by 14 raised characters at various angles.
- **Speech-to-text reporter (STTR):** a STTR types a verbatim (word for word) account of what is being said and the information appears on screen in real time for users to read. A transcript may be available and typed text can also be presented in alternative formats. This is a type of communication support which may be needed by a person who is D/deaf or has hearing loss and able to read English.
- **Translator:** a person able to translate the written word into a different signed, spoken or written language. For example a sign language translator is able to translate written documents into sign language.
- **Voice Output Communication Aid (VOCA):** also known as a speech-generating device (SGD). An electronic device used to supplement or replace speech or writing for individuals with severe speech impairments, enabling them to verbally communicate.

8. Associated Documents

- Alerts Policy and Protocols
- Production of Patient Information Policy
- Trust Procedural Document Control Policy
- Trust Interpretation and Translation Policy
- Equality, Diversity and Inclusion Strategy 2019-2022
- Learning Disability Strategy 2021-2023

9. Sources/References

- NHS England Accessible Information Standard 2016
- Accessible Information: Specification v.1.1

10. Training Needs Analysis

Staff Role	Training Requirement	Frequency	Training Delivery Method
All staff with interaction with patients and their health records	Introduction to Accessible Information (20mins)	Once	e-learning The Accessible Information Standard: Introduction (e-learningforhealthcare.org.uk)

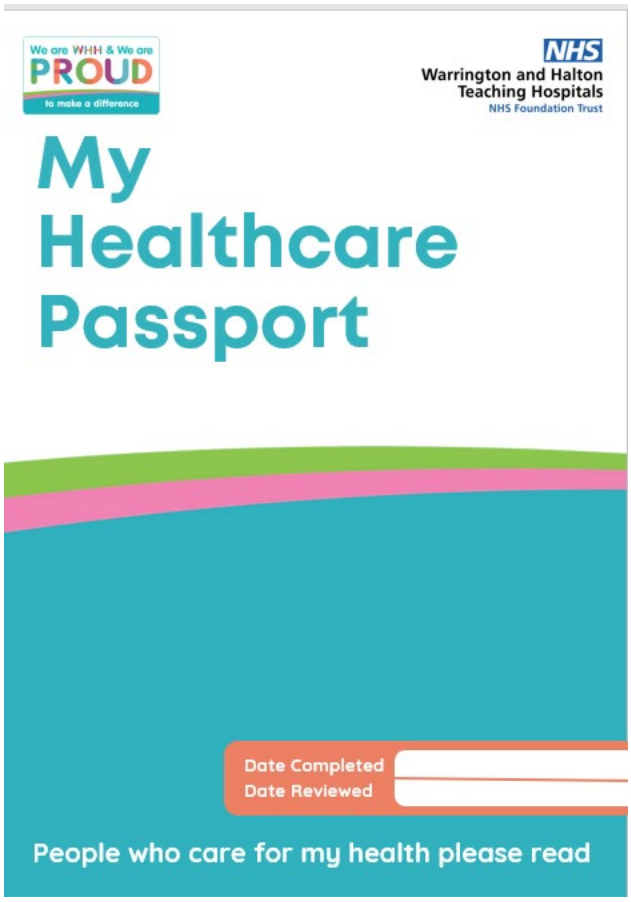
Communications, Patient Experience and ED&I teams	Accessible Information - Towards Excellence (20mins)	Once	e-learning The Accessible Information Standard: Towards Excellence (e-learningforhealthcare.org.uk)

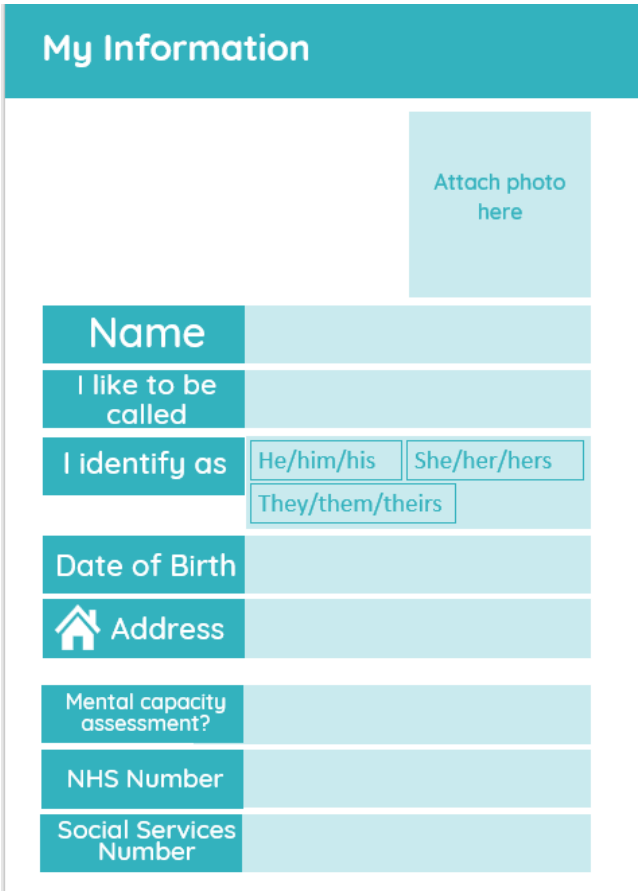
Appendix One – Health Passport 'This is Me'

Health Passport/ This is Me

This document can assist staff in assessing the needs of a person with learning disabilities. It is a document carried by the individual that contains information on his/her health status, medication, eating and drinking and likes and dislikes. A copy of the latest version of the health passport can be found here https://extranet.whh.nhs.uk/application/files/6514/6486/2107/This_is_me_v3_revised.pdf

Staff should always ask the patient if they have a health passport and ensure it is brought into hospital with them. Staff should also ensure that the passport remains with its owner and goes home with them.





Appendix Two – Constitutional and Legal Implications

1. **The NHS Constitution** establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

   The first principle of the NHS Constitution states that, "The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status…"

   Principle 4 states that "The NHS aspires to put patients at the heart of everything it does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services."

   As a patient, "You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices."

   A further pledge is that, "The NHS commits…to offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices."

2. **Equality Act 2010** became law in October 2010 and covers the same groups that were protected by previous equality legislation, with the following Protected Characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

   The Act places a legal duty on all service providers to take steps or make "reasonable adjustments" in order to avoid putting a disabled person at a substantial disadvantage when compared to a person who is not disabled. It is explicit in including the provision of information in "an accessible format" as a 'reasonable step' to be taken. As explained in 'Equality Act 2010: What do I need to know? Disability Quick Start Guide', "Service providers are required to make changes, where needed, to improve services for disabled customers or potential customers. There is a legal requirement to make reasonable changes to the way things are done (such as changing a policy)…and to provide auxiliary aids and services (such as providing information in an accessible format, an induction loop for customers with a hearing aid, special computer software or additional staff support when using a service)."

3. **Public Sector Equality Duty (PSED)**

   Under the PSED as outlined in section 149 of the Equality Act 2010, public sector organisations should seek to improve their performance in service design and delivery to ensure its services are fair and accessible to

all through engagement with the diverse communities we serve. Warrington and Halton Teaching Hospitals (WHH) are required to have 'due regard' when carrying out its functions to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the Equality Act 2010.
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

4. Health and Social Care Act 2012

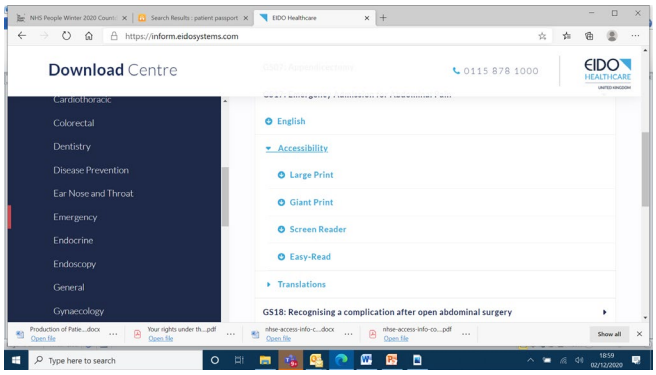
The NHS in England has legal duties to address health inequalities as outlined in the National Health Service Act 2006 (and as amended by the Health and Social Care Act 2012). This includes duties to:

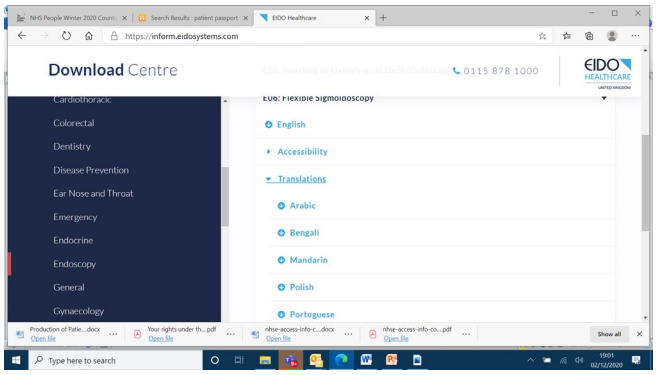
- have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.13G);
- exercise its functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where it considers that this would improve quality and reduce inequalities in access to those services or the outcomes achieved (s.13N).
- Implementing this policy will support the reduction in inequalities for patients in access to health services and the outcomes achieved. It will also demonstrate that WHH is meeting its legal duties to reduce health inequalities.

Appendix Three – EIDO

The EIDO database is accessible via the extranet. The Trust subscribes to an enhanced service to ensure accessible formats are available for patients including a wide range of foreign languages, easy read formats, large and giant print and screen reader-friendly formats.

Services should check their common clinical procedures are available in the desired formats and contact the Communications Team if they are not available on the database.





Equality Impact Assessment (EiA)

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 Yes No Yes No No No No	This policy aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, therefore potential or actual impacts are intended as positive. This policy should be read in conjunction with the Interpretation and Translation policy. This has positive potential and/or actual impact on individuals where their first language is not English (Section 5.2) details steps to be taken to ensure an interpreter is present.
Is there any evidence that some groups are affected differently?	Yes	This impact is intended to be positive, not negative.
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	Yes	
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	Potential and/or actual impact is likely to be positive.
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the Human Resource Department together with any suggestions as to the action required to avoid /reduce this impact. For advice in respect of answering the above questions, please contact the Human Resource Department.		
Was a full impact assessment required?	No	
What is the level of impact?	N/A	

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/68**	
SUBJECT:	**Quality Account 2021/22**	
DATE OF MEETING:	25th May 2022	
AUTHOR(S):	Layla Alani, Director of Integrated Governance Alison Talbot, Associate Director of Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	All NHS providers since June 2010 have had a legal duty to publish an annual Quality Report (Account) and are required to distribute the *draft* version for a formal consultation and response to various groups. This draft document has been disseminated externally to key stakeholders as part of the consultation process including:	

	• CCG • Healthwatch • Warrington Health wellbeing overview and Scrutiny Committee • Governors To date the CCG and Healthwatch have not provided feedback. The Director of Governance has spoken with the CCG and has been informed that feedback will be provided following a Quality Account presentation day to be held on 10th June 2022. Please note similarly to last year there is no formal requirement for the external auditing of the Quality Account. Cancer performance data cannot be provided within this report due to the timing of data analysis. This is expected to be received by 8th June 2022.			
PURPOSE: ***(please select as appropriate)***	Information	Approval x	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the Quality Account ahead of parliamentary submission on 29th June 2022 and to take Chairs actions in the absence of the cancer performance data which will be provided by 8th June 2022.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/05/116		
	Date of meeting	3rd May 2022		
	Summary of Outcome	Approved pending cancer performance data in June 2022		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Quality Account

2021/22

Contents

PART 1

PART 2

PART 3

Quality Account 2021/22

Quality is our number one priority.

Our Quality Account sets out how we have performed against the standards we set last year and what we will achieve in the coming year.

Part 1

1. A Statement on Quality from the Chief Executive, Simon Constable

Warrington and Halton Teaching Hospitals NHS Foundation Trust is dedicated to the provision of high-quality care and clinical excellence. Recognising that our patients and staff deserve nothing less than OUTSTANDING, we have embarked on an organisation- wide journey referred to as 'Moving to Outstanding'.

I am pleased to present our Quality Account for 2021/22. The Quality Account is an annual report which reviews our performance and progress against the quality of services that we provide and outlines our key quality priorities for the year ahead. It is an opportunity to celebrate our continued achievements and improvements that have impacted upon the care of our patients and their families.

Looking ahead to 2022/23, we will continue to drive the Trust's Quality Strategy priorities. These are as follows:

Priority 1 The Trust is committed to developing and enhancing its patient safety and learning culture where quality and safety is everyone's top priority.

Priority 2 Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.

Priority 3 By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

The priorities have been chosen based upon national and local drivers and our internal governance intelligence, identifying areas for improvement. Emphasis remains upon working across organisational boundaries in partnership with others and across the Integrated Care System (ICS), to ensure that we provide efficient and safe patient pathways to optimise health outcomes and enhance patient experience. We aim to become an integrated provider of clinically and financially sustainable, acute and community services providing outstanding care.

In conclusion, the Quality Account evidences that despite the challenges experienced throughout the year we have made significant progress in improving the care and services that we deliver to our patients. This will continue throughout the coming year and will be evidenced through our quality priorities and performance metrics for 2021/22.

I am pleased to present this year's Quality Account outlining the governance processes that have allowed myself and the Trust Board to authorise this document as a true and actual account of quality at Warrington and Halton Teaching Hospitals NHS Foundation Trust.

Signed by the Chief Executive to confirm that, to the best of his knowledge, the information in this document is accurate.

Simon Constable

Chief Executive

1.1 Introduction from Kimberley Salmon-Jamieson, Chief Nurse and Deputy Chief Executive and Paul Fitzsimmons, Executive Medical Director

The Quality Strategy 2021- 2024 demonstrates our commitment to improving the quality of care for our patients and describes how we planned to make this a reality. We believe that supporting our staff and equipping them with the right, skills, training, is fundamental in achieving our vision to deliver the highest quality of patient care, every day.

It is important to recognise the challenges faced by all healthcare providers this year caused by the Covid-19 pandemic. We are incredibly proud of how our dedicated staff have responded to these challenges whilst continuing to keep themselves, our patients, and the community safe. We have continued to improve the services that we provide and have taken great strides forward in delivering many improvements to the safety and quality of patient care. Furthermore, we are committed to ensuring that we continually improve our services, to ensure that we are providing the best care that we can to our patients and their families.

In 2019 the Trust was assessed as 'Good' in the Care Quality Commission (CQC) ratings, and we are working towards our 'Moving to Outstanding' rating for our patients and their families. This will be achieved by ensuring that all staff who work in our hospitals continue to strive for excellence in all that they do evidencing the provision of safe, effective and responsive care.

In 2021/22 the Trust has expanded provision within the Quality Academy recognising the fundamental role of quality improvement and research in improving patient outcomes and quality of care. This has included the introduction of the Halton Clinical Research Unit (HCRU) and a newly appointed Head of Research.

Our Quality Strategy for 2021 - 2024 will form the foundation for the next three years to further drive quality across the organisation on our journey to 'outstanding'. We will report measurable success in our Annual Quality Account and will commit to celebrating our achievements year on year.

Kimberley Salmon-Jamieson
Chief Nurse and Deputy CEO

Paul Fitzsimmons
Executive Medical Director

Part 2

2. Priorities for Improvement and Statements of Assurance from Board

Warrington and Halton Teaching Hospitals NHS Foundation Trust provides services at Warrington Hospital, Halton General Hospital and the Cheshire and Merseyside Treatment Centre, located in the North West of England. The Trust has Operating income from patient care activities of £261 million, employs over 4,200 staff and provides nearly 500,000 appointments or treatments each year. The majority of our emergency care and complex surgical care is based at Warrington Hospital, whilst Halton General Hospital in Runcorn is a centre of excellence for routine surgery. The Halton campus is also home to our orthopaedic facility, The Captain Sir Tom Moore Building (formerly known as the Cheshire and Merseyside NHS Treatment Centre).

Our vision is laid out in Quality, People and Sustainability Framework (QPS); working to achieve nationally and locally set standards to ensure that patients receive the care they need when they need it. We also provide, like all NHS trusts, those services within a financial budget, which we are responsible for delivering. Some of the challenges we have set ourselves are:

- **Quality - Patient Experience** – This section will be updated.
- **People - Employee Wellbeing & Engagement** - This section will be updated.
- **Sustainability - Work with other acute care providers** This section will be updated.

2.1 Organisational Structure

The Trust's organisational structure allows us to be more responsive to challenges through improved clinical engagement, strong and resilient leadership at all levels, with an emphasis on responsibility and accountability, to achieve the best for our patients and continuous improvement, transformation and innovation. The structure was developed collaboratively and facilitates clinical specialities within a Clinical Business Unit (CBU) model.

There are six Clinical Business Units within the Trust, who report into the Executive Directors. The Clinical Business Units are supported by 'Clinical Support Services' as well as 'Corporate Support Services'.

The Trust's organisational structure embraces the concept of true leadership synergy between the 'triumvirates' which brings together lead doctors, nurses/allied health professionals and managers working seamlessly with the wider corporate teams who are responsible for the clinical, operational and financial functioning of their CBU.

The CBUs have been created through innovation and collaboration with partners with the aim of improving access and quality of care, whilst being cost efficient through effective ways of working.

2.2 Priorities for improvement - Improvement Priorities for 2021/22 update

The following improvement priorities and quality indicators were identified following a review of the domains of quality.

The progress of each priority is reported on a quarterly basis to the Trust's Patient Safety and Clinical Effectiveness Sub Committee which reports into the Quality Assurance Committee. Where possible we include performance indicators to measure and benchmark our progress.

The Trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care. The 3 quality priorities; Patient Safety, Clinical Effectiveness and Patient Experience are all supported by a separate group of indicators which are detailed further on.

The Quality Strategy uses the following measures of success:

- ✓ We will ensure every patient has the opportunity to feedback about their experience and we promise to use this to improve care and services
- ✓ We will always put our patients first in everything we do, and we promise to communicate based on what matters most to you and in line with our values
- ✓ We will ensure that we minimise harm for patients
- ✓ Our patients should always experience care that is based on their specific needs, and we promise to work in partnership with you and your carers to achieve best possible outcomes
- ✓ Every patient should experience care and treatment in the right environment, and we promise to continuously improve what you can see, do, hear and feel during your stay.
- ✓ Our processes should be designed to support our patients and we promise to develop these so that everything is simple, done in a timely manner and easy to understand.
- ✓ We will be the best place to work and have safe systems of work in place
- ✓ We will ensure partnership working and needs based care.

With the above measures of success in mind, the following infographics details some of our key achievements from the Quality Priorities for 2021-22.

Key Quality

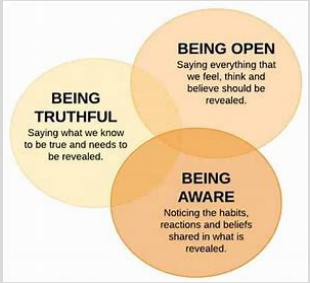
Achievements To Date

Complaints – Response Times Achieved

The Trust has successfully achieved 100% response rate within the allocated timeframe In December 2021, the Complaints Department had the lowest number of complaints open, 33 in total.

Consistent Incident Reporting

Incident reporting has significantly increased which demonstrates a positive reporting culture within the Trust. The data shows that there are high numbers of low/no harm incidents and low numbers of moderate/high/major harm incidents. This evidences a safe and transparent culture.



Achieved Statutory Duty of Candour Requirements

The Trust has achieved 100% compliance with notifying a patient of a verbal and written Duty of Candour within 10 working days after becoming aware that a notifiable safety incident has occurred.

Our 3 strategic objectives under the three priority quality domains are:

- **Priority 1 - Patient Safety:** The Trust is committed to developing and enhancing its patient safety and learning culture where quality and safety is everyone's top priority.
- **Priority 2 - Clinical Effectiveness:** Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.
- **Priority 3 - Patient Experience:** By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

The following section includes a report on progress with our improvement priorities for 2021/22 which were:

Patient Safety

- DNACPR- Improve communication with family/patients with effective communication, documented discussion and inclusive decision making.
- COVID Recovery- robust waiting list management, with clear clinical oversight to avoid and recognise potential patient harm.
- A reduction in Gram Negative Bloodstream Infections (GNBSI) – ensuring that there is a 5% reduction per quarter in bloodstreams infection.

Clinical Effectiveness

- Medical Examiner- embed the service across the acute setting and act as the pilot site for community roll out.
- Evidence-based Interventions- Ensure effective decisions about health care are based on the best available, current, valid and reliable evidence.
- CBU Governance- to be strengthened ensuring consistency across the organisation.

Patient Experience

- End of Life – Serious Illness Programme; Better Communication and Better Care for those sadly reaching the end of life.
- Learning Disabilities and Mental Health Strategies - Implementation of the Trust Learning Disability Strategy.
- Improve patient experience by enhancing the standard and timely delivery of nutrition.

Priority 1 - Patient Safety: The Trust is committed to developing and enhancing its patient safety and learning culture where quality and safety is everyone's top priority.

Gram Negative Bloodstream Infections - A 5% reduction in Gram Negative Bloodstream Infections (GNBSI)

Gram Negative Bloodstream Infections – Background:

The UKs 5-year national action plan (2019) details the ambition to halve healthcare associated Gram-negative bloodstream infections delivering a 25% reduction by 2021-2022 with the full 50% by 2023-2024.This priority links with our Quality Strategy to develop and enhance patient safety.

How progress will be monitored, measured and reported:
Infection Prevention and Control Sub Committee monthly.

Patient Safety and Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report is presented to the Quality Assurance Committee that will track milestones for the Quality Account priorities.

Gram Negative Bloodstream Infections (GNBSI) and Healthcare Associated Infections - Implementation and Performance:

An overall summary of GNBSI and Healthcare Associated Infections will be provided at the end of April 2022 when the national data is available.

Number of Cases Reported	Gram Negative Bloodstream Infections
1	Methicillin-Resistant Staphylococcus aureus (MRSA)
29	Methicillin-Sensitive Staphylococcus aureus bacteraemia (MSSA) *
46	Clostridioides difficile (C. difficile) (unavoidable, avoidable and cases awaiting review by the Clinical Commissioning Group (CCG) review panel to determine cause). C. difficile cases include community onset/healthcare associated and hospital onset/healthcare associated cases
63	E. Coli Bacteraemia
26	Klebsiella Bacteraemia*
3	P. Aeruginosa Bacteraemia*
*There are no targets set nationally for MSSA; Klebsiella, P. aeruginosa bacteraemia cases There is no nationally set target for MSSA.	

The tables below are extracts from the Trust Integrated Performance Report.

Graph 1 shows the results for MSSA bacteraemia and MRSA bacteraemia cases in 2021/22.

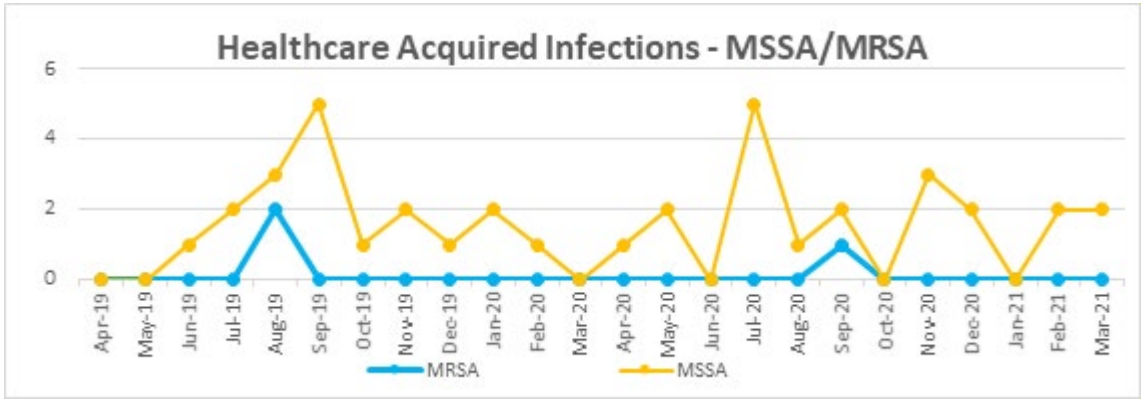
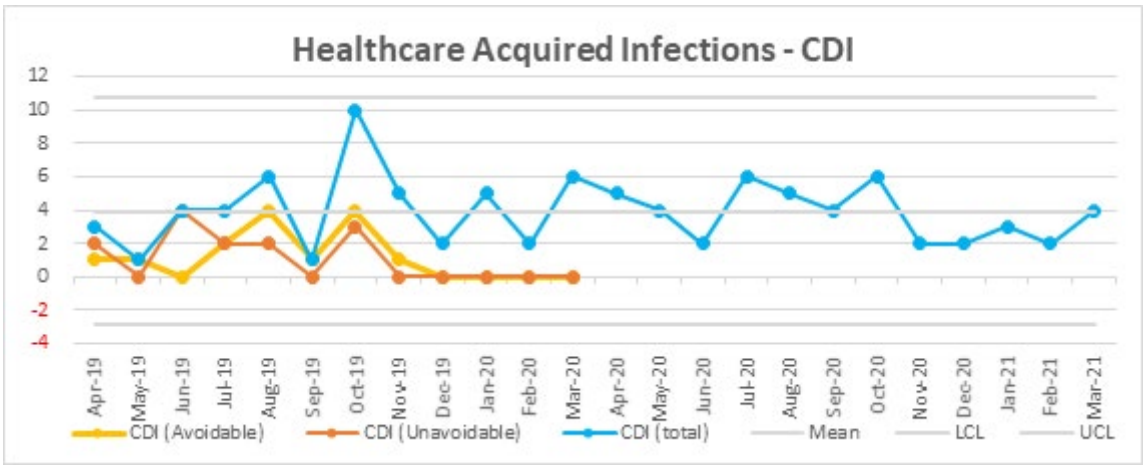
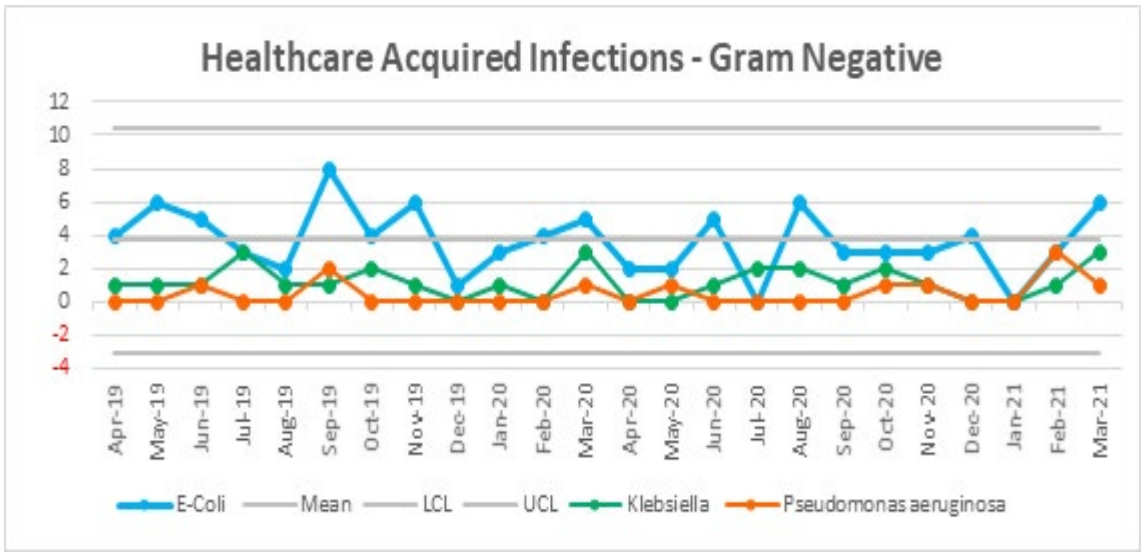


Table 2 shows the results for C. difficile cases in 2021/22. The data will be updated at the end of when the national data is available.



Graph 2 shows the results for Healthcare Associated infections in 2021/22.



Improving performance in relation to healthcare associated Infections remains a key priority for the Trust.

COVID Recovery- robust waiting list management, with clear clinical oversight to avoid and recognise potential patient harm

Covid Recovery - Background:

The COVID-19 pandemic has challenged the NHS in many different ways, including operational delivery, capacity and capability. The Trust will continue to ensure that a robust and proactive process for the management of waiting lists is in place to avoid unnecessary delays to clinical review and treatment potentially resulting in clinical harm.

Covid Recovery - How progress will be monitored, measured and reported:

Clinical Oversight Recovery Group.

Patient Safety and Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report is presented to the Quality Assurance Committee to track milestones for the Quality Account priorities.

COVID Recovery - Implementation and Performance:

The Trust achieved the revised 104 trajectory submitted to NHSEI.

The revised stretch target has been achieved in relation to the admitted and non-admitted targets following additional central funding.

The Trust will continue to prioritise the longest waiting patients and those of greater acuity and urgency (Urgent, P2 and long waiters) in line with local and national recommendations.

The Covid Recovery Programme is monitored via the Trusts Clinical Recovery Oversight Group which is chaired by a Non-Executive Director in addition to a Strategic Executive Oversight Group chaired by the Chief Operating Officer. Covid Recovery will remain a key focus as part of Quality Priorities for 2022/23. Detail of the Recovery Programme has consistently been shared with the CCG and the CQC.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR): Improve communication with family/patients with effective communication, documented discussion and inclusive decision making.

DNACPR Background:

Communication is fundamental in the decision-making process regarding the completion of a DNACPR form, for patients and how options and recommendations for DNACPR are discussed with patients, carers and their families.

DNACPR - How progress will be monitored, measured and reported:

Patient Safety and Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report is presented to the Quality Assurance Committee to track milestones for the Quality Account priorities.

DNACPR - Implementation and Performance:

- **Education and Training**
  - The new training on CPR Decision Making and Discussions continues at pace and feedback, including pre and post training confidence scores, is encouraging.
  - Following an SJR at MRG, encouraging feedback and valuable discussion were generated following a Grand Round focussing on identifying dying and decision making - evidence of cultural change has been noted.

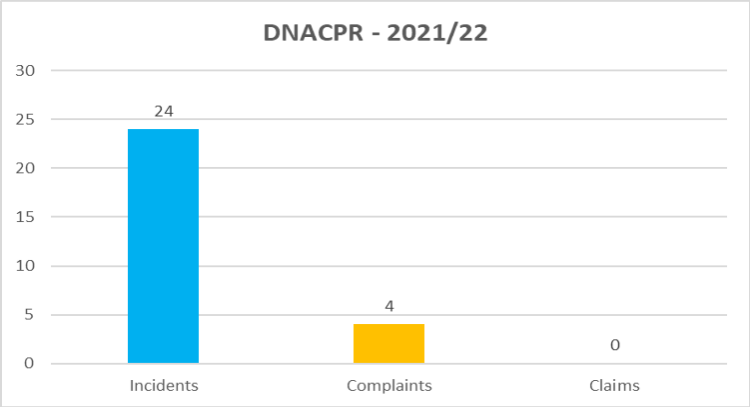
- **Documentation and Communication**
  - The new Lorenzo Form to document and prompt appropriate CPR Decisions and Discussions, encompassing treatment escalation planning and holistic, patient focussed end of life care planning has been launched
  - This will enable launch of the amended audit focussing on quality of the discussions which forms part of a Quality Improvement Project

- **Audit (including Audit of Quality)**
  - Audit of the uDNACPR forms shows increased compliance with all areas showing above 90% compliance.
  - A subsequent Audit will also include the MIAA recommendation that forms are verified by consultant/ associate specialist within 48 hours.
  - A Quality Improvement Project will focus on the implementation and changes following the new Policy and Lorenzo Form- namely quality of the decision, discussion and documentation, as well as access and filing of the paper forms.

- **Updated Policy**
  - The new Adult Cardiopulmonary Resuscitation (CPR) Decision Making Policy (which replaces the DNACPR policy) has been ratified at Policy Review Group on 26.1.2022 and has been launched on 15.2.2022.
  - This policy was welcomed by MIAA which recommended two included clarifications - that verification of uDNACPR forms by a consultant/ associate specialist should happen within 48 hours, and that there is a unified and recognisable filing system in all areas for completed uDNACPR forms.

- **Acute-Community Collaboration**
  - Collaborative plans are in development to improve early decision making and treatment escalation planning in the community.
  - There is support from community partners to progress to a ReSPECT process, discussions at CCG level regarding this remain ongoing.

The graph below identifies how many incidents, complaints and claims there were in 2021/22 relating to DNACPR.



Priority 2 – Clinical Effectiveness - We will improve outcomes, based on evidence and deliver care in the right place, first time, and every time

Medical Examiner – embed the service across the acute setting and act as a pilot site for community roll out

Implementation of the Medical Examiner Role into the Trust - Background:

The Medical Examiner System has now been embedded into the Trust since September 2020. Medical Examiners are part of a National Network of highly trained Independent Senior Doctors from any speciality who perform scrutiny of patient's who pass away both in Warrington and Halton NHS Foundation Trust, and the non-acute sector.

The Service is overseen by the National Medical Examiner, and Regional Medical Examiner. The Service scrutinises all deaths that are not reportable to H M Coroner, the Medical Examiner will discuss the care and cause of death with the Attending Practitioner, record any opportunities to share and learn from deaths and to improve the quality of the Medical Certificate of Cause of Death, in addition the bereaved family have an opportunity to ask questions or raise any concerns to an independent service.

Implementation of the Medical Examiner Role into the Trust - How progress will be monitored, measured and reported:

Mortality Review Steering Group held monthly.

Mortality and Morbidity (M&M) meetings monthly

Patient Safety and Clinical Effectiveness Sub-committee held monthly.

A quarterly Quality Report presented to the Quality Assurance Committee will track milestones for the Quality Account priorities.

A quarterly report is provided to the National Medical Examiner Office via the online portal.

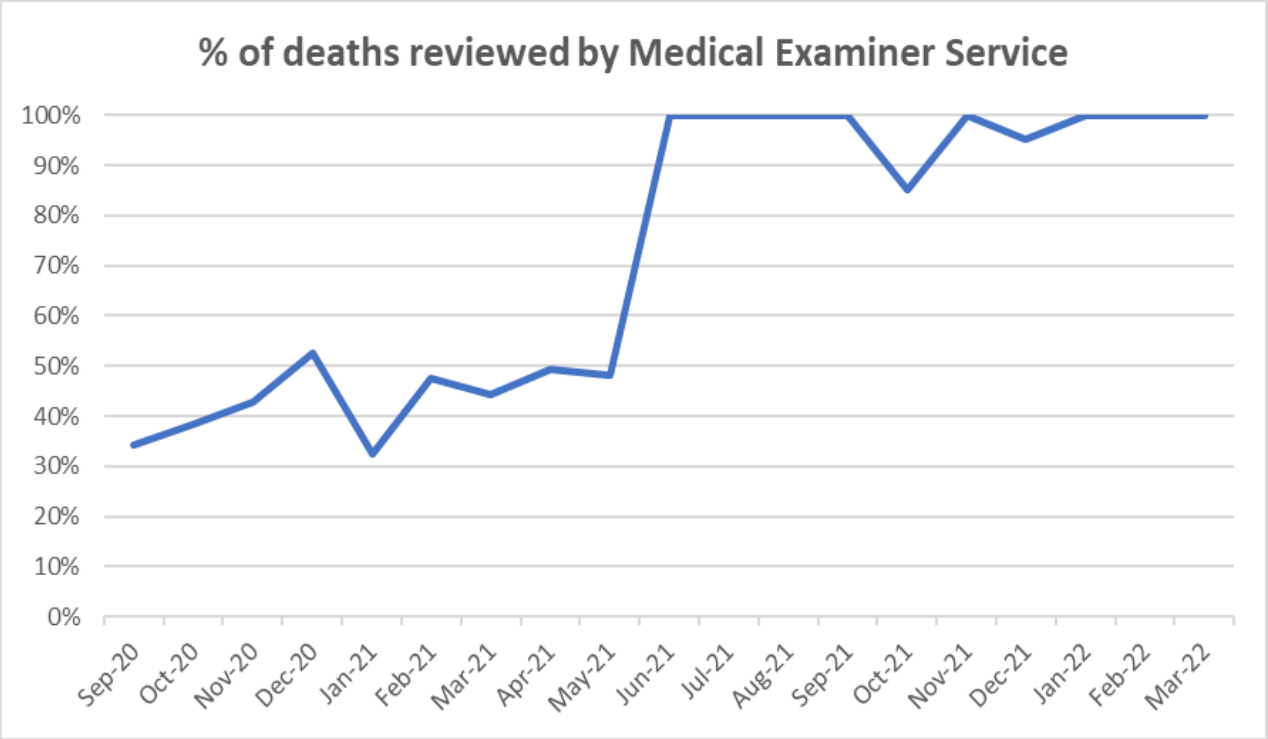
Sharing of this data with the Quality Assurance Committee and other relevant groups in the Trust.

A report of the same data is provided to the Head of Clinical Effectiveness and Quality and the Clinical Effectiveness Manager on a monthly basis.

Any identified learning is shared with the Mortality Review Group, Mortality and Morbidity meetings and the Governance team via Datix on a case-by-case basis if applicable.

Implementation of the Medical Examiner Role into the Trust – Implementation and Performance:

Graph 1 below details the number of deaths scrutinised by the Medical Examiner(s) in 2021/22 from when the service was implemented in September 2020.



Demonstrate that health care is based on the best available, current, valid and reliable evidence from GIRFT and NICE

GIRFT and NICE - Background:

The Getting it Right First Time (GIRFT) programme is a national programme designed to improve the quality of care within the NHS by reducing unnecessary variations in service. By sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

NICE develops national guidance, advice and standards on promoting good health, preventing and treating ill health and on the care, people should receive from social care. NICE guidance covers a range of areas including health technologies, clinical practice, public health and social care. NICE guidance aims to improve quality by providing health and social care professionals, and patients and the public, with the information they need to make decisions about treatment and care.

GIRFT and NICE - How progress will be monitored, measured and reported:

Patient Safety & Clinical Effectiveness Sub-committee

A quarterly Quality Report is presented to the Quality Assurance Committee that will track milestones for the Quality Account priorities.

GIRFT and NICE - Implementation and Performance:

The COVID-19 pandemic has impacted upon the GIRFT Regional Implementation Teams ability to deliver planned works due to redeployment and subsequent redesign, which is outside of any Trust's control. In July 2021 NHS E/I launched the new GIRFT toolkit, a document that outlines best practice when implementing GIRFT within an organisation. The Trust's leads for GIRFT have outlined a proposal for the launch of the Trust's new GIRFT process which will be taken forward in 22/23.

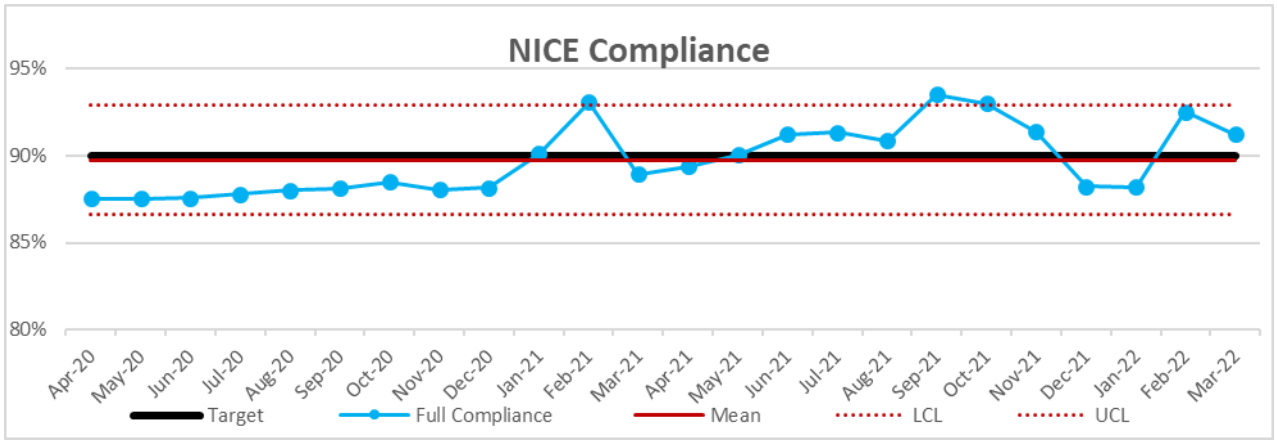
Most GIRFT activity by the regional NHS E/I teams has been paused, with the exception of two virtual reviews and one data request (details below):

- In October 2021 the NHSE/I GIRFT team undertook a virtual review of Urology services within the Trust and across the region. The Trust received positive feedback during the process and are awaiting the final report.
- In Trauma and Orthopaedics a virtual review was undertaken in October 2021, by virtue of submission of a survey. The Trust has received no further requests for information following this review and is currently awaiting the outcome. The outcomes for these reports have been delayed due to the pandemic.
- A further dataset was submitted to NHSE/I for high volume, low complexity surgery to support the GIRFT Demand and Capacity waiting list workstream in February 2022.

Throughout 2021/2022 the national GIRFT programme continued to analyse data and provide GIRFT national speciality reports which have been shared with all specialties. The national reports have provided a useful benchmark until the full programme recommences, which have been shared at local governance meetings.

Demonstrate that health care is based on the best available evidence from NICE - Implementation and Performance:

NICE guidance is applied to support the improvement of clinical outcomes using evidence-based practice. The graph below details the Trust compliance against the 90% required target. The graph below demonstrates a positive increase in overall compliance for NICE over the last 12 months.



CBU Governance will be further strengthened and embedded consistently and effectively across all areas

CBU Governance to be strengthened - Background:

CBU Governance will be further strengthened ensuring consistency across the organisation to ensure that there is no unnecessary variation in the quality of care provided. It will also emphasis learning as part of the Trust learning framework to optimise opportunity to continually improve clinical practice Trustwide.

How progress will be monitored, measured and reported:

Patient Safety & Clinical Effectiveness Sub-committee

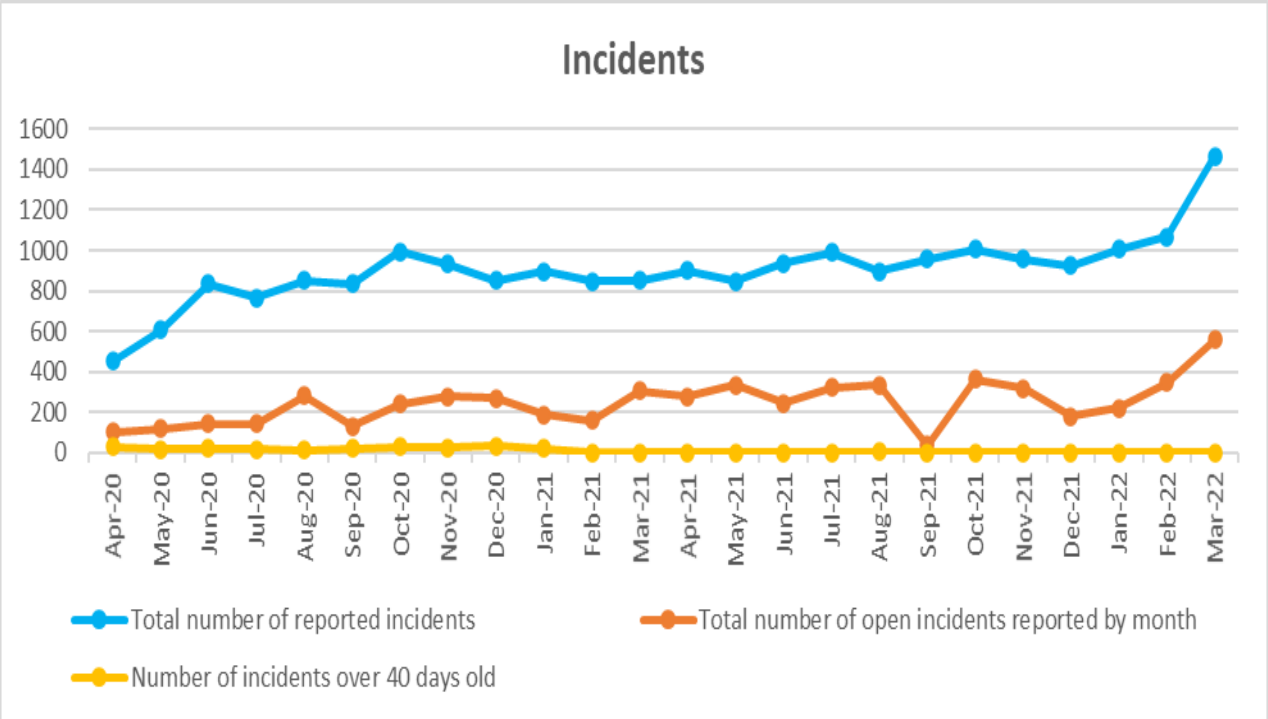
CBU Governance to be strengthened ensuring consistency across the organisation. Clinical governance aims to shift the performance of all health organisations closer to the standards of the best. It hopes to reduce unjustifiable variations in quality of care provided.

A quarterly Quality Report is presented to the Quality Assurance Committee that will track milestones for the Quality Account priorities.

CBU Governance to be strengthened - Implementation and Performance:

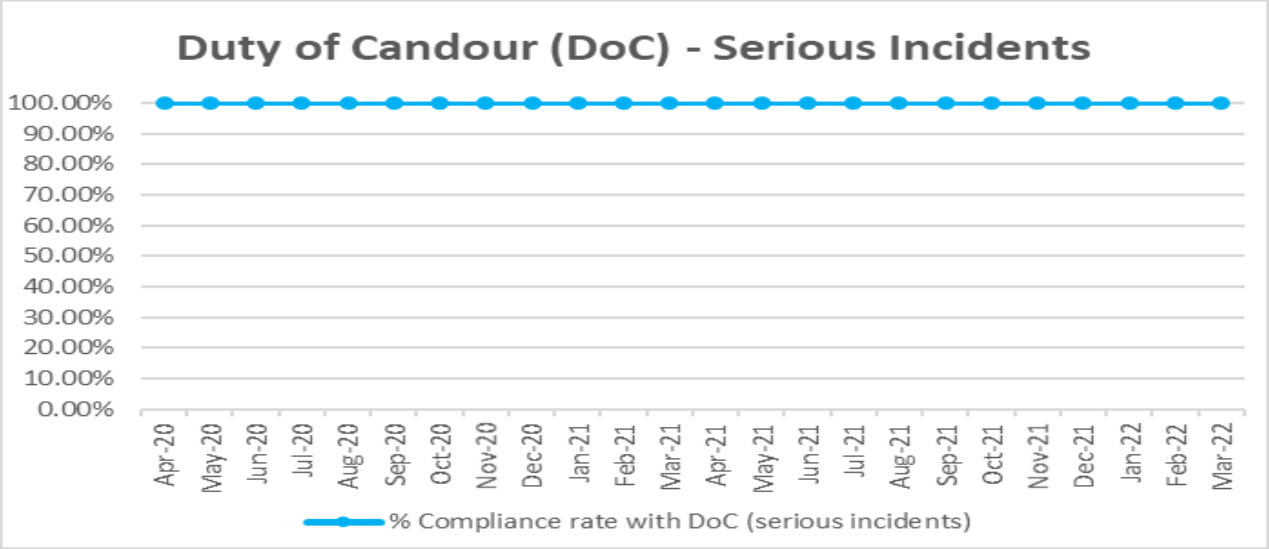
Incidents

The data demonstrates that the Trust has a positive culture of incident reporting as indicated in the graph below. There is robust monitoring of grading of incidents to confirm validation of the level of harm. In addition, incidents are monitored weekly via the governance framework.



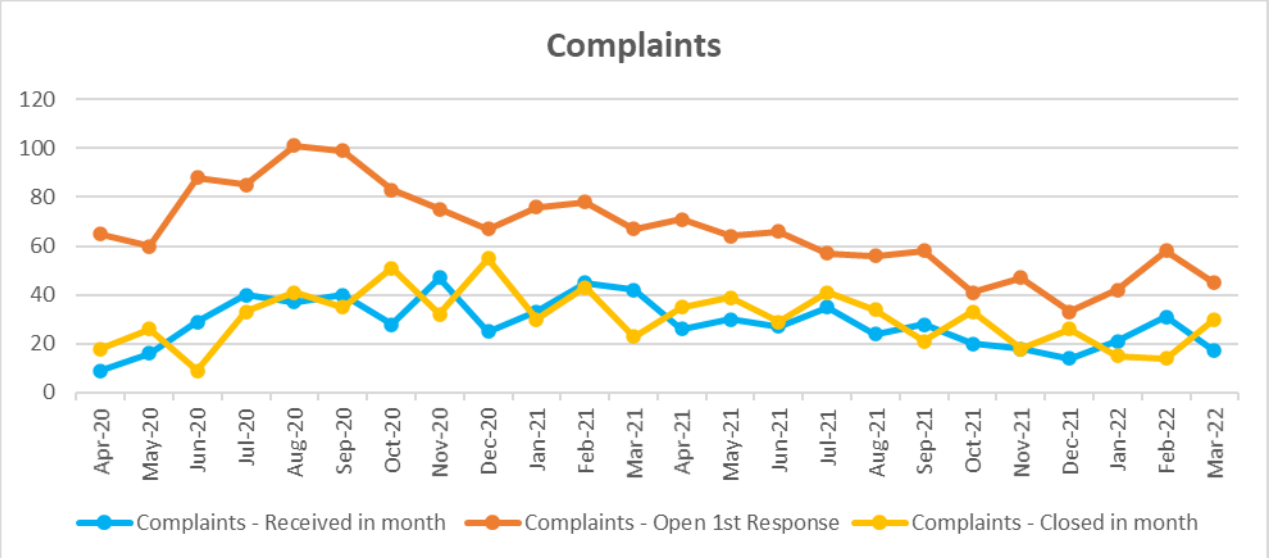
Duty of Candour

The Trust has achieved 100% compliance with notifying a patient of a verbal and written Duty of Candour (DoC) within 10 working days after becoming aware that a notifiable safety incident has occurred. This is a key focus for each CBU ensuring that early high quality conversations with families are had.



Complaints

A key focus has been to reduce the number of formal complaints in order to optimise patient or relative experience. This is evidenced through the number of complaints received. The table below notes the number of complaints opened and closed. This increase in performance is largely attributed to engagement from each of the CBUs to support with timely resolution and focus on the quality of responses provided. All complainants are initially offered a meeting with the relevant teams to facilitate a supported approach.



Risk Management and Governance

A key focus was to review risk management within the Trust to ensure the following:

- The risk processes and risk registers are continually monitored by the CBU Governance meetings and the Trust monthly Risk Review Group.
- Risk registers are updated regularly and kept in date.
- There is a positive and open risk management culture throughout the Trust.
- Staff are aware of the process for the management of risk at a local and Clinical Business Unit (CBU) level.
- Identification of any training needs i.e., Risk Assessment Training.
- Planned training is in progress for 2022 via formal risk management training.

Priority 3 – Patient Experience - We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for

Improve patient experience by enhancing the standard of nutrition and hydration

Work has continued to ensure the delivery of the recommendations outlined in the "Independent Review of NHS Hospital Food" report, although COVID-19 and operational pressures have impacted on delivery timescales. This is monitored via an action plan at the WHH Expert Food Panel, ensuring that hydration and nutrition continue to remain an integral element of the patient experience quality priorities for 2021-22.

The Expert Food Panel following a review of its Terms of Reference convenes in a multi-disciplinary approach to ensure that through discussion an inclusive style is adopted. This triangulates into an action plan that focuses on improvements in patient care, wellbeing and experience.

The expert food panel adopted a three-phase approach to drive improvements in nutrition and hydrations, they include:

- **Phase 1 –** A communication piece to ensure all wards and departments are aware of 'the offer' to patients' meals, this includes the process to follow for supplementary menus and special diets, e.g., cultural requirements. This is currently ongoing into quarter 4 with a standard operating procedure (SOP) being designed for the service of food at ward level.
- **Phase 2 –** Review of the current catering questionnaire to gain qualitative feedback from patients. This includes the implementation of questionnaires in accessible formats (e.g., Easy Read) to ensure feedback is received from all patient groups.

- **Phase 3 –** Begin to utilise feedback received through phase 2 to enhance the Expert Food Panel action plan to meet improvements, with the patient voice driving change.

The National Adult Inpatient Survey 2020 results highlighted focused improvement is still required on nutrition and hydration. The quantitative findings and subsequent comments report have been incorporated into the action plan for the Expert Food Panel and further details related to dietetics will be shared through the Trust Nutritional Steering Group by the Patient Experience and Inclusion Team.

Additional progress to date against the action plan in place includes:

- Patient nutritional and hydration needs is a standing item on key meetings within the Trust including the Patient Experience Sub Committee.
- Review of the Catering Policy
- A 1.8million capital bid has been secured in order to upgrade the kitchen on the Warrington site.
- The introduction of snack boxes for adults and "pizza take out" for children's ward to support patient choice.
- Food tasting with key stakeholders – Board members, Governors, Patient Experience and Inclusion Team to support ongoing improvements.

End of Life – Serious Illness Programme; Better Communication and Better Care for those sadly reaching the end of life.

End of Life Serious Illness Programme Background:

The Serious Illness Care Programme - Better Communication, Better Care - is a system-level intervention designed to improve the lives of people with a serious illness by optimising the timing, frequency, and quality of serious illness conversations.

Comprising clinical tools, training, support, and systems innovations, the programme empowers patients to actively participate in planning for the future with their illness. It enables clinicians and other professionals in the wider healthcare system to personalise care according to the goals and priorities of individual patients.

Effective communication is key to ensuring that a patient feels empowered to input into their healthcare needs and to ensure that they understand the discussion that has taken place.

End of Life Serious Illness Programme - How progress will be monitored, measured, and reported:

End of Life Care Steering Group Monthly

A quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities

End of Life Serious Illness Programme - Implementation and Performance:

Due to staffing pressures relating to the COVID-19 pandemic, this priority has not progressed.

Learning Disability Strategy and Mental Health Strategy - Implementation of the Trust Learning Disability Strategy.

Learning Disability and Mental Health Strategy Background:

Implementation of the Learning Disabilities Strategy aspires to ensure that the needs of people with learning disabilities and autism are met to the highest standard, optimising clinical outcomes and patient experience.

Implementation of the Trust Mental health strategy will evidence that dedicated mental health and psychology provision as part of an integrated service can substantially reduce poor health outcomes and increase the quality of Mental Health Act provision.

Learning Disability and Mental Health Strategy: How progress will be monitored, measured and reported:

- Safeguarding Committee.
- Patient Safety & Clinical Effectiveness Sub-committee
- Quality Assurance Committee.
- Patient experience survey

Learning Disability and Mental Health Strategy: Implementation and Performance:

WHH has a Learning Disability Strategy and Mental Health Strategy in place to ensure the delivery of safe care for our patients, optimising health outcomes. This is a three year strategy and implementation will continue in 22/23 as part of the Trusts focused work on Quality Priorities.

The strategy has been supported by training opportunities to support staff in the delivery of care at levels 1, 2 and 3. The training compliance is ahead of trajectory with positive evaluation. Areas across the Trust are supported through LD and MH champions who disseminate learning and offer specialist advice.

- WHH has also introduced Makaton Monday weekly sessions which are provided via the Trust Wide Safety Brief. These have been well received.
- WHH has a robust alert system in place to ensure that patients with LD, MH challenges and autism are promptly identified through the EPR system enabling the provision and delivery of timely and specialist care as required. ICE notifications are also utilised to ensure Safeguarding support is sought for patients who are under the Mental Health Act. WHH continue to attend
- the Warrington LD board, the Cheshire and Merseyside LD Improvement Group, regional LD network and transition meetings, thus supporting wider learning for continual improvement.

2.3 Improvement Priorities and Quality Indicators for 2021/22 - How we identify our priorities – stakeholder engagement

The Trust has a duty to fully engage with stakeholders and members to ensure that we are listening to their views on quality and quality priorities moving forward. The priorities have been identified through receiving feedback and regular engagement with governors, staff, patients, the public, and commissioners of NHS services, overseeing scrutiny groups and other stakeholders. Progress on the planned improvements are reported through the Trust's Quality Assurance Committee and ultimately through to Trust Board.

Our staff, governors, members and patients are the eyes and ears of the organisation and their views are constantly sought to ensure that we are focussing on the things that will make the most difference. We surveyed staff, patients and visitors, through the Staff Survey and the Friends and Family Test and from those results we capture the views of the staff and wider public in relation to the range of priorities.

2.4 Improvement Priorities for 2022/23

The Trust Board, in partnership with staff and Governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2022/23 will continue to be:

We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.

We will improve outcomes, based on evidence and deliver care in the right place, first time, and every time.

We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for.

In order to embed the above improvement priorities, we have established nine local quality indictors to support their implementation.

Patient Safety –

We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority.

Continue to develop models of waiting list management in line with national guidance ensuring appropriate clinical prioritisation.

1. Continue to undertake clinical triage process.
2. Continue to undertake harm review process.
3. Continue to report for assurance via Clinical Oversight Group and Quality Assurance Committee.

Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework.

1. Ensure a patient safety culture continues to be embedded across the organisation in accordance with the requirements of the patient safety strategy and alterations to the investigation process utilising new methodologies.
2. Evidenced through the use of incident reporting, learning, risk management and triangulation of clinical governance.
3. Evidenced through implementation of a learning framework.

Clinical Effectiveness –
Ensuring practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients.

To evidence a culture of quality, safety and learning across clinical services

1. Implementation and Audit of LOCSIP safety standards which apply to invasive procedures
2. Audit of WHO checklist effectiveness and with evidence of effective operative debriefs delivering effective learning, team culture and improvement.
3. Improve safety through delivery and evaluation of human factors training.

Discharge processes will be strengthened to improve the quality of discharge to home and community providers

1. Ensuring early measures are in place to facilitate timely discharge, improving length of stay with data presented by each ward.
2. Patients will be partners in their care through communication and information sharing, measured through survey feedback.
3. Plan for discharge from the point of admission with effective management of EDDs identified at Board rounds and high quality discharge summaries.

Patient Experience –

By focusing on patient experience, we want to plan the quality of patient experience at the heart of all we do, where “seeing the person in the patient” is the norm.

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Nutrition and Hydration – ensuring patients receive and are supported to optimise dietary and hydration needs.

1. Implement and monitor the action plan to deliver the outlined recommendations of the 2020 'Independent Review of NHS Hospital Food' report ensuring access to high quality food and choice supported by an independent industry expert.
2. To ensure all patients hydration needs are met and monitored in accordance with their health needs, utilising ward-based quality metrics.
3. Refresh and implement the Nutritional Care Strategy in collaboration with patients.

Ensure the Mental Health and Learning Disability Strategies are implemented Trust wide.

1. Audit the use of patient's passports by Care Group via the Learning Disability and Mental Health Steering Groups.
2. Evidence effective and robust alert processes for the Trust EPR system.
3. Competency based training for Learning Disability, Autism and Mental Health to be available for all staff groups in the Trust.

Through patient centred communication and service development address inequalities for access to health.

1. Work with partners to support our population to access preventative and early intervention services specific to the needs of each person through the co-design of digitally enabled services.
2. Deploy and audit the accessible information standards policy across WHH.
3. Monitor and deliver against the First Impressions project – listening and improving the experience for patients, service users, their families, carers and our workforce.

2.5 Local Quality Indicators 2022/23

The Trust Board, in partnership with staff and Governors, has reviewed performance data relating to quality of care and have agreed that in addition to our improvement priorities our quality indicators for 2022/23 will include:

Local Quality Indicators 2022/23
CCG1: Flu vaccinations for frontline healthcare workers
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
CCG4: Compliance with timed diagnostic pathways for cancer service
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle
CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery
CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service.
CCG8: Supporting patients to drink, eat and mobilise after surgery
CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients

2.6 Statements of Assurance from the Board

During 2021/22, the Warrington and Halton Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted seven relevant health services.

The Warrington and Halton Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the NHS services reviewed in 2021/22 represents 100 per cent of the total income generated from the provision of relevant health services by the Warrington and Halton Teaching Hospitals NHS Foundation Trust for 2022/23.

2.7 Data Quality

The data is reviewed by the Board of Directors in the form of a Quality Dashboard. The data reviewed covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Our success in achieving the improvement priorities will be measured, where possible, by using nationally benchmarked information from the NHS Information Centre; Healthcare Evaluation Data (HED system); Advancing Quality Alliance (AQuA); NHS England datasets including the Safety Thermometer; Friends and Family, Dementia and VTE Risk Assessments and national survey results. WHH also uses measurement tools that are clinically recognised for example the Pressure Ulcer Classification Tool of the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP).

The processes that we use to monitor and record our progress has been audited by Mersey Internal Audit Agency to provide assurance on the accuracy of the data collection methods employed.

2.8 Participation in National Clinical Audits and National Confidential Enquiries 2021/22

During 2021/2022, **31** National Clinical Audit Programmes covered relevant health services that Warrington and Halton Teaching Hospitals NHS Foundation Trust provides. The National Clinical Audits Warrington and Halton Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2021/22 were as follows: -

HQIP ID	National Clinical Audit	Participated	Data Collected	Stage / Number / or % of cases submitted 2021/2022
1	Case Mix Programme (CMP)	Yes	Yes	100% (871)
3	Chronic Kidney Disease registry	Yes	Yes	100%
5	Elective Surgery - National PROMs Programme	Yes	Yes	EuroQol-visual analogue scales (EQ VAS) modelled records for 2020 Hip replacement primary 89 - not an outlier Hip replacement revision 3 (insufficient records) Knee replacement primary 127 - not an outlier Knee replacement revision 3 (insufficient records) Total Hip replacement 92 - not an outlier Total knee replacement 132 - not an outlier
6	Emergency Medicine QIPs: Pain in Children	N/A	N/A	Audit did not run
6	Emergency Medicine QIPs: Severe sepsis and septic shock	N/A	N/A	Audit did not run
7	Falls and Fragility Fractures Audit programme (FFFAP): National Audit of Inpatient Falls	N/A	N/A	Audit did not run
7	Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	Yes	Yes	100% (333)
8	Inflammatory Bowel Disease (IBD) Registry	Yes	Yes	Ongoing data collection 290 submitted
10	Maternal, New-born and Infant Clinical Outcome Review Programme	Yes	Yes	100% (20)
13	National Diabetes Audit: National Diabetes Core Audit	Yes	Yes	100% (1183)

HQIP ID	National Clinical Audit	Participated	Data Collected	Stage / Number / or % of cases submitted 2021/2022
13	National Diabetes Audit: National Pregnancy in Diabetes Audit	Yes	Yes	100% (10)
13	National Diabetes Audit: National Diabetes Footcare Audit	Yes	Yes	Ongoing data collection 138 submitted
13	National Diabetes Audit: National Inpatient/Harms	Yes	Yes	Ongoing data collection 15 submitted
14	National Asthma and Chronic Obstructive Pulmonary Disease Audit: Paediatric Asthma Secondary Care	Yes	Yes	Ongoing data collection 19 submitted
14	National Asthma and Chronic Obstructive Pulmonary Disease Audit: Adult Asthma Secondary Care	Yes	Yes	Ongoing data collection 113 submitted
14	National Asthma and Chronic Obstructive Pulmonary Disease Audit: Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Yes	Ongoing data collection 358 submitted
14	National Asthma and Chronic Obstructive Pulmonary Disease Audit: Pulmonary Rehabilitation-Organisational and Clinical Audit	Yes	Yes	Ongoing data collection 18 submitted
15	National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Ongoing data collection 210 submitted
16	National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	Ongoing data collection 669 submitted
19	National Audit of Dementia	N/A	N/A	Audit did not run
21	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	Ongoing data collection 49 submitted
22	National Cardiac Arrest Audit (NCAA)	No	No	WHH formally withdrew from the National Cardiac Arrest Audit due to Covid-19 pressures.
23	National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management	Yes	Yes	Ongoing data collection 219 submitted
23	National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project	Yes	Yes	Ongoing data collection 516 submitted
23	National Cardiac Audit Programme (NCAP): National Heart Failure Audit	Yes	Yes	Ongoing data collection 478 submitted
26	National Comparative Audit of Blood Transfusion:	No	No	WHH did not participate due to

HQIP ID	National Clinical Audit	Participated	Data Collected	Stage / Number / or % of cases submitted 2021/2022
	2021 Audit of Patient Blood Management & NICE Guidelines			Covid-19 pressures.
26	National Comparative Audit of Blood Transfusion: 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery			Audit did not run
27	National Early Inflammatory Arthritis Audit	Yes		Data collection has just been reinstated
28	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Ongoing data collection 124 cases submitted
29	National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer	Yes	Yes	<65% - our case ascertainment figure is currently being reviewed by NHS Digital
29	National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit	Yes	Yes	Ongoing data collection 83 submitted
30	National Joint Registry (NJR)	Yes	Yes	97.7% better than expected (664)
31	National Lung Cancer Audit (NLCA)	Yes	Yes	WHH does not perform surgery, but does refer patients to the Royal Liverpool surgical unit: There were 423 surgical resections in the 2018 cohort
32	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100% (2075)
33	National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100% (422)
34	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Ongoing data collection 137 submitted
36	National Prostate Cancer Audit	Yes	Yes	Ongoing data collection 119 submitted
42	Respiratory Audits: National Outpatient Management of Pulmonary Embolism	Yes	Yes	100% (17)
42	Respiratory Audits: National Smoking Cessation 2021 Audit	Yes	Yes	100% (20)
43	Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	80-89% Cases Q1 2021 band A
44	Serious Hazards of Transfusion	Yes	Yes	100% (4)
47	The Trauma Audit & Research Network (TARN)	Yes	Yes	83% better than expected (212)

HQIP ID	National Clinical Audit	Participated	Data Collected	Stage / Number / or % of cases submitted 2021/2022
48	UK Cystic Fibrosis Registry	Yes	Yes	100% (26)

National Confidential Enquiries

During 2021/22 there were 7 NCEPOD studies, of which WHH were eligible to participate in the following 5:

	National Confidential Enquiries
1	Heart Failure
2	Alcohol related Liver Disease
3	Pulmonary Embolism
4	Epilepsy
5	Out of Hospital Cardiac Arrest

2.8.1 National Clinical Audit

The reports of 13 National Clinical Audits were reviewed by the provider in 2021/2022 and Warrington and Halton Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit Title	Quality Improvement Action Plan
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme. 2021 data	4 relevant incidents were identified as categorised below using the SHOT reporting categories: **Right Blood, Right Patient** **ADU (Avoidable, Delayed, Under/Over Transfused)** **Procedural Error** **HSE (Handling and storage error)** Actions are in place following lessons learnt regarding assurance of checking, labelling and prescribing. Learning is utilised in training sessions for new staff also.
National Maternity and Perinatal Audit (NMPA) 2017-2018 data	• Induction of labour audit (against NICE guidelines) • Evaluate Vaginal birth after caesarean birth (VBAC)

National Audit Title	Quality Improvement Action Plan
	service
National Paediatric Diabetes Audit (NPDA) 2019-2020 data	• Training patients for carbohydrate counting at diagnosis. Participate in Royal College of Paediatrics and Child Health (RCPCH) Quality Improvement study • Diabetes eye • Continued monitoring for coeliac screening at diagnosis
National Audit of Breast Cancer in Older People (NABCOP) 2014-2018 data	• Audit of reoperation rates after breast conserving surgery
National Audit of Cardiac Rhythm Management (CRM) 2019-2020 data	• 100% compliance with NICE (TA324 and TA 88) alongside actions for learning
Adult Asthma (NACAP) 2019-2020 data	• Asthma Advanced Nurse Practitioner • Asthma clinic for Fractional exhaled Nitric Oxide (FENO) testing as per NICE
National Joint Registry (NJR) 2019-2020 data	• National audit confirms positive results • Hip: Patient reported improvement measure and outcomes quality measure, within the expected range. High compliance (98%) with NICE primary recommended implants • Knee: Patient reported improvement measure and outcomes quality measure within the expected range.
Maternal, New-Born and Infant Clinical Outcome Review Programme (MBRRACE) - Maternal Deaths 2016-2018 data	• Audit looking at smoking rates, intended place of birth at booking and expected date of delivery
Myocardial Ischaemia National Audit Project (MINAP) 2019-2020 data	• Angiography pathway with Liverpool Heart and Chest Hospital
National Diabetes Inpatient Audit (NaDIA) 2019 data	• Hypoglycaemic rescue and Diabetic Keto acidosis was appropriately treated. • No hyperosmolar and Diabetic new foot ulcer cases reported within the audit periods
Non-Invasive ventilation (NIV) 2018-2019 data	• Compliance with national NIV treatment guidelines
Royal College of Emergency Medicine (RCEM): Mental Health 2019-2020 data	• Mental health triage form in Emergency Department and Core 24 service well established
National Diabetes Inpatient Audit (NaDIA) 2019 data	• Hypoglycaemic rescue and Diabetic Keto acidosis was appropriately treated • No hyperosmolar and Diabetic new foot ulcer cases reported within the audit period

2.8.2 Local Clinical Audit

The reports of 74 local clinical audits were reviewed by the provider in 2020/2021 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Title of Audit	Action
Clinical Support Services	
Audit of Reporting of Liver Biopsies	• Reporting processes reviewed • Clinicopathological correlation
Administration of Blood Audit: Bedside Practice	• All Transfusions to be given through a pump
Applying the Paris System for Reporting Urinary Cytology	• Paris System as reporting standard for urine Cytology • Implement TPS as reporting standard for urine cytology
Audit of accuracy of Gentamicin Dosing Within WHH	• Gentamicin calculator at Safety Brief
Clinical Audit to Review Prescribing and Administration of Medicines by Qualified Physician Associates at the Trust	• Physician Associate Governance Framework • Clinical supervision sessions to ensure best practice and learning
Evaluating the Prevalence and Effectiveness of the Anticholinergic Burden (ACB) Score Reduction in Patients Admitted Following a Fall	• ACB screening tool with IT to automatically calculate ACB to be used by pharmacists, pharmacy technicians, medical staff, and the frailty team & showcase to staff
Dental X-ray Quality Audit	• Circulation of information to support improvements • Clear annotations to be circulated
Re-Audit of Compliance with WHH Lung Cancer Imaging Pathway	• Prompt escalation and review
Adequacy of Magnetic Resonance Imaging of the Shoulder Re-Audit	• Improvement in the coverage parameter as depicted by the European Society of Musculoskeletal Radiology (ESSR) guidance • Use of correct imaging planes as depicted by the ESSR guidance • All patients must have their arms in the mid-external rotation if able
Re-Audit of Reporting Profiles in Cervical Biopsy Reporting	• Inform individual pathologists of their results) • Re-audit on a yearly basis
CT Dose Survey: Paediatric Head	• No actions required
Discrepancy Rates for Trauma CT Reporting at the Regional Radiology	• Presentation at departmental audit meeting

Title of Audit	Action
Hub	
Re-Audit of free foetal DNA (ffDNA) Compliance for RhD Negative Women During Pregnancy	• No actions required
Corporate Services	
7 Day Services Clinical Standard 2 Audit: Time to Consultant Review: 14 hours - Paediatrics	• Develop a Standard operating procedure (SOP) outlining which paediatric patients can be considered low-complexity, and thus not in need of consultant review
Discharge Summaries	• Discharge Summary teaching to FY1 doctors should draw on the findings of this audit; include examples of discharge summary completion on a mock patient on Lorenzo • Review Inpatient E-Discharge Summary form with IT team to enable higher compliance with completion • Liaise with Operational Safety Group and Discharge Planning improvement workstream to agree process for nursing discharge documentation • Disseminate key points at safety huddle at doctors' shift handovers • Link in with Discharge planning improvement workstream to coordinate improvement of the discharge process overall including timely completion of the Discharge Summary • Liaise with Medicines Improvement Group to improve discharge medication information and changes to medication information • Re-audit in 3 months with amended audit tool
Enhanced Care Audit	• Identify wards where compliance fell below expected standard to provide tailored support/education • Re-audit as per policy
Falls Policy Audit	• Repeat falls policy audit bi-yearly to monitor compliance • Trust wide falls walk rounds to be completed to highlight areas of concern/ share good practice
Fluid Balance	• Create new audit tool proforma • Create new fluid balance guidelines • Implement new fluid balance guidelines
Trust Wide Record Keeping Audit	• Share single point lesson on standards of record keeping with the ward managers for dissemination • Lead nurses to note the additional audit and progress in their HLBP until associated actions complete • Documentation audit & ward audit & associated actions to be shared at Governance meetings
Do Not Attempt Cardiopulmonary	• No actions required

Title of Audit	Action
Resuscitation (DNACPR)	
Digestive Diseases	
7 Day Services Clinical Standard 2 Audit: Time to Consultant Review: 14 hours - Surgery	• Develop a Standard Operating Procedure (SOP) to delegate review of certain categories of admission to the Surgical Registrars (such as head injuries, simple rib fractures and abscesses) • Facilitate a more user-friendly IT interface for doctors to a) become aware of time of decision to admit and b) easily document consultant reviews in real time
Management of Acute Cholecystitis, Gall Stone Pancreatitis and Biliary Colic During COVID-19 Pandemic.	• Extra weekend and evening cholecystectomy lists • Clinical priority coding to be introduced • Utilise a green surgical elective pathway • Increase awareness among surgeons to perform hot gallbladder on emergency list
Photo-documentation in Upper GI Endoscopy (Re-Audit)	• Present and make sure that endoscopists are aware of the updates from the British Society of Gastroenterology (BSG) guidelines
Post operative handover between the anaesthetist and Post Anaesthesia Care Unit (PACU) and the continued care of the patient in PACU ready for discharge to the ward	• Re-instate the sticker (cannula flushed) to be signed in recovery
Datix Reporting	• Departmental education about incident reporting system, how the system works
Antibiotic Prescribing for Acute Cholecystitis and Adherence to the Local Trust Formulary: An Audit in Warrington Hospital	• EPMA changes • Audit Presentation
TIVA Snapshot Audit	• No actions required
Integrated Medicine & Community	
A Re-Audit to Assess the Prevalence and Management of Pressure Ulcers and Moisture Lesions in Elderly Patients	• All nursing staff in wards B12 and B14, to have a small session in where the importance of documenting adequately in the individualised care plan must be emphasised (completed)
Pulmonary Embolism in COVID-19-19 Positive Patients Undergoing Computed Tomography Pulmonary Angiography (CTPA)	• No actions required

Title of Audit	Action
Medical Care	
An Audit to Assess the Recognition and initial management of Acute Kidney Injury (AKI) among medical admissions in Acute Medical Unit	• Monitor completion of fluid balance • Implementation of AKI care Bundle in the trust policy
Audit of National Early Warning Score (NEWS) 2	• Decide at which point (in seniority) doctors and advanced clinicians such as Advanced critical care practitioners (ACP's) can make modifications to frequency/targets for physiological observations, adjusting the policy if indicated
Diabetic Inpatient Medication Errors	• Intensive Care Unit to use the same E-prescribing system as wards • Reinstate Diabetes Educator
Spot Audit Diabetic Inpatient Care	• Safety brief on the need to lock away insulin for inpatients
Seniority of Staff Undertaking Advanced Airway Management in Patients Suffering COVID-19-19 and Complications Arising	• No actions required
Your COVID-19 Recovery Website Usage for Management of Long COVID-19	• No actions required
Prescription of Medications in Acute Coronary Syndrome (ACS) Patients in the Acute Setting	• Follow the new order set completed to ensure timely prescription of ACS medications.
Surgical Specialties	
Audit on Thyroid Surgeries	• No actions needed – all British Association of Endocrine & Thyroid Surgeons (BAETS) standards met
Outcome Of Redesigned Paediatrics Referral Pathway	• Update wording on Health Visitor referral pathway to support triaging children < 2 years of age to a face-to-face clinic for their first appointment, if indicated
Quality standards for Neuro-Ophthalmology	• Review orthoptic-led neuro-ophthalmology guidelines and update on the Intranet Hub
Audit to Assess How Radiographs are Reported at Warrington and Halton Orthodontic and Maxillofacial Departments, March 2021	• Clinicians to start recording of the Quality Assurance grade of the radiograph they have requested • Improvement in compliance for examine the requested radiographs and record the findings in the patient's notes
Amblyopia Audit – Orthoptic Treatment Guidelines	• Update sbisa bar guidelines to be in line with British and Irish Optics Society (BIOS) guidelines

Title of Audit	Action
Atropine Audit: Compliance with local Guidelines and the Vision Outcomes of Amblyopic Children who are Treated with Atropine	• To create an amblyopia proforma/checklist to be used on Medisight
Are we Data Safe Whilst in Hospital	• Education – to spread the message via common email, IT Training and Stickers on Computers • Request support for IT Induction to be emphasising data security • Request Imprivata
British Orthopaedic Association Audit Standard for Trauma (BOAST) Ankle Audit	• Review and update department ankle fracture guidance by the foot and ankle team • Re-audit in 12 months as per BOAST guidance
Spinal Audit – Compliance with the Cauda Equina Pathway; 2nd Cycle	• Clearly display pathway in Majors area • Presentation on Cauda Equina Neurological Examinations to be delivered • To clarify the GP referrals and SHOs to reiterate written handover from GP with neurological findings
Management and follow up of Patients with Ureteric Stents at WHH	• Ensure current literature from BAUS and EIDO are present on the hub to be provided on discharge • Re-audit once other actions are implemented
Hip & Knee Arthroplasty Surgery Documentation	• Share information required to document with all lower limb consultants so they can include in their operation note templates
COVID-19-19 Cases in Sir Tom Moore Building (formerly known as the Cheshire and Merseyside Treatment Centre)	• No actions required
New and Follow Up Head and Neck Cancer Patients During the COVID-19-19 Pandemic	• No actions required
Integrate COVID-19-19 Ears, Nose & Throat (ENT) Emergency Care Audit	• No actions required
COVID-19 Minor Trauma Snapshot	• No actions required
Compliance of Ophthalmology Local Safety Standard for Invasive Procedures (LocSSIPs)	• Redesign the Ophthalmology LocSSIP's in line with Trust standards • Send updated locSSIP for central logging of all Trust approved lOcSSIP's • Complete audit registration
Audit of Outcomes Following Surgical Revision of Dislocation of Primary Hip Arthroplasty.	• No actions required

Title of Audit	Action
Listing for Lower Third Molar Removal – Are We Conforming to the Norm Part 2 - Re-Audit	• No actions required
Microsuction of the Ear Canal as an Aerosol Generating Procedure (AGP)	• No actions required
Hot Joint Referrals to Trauma & Orthopaedics	• No actions required
Urgent & Emergency	
Review of standard 1 of the NICE Guideline CG143– Pain Relief for Patients Presenting with Acute Sickle Cell Crisis	• Inform staff of the pathway and for multimodal analgesia • Reiteration of pain scoring in triage • Organise a 'TED Talk' on Sickle Cell Crisis
The Management of Ankle Fractures Presenting to Warrington A&E	• A re-audit will then be performed to assess if this has been successful in reducing
WHH Adherence to Royal College of Emergency Medicine (RCEM) Standards of Care for Fracture Neck of Femur (#NOF)	• Safety brief • To ensure training of all new Emergency Department Senior House Officers in Fascia Iliaca Block (FIB) application • Discuss addition of pain re-evaluation column into #NOF pathway in audit meeting
Pulmonary Embolus Audit	• Disseminate findings of poor Wells and Pulmonary Embolism Rule-out Criteria (PERC) scoring at audit meeting and safety briefs
Women & Children	
Post Operative Caesarean Section Analgesia	• change prescribing set on Lorenzo in conjunction with E-prescribing lead and Pharmacy so Non-Steroidal Anti-Inflammatory Drugs (NSAID) are prescribed regularly • Discuss options with Pharmacy as this drug is not always needed but if so, prescription should be regular • Add laxative to prescription set
Audit of Continuous Antenatal Risk Assessment During the Maternity Pathway	• Spot check audits to be completed by midwifery managers to monitor improvement in compliance
Induction of Labour (IOL) 3-month Audit	• Produce a 1-page prompt sheet of reasons for IOL and appropriate gestations for IOL. This will be laminated and displayed in Ante natal rooms, Triage and Delivery Unit • Update the Trust IOL guideline with the new national RCOG guideline
Referral pathways to Out-Patient	• Coil clinic to commence on a weekly basis, currently clinics are set up and ready for patients to be booked

Title of Audit	Action
Hysteroscopy Service for intrauterine Contraceptive Device (IUCD) Insertion/Removal Audit	into
Injuries in Under 1's Presenting to the Emergency Department	• Guidance on injury in the non-ambulant child to be reissued and communicated
Intra Venous Fluids Therapy in Children and Young People in Hospital	• Review and update IV Fluids guideline (no major changes expected) • Ensure Fluid calculations and choices are on Induction Programme
Management of Healthy Breast Fed Babies Admitted with Weight Loss	• Create referral pathway to Paediatric Acute Response Team for follow up of babies admitted with weight loss • Develop E-learning Tool to promote correct prescribing • Disseminate the audit finding to community midwives and nursing staff • Develop a proforma for new-born babies admitted with weight loss more than 10%
Maternity Safeguarding Note Audit	• Managers to share learning with staff via ward safety briefs to screen for domestic abuse at every opportunity and how document appropriately in the records • Senior managers to share in safety briefs reminding staff to add safeguarding stickers to records and how to apply a correct Lorenzo alert • All staff to attend domestic abuse training to ensure they are aware of how to screen, document and why this is required
Neonatal Cooling Treatment Audit	• Actions from the Healthcare Safety Investigation Branch (HSIB) recommendations monitored through CBU governance • Ensure robust system for timely follow ups for all cases is developed • Ensure appropriate local investigation for babies not investigated by HSIB • Update the Difficult Intubation Pathway
Paediatric National Early Warning Score (PEW's) and Escalation Audit	• Single point lesson through departmental newsletter to raise awareness regarding importance of documentation and escalation of PEWS chart by • Trust wide safety brief to be used to raise awareness about importance of using PEWS chart for recognising a sick child before they deteriorate
Meningitis Paediatric Patients Referred for Audiology Assessment	• No actions required
Infectious Diseases in Pregnancy Screening Programme	• No actions required

Title of Audit	Action
Fetal Anomaly Screening Programme	• No actions required
Diagnosis and Management of Meningitis	• To include neonatal meningitis e-module for new doctors at induction

2.9 Participation in Clinical Research and Development

The number of patients receiving NHS services provided or sub- contracted by Warrington and Halton Teaching Hospitals NHS Foundation Trust in 2021/22 recruited to participate in research approved by a research ethics committee was 662. Please find these studies listed in the table below:

Study Type	Study Sponsor	Short Name	Study Title	Recruits
Commercial	VALNEVA	COV-COMPARE Immunogenicity of vaccine VLA2001 compared to AZD1222	A RANDOMIZED, OBSERVER-BLIND, CONTROLLED, SUPERIORITY STUDY TO COMPARE THE IMMUNOGENICITY AGAINST COVID-19, OF VLA2001 VACCINE TO AZD1222 VACCINE, IN ADULTS INCLUDING A RANDOMIZED, OBSERVER-BLIND, PLACEBO CONTROLLED PART IN ADOLESCENTS (~12 TO <18 YEARS)	160
Commercial	SANOFI	Booster Dose of SARS-CoV-2 Vaccine with Adjuvant	Immunogenicity and Safety of SARS-CoV-2 Recombinant Protein Vaccines with AS03 Adjuvant in Adults 18 Years of Age and Older as a Primary Series and Immunogenicity and Safety of a Booster Dose of SARS-CoV-2 Adjuvanted Recombinant Protein Vaccines (two Monovalent and one Bivalent)	31
Non-Commercial	University of Oxford	Clinical Characterisation Protocol for Severe Emerging Infection	Clinical Characterisation Protocol for Severe Emerging Infection	346
Non-Commercial	NHS Lothian	GenOMICC	Genetics of susceptibility and mortality in critical care (GenOMICC)	18
Non-Commercial	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	The 'Big Baby Trial'	Induction of labour for predicted macrosomia	4

Study Type	Study Sponsor	Short Name	Study Title	Recruits
Non-Commercial	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	IBD-BOOST: SURVEY	What is the relationship between fatigue, pain and urgency in people with inflammatory bowel disease? The IBD-BOOST Survey	3
Non-Commercial	University of Oxford	Surgery or Cast for Injuries of the EpicoNdyle in Children's Elbows	SCIENCE Surgery or Cast for Injuries of the EpicoNdyle in Children's Elbows:A multi-centre prospective randomised superiority trial of operative fixation versus non-operative treatment for medial epicondyle fractures of the humerus in children.	1
Non-Commercial	King's College London	The PARROT-2 Trial	Placental growth Factor Repeat sampling for Reduction of adverse perinatal Outcomes in women with suspected pre-eclampsia	2
Non-Commercial	University of Oxford	CRAFFT – Children's Radius Acute Fracture Fixation Trial	CRAFFT – Children's Radius - Acute Fracture Fixation Trial: A multi-centre prospective randomised non-inferiority trial of surgical reduction versus non-surgical casting for displaced distal radius fractures in children.	2
Non-Commercial	University of Oxford	RECOVERY trial	Randomised Evaluation of COVID-19 Therapy (RECOVERY)	21
Non-Commercial	Imperial College of Science, Technology and Medicine	Pregnancy and Neonatal Outcomes in COVID-19	Pregnancy and Neonatal Outcomes in COVID-19: A global registry of women with suspected or confirmed SARS-CoV-2 infection in pregnancy and their neonates, understanding natural history to guide treatment and prevention	8
Non-Commercial	Aston University	EnED- Education in Emergency Departments	Service Improvement Project to Learn from the Covid 19 Crisis and Plan Resilience for Future Peaks in Service Demand – Education in Emergency Departments – EnED	1
Non-Commercial	INTENSIVE CARE NATIONAL AUDIT AND RESEARCH CENTRE (ICNARC)	UK-ROX	Evaluating the clinical and cost-effectiveness of a conservative approach to oxygen therapy for invasively ventilated adults in intensive care.	9
Non-Commercial	LEEDS COMMUNITY HEALTHCARE	National AHP Research RCC Survey	AHP perceptions of NHS research capability and culture: A national research capacity in context survey	16

Study Type	Study Sponsor	Short Name	Study Title	Recruits
	NHS TRUST			
			TOTAL	**622**

In 2020/2021 the Trust were delighted to open the Halton Clinical Research Unit (HCRU), within the Nightingale Building on the Halton site at Runcorn, which will provide opportunities for people in Halton, Warrington, Cheshire and Merseyside to participate in clinical trials and research close to home.

The Trust has been working with the National Institute for Health Research (NIHR), Clinical Research Network North West and Liverpool University Hospitals NHS Foundation Trust (LUHFT) to further develop its research and investigation capability. In 2020/2021 we were delighted to have commenced the first clinical trial, a COVID vaccine trial on Ward B1. The HCRU has since hosted a further covid19 vaccine trial with another to open in April 2022.

The unit was officially opened on Thursday 4th March 2021 by the Trust's Chairman alongside partners who form the Trusts Research Partnership Board. This partnership consists of LUFT and the Nort West Clinical Research Network. and has enabled both opportunity for staff and the local population to be provided with the opportunity to access clinical trials within the locality HCRU continues to provide flexible accommodation and staff to support different types of clinical research and trials. In its second year, the unit will continue to support covid19 studies but will also focus on expanding into other research areas, including vaccines for other diseases and paediatric medicine.

This investment in the Halton Hospital site is a further demonstration the Trust's commitment to the further development of its research and investigation capacity, supported by the Quality Academy's Research and Development Team. It provides an exciting opportunity for local people and for WHH staff and is pivotal to supporting continual improvement of services provided by the Trust.

2.10 The CQUIN Framework

The Commissioning for Quality and Innovation (CQUIN) framework forms one part of the overall approach on quality, which includes: defining and measuring quality, publishing information, recognising and rewarding quality, improving quality, safeguarding quality and staying ahead.

The aim of the CQUIN payment framework is to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. The framework is intended to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing the commissioners to link a specific modest proportion of providers' contract income to the achievement of locally agreed goals.

A proportion of Warrington and Halton Teaching Hospitals NHS Foundation Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between Warrington and Halton Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

2.11 Care Quality Commission (CQC) Registration

Warrington and Halton Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Warrington and Halton Teaching Hospitals NHS Foundation Trust during 2021/22.

The Trust is registered to provide the following services:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

Warrington and Halton Teaching Hospitals NHS Foundation Trust has not been subject to any special reviews by the Care Quality Commission during 2021/22.

2.12 CQC Engagement

The Trust has not been inspected during 2021/2022. The CQC continued their regulatory approach using their Transitional Regulatory Approach with a focus on engagement meetings and assessments against the CQC's interim assurance frameworks. The CQC will launch a new regulatory approach in 2022/2023. Engagement meetings have continued throughout the reporting period with the CQC. In 2021/2022 the Trust has:

- Been assessed against the CQC's transitional regulatory approach for:
    - Maternity services
    - Urgent and Emergency Care
    - Trust-wide
- Commenced an internal programme of 'mock CQC inspections' with further inspections scheduled in 2022/2023.

Post CQC Inspection Activity

The post inspection action plan from the Trust's 2019 CQC inspection was completed in November 2020. The Trust has continued to focus on workstreams to support the Trust to 'Move to Outstanding', in line with our Moving to Outstanding Sub Committee which meets monthly. This reports into Quality Assurance Committee ahead of Trust Board.

2.13 Trust Data Quality

Warrington and Halton Teaching Hospitals NHS Foundation Trust submitted anonymised clinical data for patients seen and treated during April – February 2021/22* to the Secondary Uses Service (SUS) for inclusion in the national Hospital Episode Statistics.

The percentage of records in the published data which included the patient's valid NHS Number will be updated at the end of April 2022 when the national data is available.

National Data Set	Trust Valid	National Average Valid	Date Range
Admitted Patient Care	99.90%	99.70%	Apr 2021 – Feb 2022
Outpatient Care	100.00%	99.80%	Apr 2021 – Feb 2022
A&E Care – Type 1	98.90%	98.90%	Apr 2021- March 2022
A&E Care – Type 3	87.70%	87.70%	Apr 2021 – March 2022

The percentage of records in the published data which included the patient's valid General Medical Practice Code will be updated at the end of April 2022 when the national data is available.

National Data Set	Trust Valid	National Average Valid	Date Range
Admitted Patient Care	100%	99.70%	Apr 2021 – Feb 2022
Outpatient Care	100%	99.60%	Apr 2021 – Feb 2022
A&E Care – Type 1	99.50%	99.50%	Apr 2021- Mar 2022
A&E Care – Type 3	96.00%	96.00%	Apr 2021 – Mar 2022
*Data source provided from SUS – Cumulative year to date to Feb 2021/2022			

Warrington and Halton Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve data quality and validity where it does not achieve 100% completeness.

- The Trust's Data Quality Team will continue to work closely with operational teams to ensure accuracy and completeness of the Trust key systems.
- A data quality dashboard has further supported the monitoring of data capture completeness.
- The Data Standards and Assurance Group continues to focus on areas requiring improvement relating to general data quality, Trust key performance indicators, operational areas and finance and contract performance.
- As part of the Trust governance structure the Data Standards and Assurance Group reports into the Information Governance and Corporate Records Sub-Group which in turn provides assurance to the Quality Assurance Committee.
- A Data Quality Policy is in place which identifies clear roles- and responsibilities for data quality and is routinely reviewed to ensure that it supports reporting and statutory obligations around national datasets.

2.14 Information Governance

The Trust uses the Data Security and Protection Toolkit in conjunction with the Datix Risk Management system to inform the work of its Information Governance and Records Sub-Committee. The Information Governance and Records Sub-Committee is accountable to the Quality Assurance Committee which is a sub-committee of the Trust Board.

The Trust's Senior Information Risk Owner (SIRO) chairs the Information Governance and Corporate Records Sub-Committee which is also attended by the Trust's Caldicott Guardian. The SIRO (Chief Information Officer) acts as the Trust's lead for information risk. Any areas of weakness in relation to the

management of information risk which are identified, or are highlighted by internal audit review, are targeted with action plans to ensure that we continue to strive to be information governance assured. In 2021 the Trust was the subject of a two-part Data Security and Protection Toolkit review conducted by Mersey Internal Audit Agency (MIAA). Part one of the review concluded that the Trust's self-assessment deviated only minimally from the independent assessment. On that basis the assurance level awarded in relation to the veracity of the self-assessment was substantial assurance.

Part 2 of the review conducted by MIAA was comprised of an assessment against the National Data Guardian's 10 data security standards. The assurance level awarded across all 10 data security standards was moderate. The moderate assurance rating was awarded on the basis that no standards rated as unsatisfactory, and none rated as limited. The Trust's compliance with 7 of the 10 domains within the NDG standards were rated as substantial with three rated as moderate.

2.15 Clinical Coding/Payment by Results (PBR)

Nationally, Payment by Results was temporarily replaced by block contract arrangements from the start of the pandemic for financial years 2020/21 and 2021/22. These arrangements have continued into 2022/23.

There is a national shortage of experienced qualified Clinical Coders making recruitment challenging with vacant posts being recruited to with Trainees. Trainees can take between 3 – 5years to qualify and gain appropriate experience. There is, however, a plan in place which is improving the recruitment and retention of good quality staff to support up to date coding and further improvements to the quality of clinically coded data.

Despite the resource issues, Warrington and Halton Teaching Hospitals NHS Foundation Trust continue to support data quality improvements by undertaking the following actions.

- Continuous engagement with clinicians to improve documentation and clinically coded data.
- Working with Informatics and clinicians to support migration from handwritten to digital operation notes.
- Undertake a rolling programme of internal clinical coding staff audits.
- Increased level of support to the mortality review group with documentation and clinical coding reviews.
- Continuous training and updating of skills for clinical coders.
- Targeted specialty documentation and clinical coding audits.
- Collaboration with Informatics to enhance the usability of Lorenzo to improve the coding process.
- Highlight data quality issues for resolution to the Application Support Team.

2.16 Learning from deaths

In March 2017, The National Quality Board issued "National Guidance on Learning from Deaths: a framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in care". This guidance included the requirements that trusts must publish a Learning from Deaths policy, and that from December 2018 Trusts must collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board meeting. This data should include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to

case record review. Of those deaths subjected to review, trusts must estimate how many deaths were judged more likely than not to have been due to problems in care.

Reducing mortality is a priority for the Trust which is now focused through the Mortality Review Group (MRG). The Mortality Review Group performs in-depth investigations using the Structured Judgement Review methodology into groups of patients conforming to agreed criteria as defined within the Trust Learning from Deaths policy.

The Trust has currently trained 8 clinicians in the Royal College of Physicians Structured Judgment Review (SJR) method for recording deaths, mortality reviews and their outcomes, a further 4 clinicians are currently being trained. The Trust has developed an electronic system which logs Structured Judgement Reviews (SJR) electronically and triangulates findings with complaints, claims, inquests and incidents. This facilitates richer learning across the Trust.

Mortality meetings focus upon process and system change, with the aim of developing recommendations to prevent a similar adverse outcome in the future. Any actions and improvements that have been made by the Mortality Review Group are reported to the Patient Safety & Clinical Effectiveness Sub-Committee monthly.

By 31st March 2021, 203 SJRs were completed. 9 investigations (Serious Incidents) were carried out in relation to 1100 of the deaths. They occurred in each quarter of that reporting period as follows:

- Quarter 1 - 60 SJRs completed and 2 Serious Incidents.
- Quarter 2 – 33 SJRs completed and 0 Serious Incidents.
- Quarter 3 - 77 SJRs completed and 2 Serious Incidents.
- Quarter 4 – 52 SJRs completed and 5 Serious Incidents.

In order to support learning across the Trust human factors training has been undertaken in accordance with findings of Trust internal intelligence to continually drive the standard of care delivered to patients.

This provides valuable feedback on all aspects of care and helps us to understand what we may need to improve and equally what has been effective and meaningful for our patients. In addition, quality improvement leads are now invited to mortality review group to triangulate themes identified with quality improvement initiatives.

Due to the COVID-19 Pandemic the Learning from Deaths event and Patient Safety Summit to share learning over the past 12 months had to be paused. This will be reconvened in 2022.

2.17 Core Quality Indicators 2021/22

The 2012 Quality Account Amendment Regulations (10) state that Trusts are required to report against a core set of quality indicators using the following standardised statement set out as follows:

Where the necessary data is made available to the Trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed with:

- The national average for the data.

- The NHS Trusts and NHS foundation Trusts with the highest and lowest of the same, for the reporting period.
- Present, in a table format, the percentage/proportion/score/rate/number for at least the last two reporting periods.

Trusts are only required to include indicators that are relevant to the services they provide.

2.18 Summary Hospital-Level Mortality Indicator (SHMI)

The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period was:

DATE PERIOD		TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
01 November 2020 – 31 October 2021 At the time of writing this report this is the most recent data		98.26	2	118.60	71.93	100
November 2019- October 2020		106.9	2	117.75	67.82	100
November 2018 - October 2019		106.89	2	120.12	68.48	100
October 2018 – September 2019		105.93	2	118.77	69.79	100
October 2017 – September 2018		109.92	3	126.81	69.17	100
July 2016 – June 2017		112.32	2	122.77	72.61	100
NB: This information is re-based so there may be a variation from HED monthly reporting and details the 2020/201 national comparative data available at present.						

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/shmi-data
NB COVID-19 has been excluded from the SHMI 2020-2021 at a national level by NHS Digital, this is to make the indicator values as consistent as possible with those from previous reporting periods.

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset, which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data (HED) benchmarking system to facilitate further analysis. Trusts are banded 1-3 as follows:

1. The Trust's mortality rate is 'higher than expected'
2. The Trust's mortality rate is 'as expected'
3. Where the Trust's mortality rate is 'lower than expected'

Warrington and Halton Teaching Hospitals NHS Foundation Trust were categorised 'as expected' over the past 12 months.

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust-level across the NHS in England. This indicator is produced and published quarterly, as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die at the Trust, or within 30 days of being discharged, and the number that would be expected to die, on the basis of average England figures. A number below 100 indicates fewer than the expected numbers of deaths, and a number above 100 would suggest a higher than expected number of deaths.

Mortality ratios are complex indicators and there are multiple factors that contribute to the overall score, including the quality of our documentation and coding.

We share learning from the Mortality Review group using the Mortality and Morbidity (M&M) meetings which are an opportunity for peer review, collective learning and quality improvement. These are held across all CBU's on their allocated audit days. Mortality and morbidity meetings are a professionally accountable forum based on sound educational principles. They encourage openness, honesty and transparency from participants. They focus upon learning and improvement of systems and processes of care and not on individual performance.

2.19 Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period

1. DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
01 November 2020 – 31 October 2021 At the time of writing this report this is the most recent data	55%	39%	64%	11%
November 2019- October 2020 NB:	45%	36%	59%	8%
November 2018 - October 2019	41%	36%	59%	11%
October 2018 – September 2019	40%	36%	59%	12%
October 2017 – September 2018	34.3%	33.4%	59.5%	14.3%
July 2016 – June 2017	41.7%	31.1%	58.6%	11.2%
https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/palliative-care-coding				

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data benchmarking system to facilitate further analysis.

Warrington and Halton Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the rate and so the quality of its services by investigating the detail behind the ratio numbers. We identified that our rate of service provision was the lowest in the North West prior to 2012/2013, and we have worked hard to now be in a position in which we compare favourably with local peers. The Trust has improved over the years to a steady rate, which is comparable with the England average. However, we continue to prioritise the coding of patient deaths to ensure that they are coded correctly as palliative care. Clinical Coding attend MRG meetings to support with ensuring that the coding is also appropriate.

2.20 Patient reported outcome measures (PROMs) for (i) groin hernia surgery, (ii)* varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery

***PROMs also exist for varicose vein; however, the Trust does not undertake this procedure**

This data is made available to the Trust by the Health and Social Care Information Centre with regard to the Trust's patient reported outcome measures scores for— groin hernia surgery, varicose vein surgery, hip replacement surgery, and knee surgery, during the reporting period were:

Data is being prepared and will be updated by then end of April 2022.

		Groin hernia	Hip replacement	Knee replacement
Year	Level	Average health gain	Average health gain	Average health gain
2020/21		*		
2019/2020	Trust	*	0.474	0.353
2019/2020	England	*	0.459	0.335
2018/2019	Trust		0.500	0.324
2018/2019	England		0.456	0.336
2017/2018	Trust	0.019	0.341	0.312
2017/2018	England	0.089	0.488	0.345
2016/2017	Trust	0.036	0.455	0.370
2016/2017	England	0.086	0.444	0.324

*2021/2022 and Groin hernia information for 2019/20 or 2020/10 data is not available at the time of reporting.

https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason in that the PROMs data is a nationally agreed dataset. The data is collected, processed, analysed and reported to the Health and Social Care Information Centre by a number of organisations, including hospital Trusts which perform PROMs procedures. PROMs calculate the health gains after surgical treatment, using pre- and post-operative surveys. The Health and Social Care Information Centre is responsible for scoring and publishing of PROMs data, as well as linking it to other data sets such as Hospital Episodes Statistics. In 2022/23 this will be monitored via the Patient Experience Sub-Committee.

2.21 Emergency readmissions to hospital within 28 days of discharge

NB: This data is not available on HSCIC and the technical specification for the dataset is not available so the Trust cannot replicate the data using local information.

It has been acknowledged that an external error was made in the drafting of the regulations and that the split of patients for this indicator should be

0 to 15; and

16 or over,

This indicator on the HSCIC Indicator Portal was last updated in December 2013 and the proposed update that was due to take place in August 2016 was postponed, therefore there is not up to date information.

2.22 Percentage of staff who would recommend the provider to friends or family needing care

The data is made available to the Trust by the Health and Social Care Information Centre via the National The data is made available to the Trust by the National NHS Staff Survey Coordination Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

Staff who would recommend the provider to friends or family needing care by percentage*

DATE	TRUST	ACUTE TRUSTS
2021*	64%	*Currently awaiting national results from 1st April 2022*
2020	71.3%	74.3%
2019	65.2%	70.5%
2018	60.7%	71.2%
2017	59.5%	70.6%

http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/02/NHS_staff_survey_2019_RWW_full.pdf

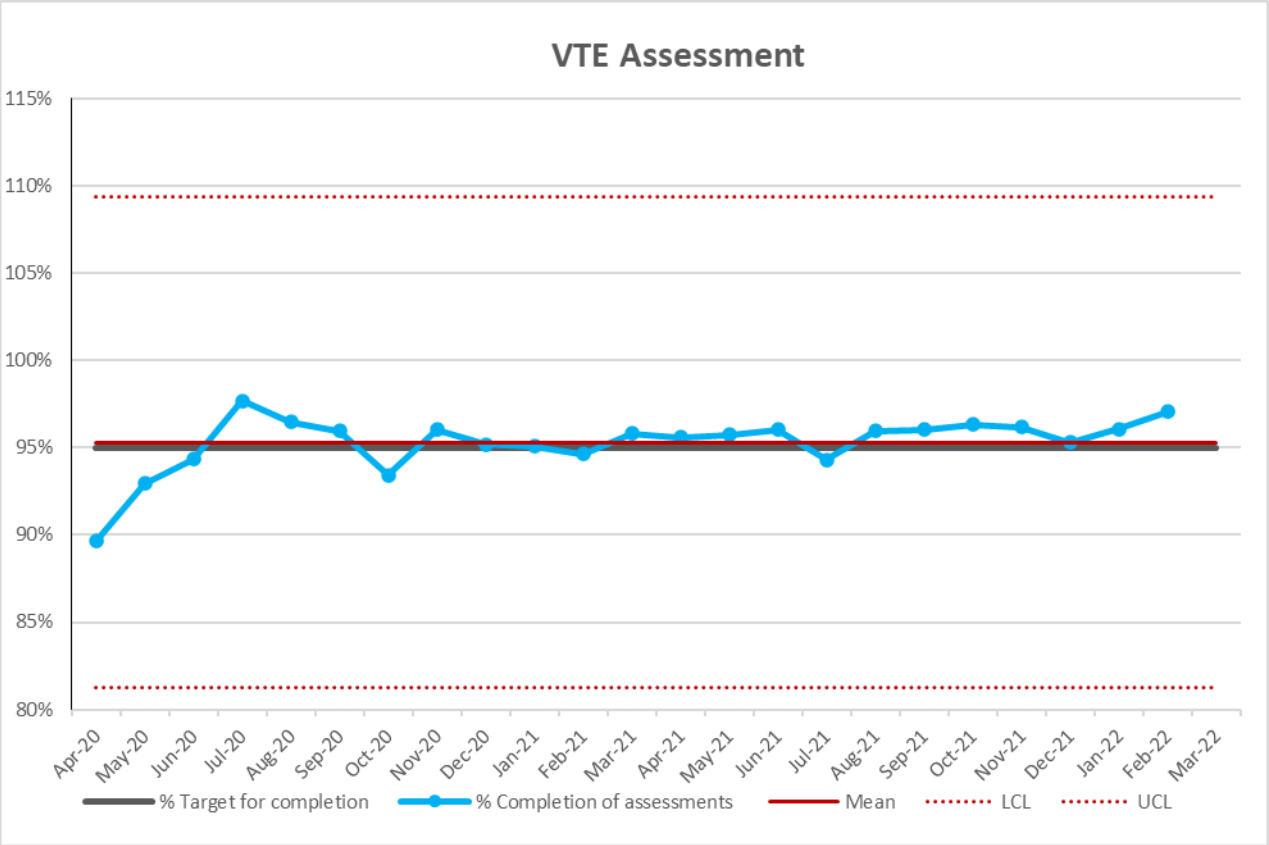
* The precise wording of the question is '*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'.*

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2021 national NHS staff survey conducted by Quality Health on behalf of the Trust. Quality Health utilises high quality research methodology and mixed method collection resulting in a 40.2% response rate which represents 1,744 staff responding to this survey.

The Trust has several workstreams in place to improve this score, utilising a range of Quality Improvement methodology to implement change via the Trust's Quality Academy and supporting improvements through collaborative working with the organisation's People Champions and Staff Networks.

2.23 Percentage of admitted patients' risk-assessed for Venous Thromboembolism

The data made available to the National Health Service Trust or NHS foundation Trust by the National Commissioning Board with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. There was a decrease in performance; however, this is now steadily increasing (see SPC below)



Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this percentage is as described for the following reasons in that this is a nationally accepted dataset which is submitted to the Department of Health at the agreed frequency.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this performance with focussed work alongside clinical teams to improve compliance with the VTE electronic risk assessment processes. The Trust has aligned the VTE audit process with the GIRFT framework for further oversight on quality.

2.24 Treating Rate of C. difficile per 100,000 bed days amongst patients aged two years and over

The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period. The data includes all cases detected and reported to Public Health England including community onset cases.

Warrington & Halton Teaching Hospitals NHS Trust Clostridium difficile infections per 100,000 bed days

DATE	TRUST REPORTED CASES	RATE	RATE (all reported cases per 100,000 population)
2020/2021	The England data will be updated at the end of April 2022 when the national data is available.		
2019/2020	78	43.6	23.5
2018/2019	65	35.9	21.9
2017/2018	55	29.9	23.9
2016/2017	65	34.1	23.3

Data Source: https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data
Annual publication of epi commentary (publishing.service.gov.uk)

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that the data is as described for the following reasons there is a robust system for data entry and validation which ensures all cases are entered onto the Public Health England Data Capture System.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Action plan in place to reduce Clostridium difficile
- Improvements to methods of investigation for Clostridium difficile cases
- Action plan in place to reduce MRSA and MSSA bacteraemia cases
- Review of all MRSA positive cases and advice provided on suppression therapy and where required antibiotic treatment

2.25 Patient Safety Incidents

Patient Safety Incidents – Rate of incidents per 1000 bed days

DATE	TRUST	TRUST NUMBER	MEDIAN	LOWEST	HIGHEST
Oct 2019 – Mar 2020	44.3	4045	50.7	15.7	110.2
April 2019 – September 2019	48.69	4272	48.5	26.3	103.8
Oct 2018 – Mar 2019	44.68	3964	44.5	16.9	95.94
April 2018 – September 2018	41.6	3833	42.4	13.1	107.4
Oct 2017 – Mar 2018	38.78	3764	42.55	24.19	124
April 2017 – September 2017	41.07	3619	42.84	23.47	111.69

NB: NRLS Report provides median rate of incidents per 1000 bed days reported by all non-specialist acute Trusts.

Patient Safety Incidents Severe Harm / Death

DATE	TRUST	NATIONAL	LOWEST	HIGHEST
Severe Harm and Death Oct 2019 – Mar 2019	0.2% (9)	x0.3% (Non-specialist acutes only)	0 (0)	1.5 (19)
Severe Harm and Death April 2019 – September 2019	0.44% (19)	0.3% (Non-specialist acutes only)	0% (0)	1.6 (58)
Severe Harm and Death Oct 2018 – Mar 2019	0.45% (18)	0.3% (Non-specialist acutes only)	0.009% (1)	1.8 (42)

DATE	TRUST	NATIONAL	LOWEST	HIGHEST
Severe Harm and Death April 2018 – September 2018	0.73% (28)	0.3% (Non-specialist acutes only)	0% (0)	1.2 (48)
Severe Harm and Death Oct 2017 – Mar 2018	0.37% (14)	0.3% (Non-specialist acutes only)	0% (0)	1.55% (99)
Severe Harm and Death April 2017 – September 2017	0.64% (23)	0.4% (Non-specialist acutes only)	0% (0)	1.98% (121)

NB - The Trust has reported by actual number & percentage by highest/lowest rates please note these will not necessarily be the same Trusts.
NB - *National = Severe Harm and Death combined.

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that it downloads all incidents via DATIX to the National Reporting and Learning System within the agreed timescales.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by:

- The *'Reporting to Improve'* campaign continued 2019-20/2020-21 which actively encourages incident reporting by all members of staff promoting an open and honest culture.
- Continued investigations to the appropriate level dependent upon the severity of the clinical incident reported.
- Continued training for staff to use the Trust online reporting system, Datix.
- Continued support for senior staff with Risk training to assist them when reviewing incidents.
- Improved monitoring of actions from incidents to ensure that they are completed in time in order to improve care for patients and staff.
- Additional scrutiny continues at the Trust Weekly Meeting of Harm.
- The Trust also has in place a Clinical Harm Review panel to support waiting list management.

Shared analysis, learning and improvement identified from clinical incidents across the Trust via the following routes:

- Quarterly Governance Reports, including the Learning from Experience Report and Learning from Deaths Report.
- Trust wide safety alerts and notifications
- Safety briefings in clinical areas
- Amendments to policy
- Annual Safety Summits
- Daily Safety Huddles
- Trust wide Safety brief
- Monthly CBU and Specialty Governance Meetings
- Weekly CBU Governance Review Meetings between CBU Managers and CBU Governance Managers

2.26 Freedom to Speak Up (FTSU)

“We consider Freedom to Speak Up (FTSU) in everything we do, all staff will know how to speak up and feel safe doing it. We will become outstanding by listening and learning from our staff.”

The Trust has a named Executive Lead, Non-Executive Lead and a FTSU Guardian. In addition, there are over 30 FTSU Champions across the Trust with as many different backgrounds and professions as possible represented. Staff across the Trust can speak up directly to the Guardian or a Champion; they can phone, email or write to FTSU team. If details are shared a member of the FTSU team will get in touch with the person raising the issue and offer a face-to-face meeting or a chat on the phone. FTSU highlight the purpose of the role and advise on what they can do next, the person raising the issue is then supported by FTSU in whatever action they decide to take. The individual can remain anonymous if they wish and we discuss if this is possible and the impact.

The Trust FTSU team completed quarterly national return on activity and reports to the Trust Board twice a year and Committee quarterly.

The Trust has a FTSU policy which is in line with the national policy stating "If you raise a genuine concern (i.e., held in reasonable belief) under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern; in fact any such attempt would warrant you raising a concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action for the person(s) involved. We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police or if it is requires to be disclosed for the purposes of subsequent disciplinary action). You can choose to raise your concern anonymously, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome."

Freedom to Speak up links to the QPS aims and objectives of the Trust and the activities of the FTSU Team are reported twice a year to the Board and Quarterly to the Strategic People Committee. The number of disclosures are benchmarked against similar Trusts and national guidance is reviewed and implemented. The Trust undertakes the toolkits provided by the national office.

2.27 Seven Day Hospital Services (7DS)

NHS England and NHSI altered their methodology for assessing compliance with the Seven Day Services priority clinical standards which has allowed the Trust to focus on Clinical Standard 2 (CS2) of the 7 Day Services, which is Time to First Consultant Review, in Paediatrics and General Surgery as a quality priority.

Paediatrics

In 2020/21, Paediatrics achieved the required 90% compliance with the standard during the Quarter 3 and Quarter 4 audit. In order to test sustainability with the compliance achieved, a further audit for Clinical Standard 2 will be implemented during 2022/23.

The Paediatric team demonstrated that 41/75 patients were evaluated and discharged on the same day with patient evaluation prioritised to registrar or Consultant based on severity and complexity. Their interpretation was a need to prioritise same day discharge to maintain flow through the unit. They also allocated admitted patient review to Consultant or Registrar based on severity. Identification of low complexity cases not requiring Consultant review is a required action.

Both specialties also identified that a patients DTA in the early evening were more likely to miss the 14-hour review in the morning ward round and recognised the need to identify when patients are approaching the 14-hour window and to reinforce morning ward rounds.

Both teams recognise the importance of achieving timely consultant review and have evaluated the audit and implemented action plans.

General Surgery

In 2021/22, General Surgery achieved the required 92% compliance with the standard during the audit. In order to test sustainability with the compliance achieved, a further audit for Clinical Standard 2 will be implemented during 2022/23.

The 2021 audit was undertaken during a period where the Trust was experiencing significant flow pressures, reduced assessment area capacity and staffing pressures. Although both specialties did not achieve the CS2 benchmark the audit has identified areas of improvement.

For General surgery 8/39 patients had no Consultant review time recorded and were therefore identified as outside the 14-hour standard.

Both specialties also identified that a patients DTA in the early evening were more likely to miss the 14-hour review in the morning ward round and recognised the need to identify when patients are approaching the 14-hour window and to reinforce morning ward rounds.

Both teams recognise the importance of achieving timely consultant review and have evaluated the audit and implemented action plans.

Part 3

2. Review of Quality Performance

Patients are at the centre of everything we do and providing high quality service for every one of our patients is at the heart of our organisation.

3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

Our aim is to be a learning organisation that consistently transforms practice by continuous learning in order to provide the best possible health care. The Trust's vision is that we will be the change we want to see in the world of health and social care.

To support our overall aim, we have developed a Quality Strategy to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients.

The Quality strategy has been developed based first and foremost to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances;

and thirdly, to deliver an experience of hospital care which is as good as it possibly can be. With the above care model in mind, we use the following three priority domains:

3.2 Quality Strategy on a page

In year one of this Quality Strategy 2021/22, there are three priorities and nine new local quality indicators. Year one 2021/22 local quality indicators are listed below and detailed in the 'Plan on A Page' below.

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3.3 Data Sources

Intelligent information is collated from, whenever possible, sources which can be benchmarked with other organisations in order to indicate the Trust's performance in relation to others. The Trust submits and utilises data from the Health and Social Care Information Centre (HSCIC) which includes for example Patient Reported Outcome Measures (PROMs) in England whereby patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS are asked to complete questionnaires before and after their operations to assess their perceived improvement in health.

The Trust also subscribes to Datix, which is web-based patient safety software for healthcare risk management. It delivers the safety, risk and governance modules which enable the Trust to have a comprehensive oversight of our risk management activities including incident reporting and complaints, compliments, comments and concerns.

In addition to this the Trust has invested in a clinically-led benchmarking system called Healthcare Evaluation Data (HED), an online solution delivering information, which enables the Trust to drive clinical performance in o der to improve patient care.

The Trust submits data to the NHS Safety Thermometer which was developed as a point of care survey instrument, providing a 'temperature check' on harm that can be used alongside other measures of harm in providing a care environment free of harm for our patients. The Trust undertakes a monthly survey on one day of all appropriate patients, to collect data on pressure ulcers, falls, urinary tract infection (UTI) in patients with catheters and VTE. The Safety Thermometer measures the percentage of patients who have experienced harm in relation to any of these issues and allows the Trust to identify weaknesses; make changes to practice and measure improvement.

Other sources of information come from Friends and Family; Inpatient, Outpatient and Staff Surveys and in-house sources including audit and transparency surveys.

3.4 Quality Dashboard 2021/22

The clinical indicators in the Quality Dashboard have been reviewed in line with the revised requirements for 2020/2021 in relation to the:-

- CQUINs – National (paused at present)
- NHSI KPI
- Quality Contract
- Quality Account - Improvement Priorities
- Quality Account – Quality Indicators

- Care Quality Commission
- Sign up to Safety – national patient safety topics
- Open and Honest

This is part of a wider review of quality to align reporting with the committee structure under safety; effectiveness and experience and reporting to the Quality Committee to provide assurance on progress. The information on this Quality Dashboard is also shared with our Governors and commissioners of services to demonstrate how care for patients is delivered and improvements are maintained.

Since April 2016 the Board has received an integrated performance dashboard which triangulates workforce, quality and financial information.

3.5 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the Trust based on performance in 2021/22 against a minimum of 3 indicators for each area of quality namely patient safety: clinical effectiveness and patient experience. These indicators were selected by the Board in consultation with stakeholders and discussions with the Quality in Care Committee of the Council of Governors. In the main, the Trust has employed indicators which are deemed to be of local and national importance to the quality of care for patients.

The report provides an explanation of the underlying reason(s) for selection and wherever possible we refer to historical data and benchmarked data if available, to enable readers to understand our progress over time and performance compared to other providers. We have also referenced the data sources for the indicators and if applicable included whether the data is governed by standard national definitions.

Where available comparative and benchmarked data has been included and unless otherwise stated the indicators are not governed by standard national definitions and the source of the data is the Trust's local systems.

The improvement priorities and quality indicators were monitored and recorded via the Quality Dashboard and the Improvement Priority Quarterly Report reported to the Quality Committee.

The quality indicators for 2021/22 can be seen below and have been reported in section 2 of this report:

Patient Safety Domain

- Gram Negative Bloodstream Infections – A 5% Reduction in Gram Negative Bloodstream Infections (GNBSI).
- Improvement in the communication process for DNACPR
- COVID-19 Recovery, waiting list management, appropriate clinical review oversight

Clinical Effectiveness Domain

- Embedding the Medical Examiner role across the Trust and Community Services.
- Ensure effective decisions about health care are based on the best available, current, valid reliable evidence.
- CBU Governance to be strengthened ensuring consistency across the organisation.

Patient Experience Domain

- Implementation of the End of Life Serious Illness Programme
- Development and implementation of the Trust Learning Disability and Mental Health Strategies.
- Nutrition- to ensure that patients have access to a choice of food and nutrition.

3.6 Parliamentary and Health Service Ombudsman

The PHSO is a free and independent service, set up by Parliament. Their role is to investigate complaints were individuals feel they have been unfairly treated or have received poor service from government departments, other public organisations and the NHS in England. The PHSO make the final decision on complaints about public services for individuals.

Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

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.

The table below details the progress of cases over the year within the Trust.

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
PHSO cases received	1	0	0	0	1	1	1	0	1	0	1	0
PHSO cases closed	0	0	1	2	0	0	0	1	0	0	1	0
Ongoing PHSO Cases at the end of 2021/22 = 5												

3.9 Friends and Family scores 2019/2020 and 2020/21 are as follows:

Inpatient Survey is a Care Quality Commission (CQC) requirement with the aim of obtaining feedback to improve local services for the benefit of the patients and the public. Survey results are reported to the CQC, who use the information as part of the Hospital Intelligent Monitoring. Patients are eligible for the survey if they are aged over 16 years or older, and have spent at least one night in hospital, and were not admitted to maternity or psychiatric units.

The 2020 Inpatient survey was undertaken by Quality Health, on behalf of the Trust and covers all aspects of patient's admission, care and treatment, operations and procedures and discharge from hospital from the inpatient specialties of General Surgery; Urology; Trauma and Orthopaedics, Cardiology, Acute Internal

Medicine, Stroke and Respiratory Medicine. The results of the Inpatient Survey (2020) were received by the Trust in September 2021 with results published by the CQC in October 2021.

The survey required a sample of 1250 consecutively discharged inpatients aged 16 and over, this sample is worked back from 30th November 2020. The final response sample was 1182 due to changes in respondent's circumstances such as not known at address or deceased. The target response rate is 60%; Trust response rate was 42%, a 2% increase in comparison to the 2019 response rate (40%).

The NHS Inpatient survey provides the Trust with intelligence around the overall patient experience, and it is vital that we review and act upon this information to address poor performance. The Picker Institute coordinates all the national results on behalf of the CQC, who publish reports which include benchmarks against performance. Seventy-six questions are asked and categorized into twelve domains as follows:

1.1. Admission to hospital
1.2. The hospital and ward
1.3. Doctors
1.4. Nurses
1.5. Your care and treatment
1.6. Operations and procedures
1.7. Leaving hospital
1.8. Overall
1.9. About you

On review of the 2020 survey results evidence of improvement since the 2019 survey is detailed below:

The Hospital and Ward

- 27% of respondents rated hospital food as 'Very good', this is an increase of 11% in comparison with the 2019 results at 16% and 2018 at 23%.
- 66% of those surveyed stated they always got enough help from staff to eat their meals, this is an increase of 9% in comparison with the 2019 survey at 57%.

Doctors

- 78% of respondents felt that when asking doctors questions, they got answers they could understand, this is a 10% increase in comparison to the 2019 survey at 68% and rates better than the Quality Health average.
- 87% of respondents 'always' had confidence and trust in the doctors treating them, this is a 10% increase in comparison to the 2019 survey at 77%

Nurses
81% of respondents felt that when asking nurses questions, they 'always' got answers they could understand, this is an increase of 12% in comparison to 2019 at 69% and is 2% above Quality Health average.

86% of those surveyed stated they 'always' had confidence in the nurses treating them, a 6% increase in comparison to 2019 at 80%.

Overall
Of those surveyed 87% stated they were 'always' treated with respect and dignity whilst in hospital, compared with 2019 results at 79% this is an 8% increase and is just short of the top 20% of Trusts who participated with Quality Health.

Overall, 44% of surveyed respondents rated their experience a '10 – I had a very good experience', this is an increase of 20% in comparison to 2019 at 24%.

Some scores for Warrington and Halton Teaching Hospitals NHS Foundation Trust are in the intermediate 60% range of Trusts surveyed by Quality Health. Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, central to the Trust ethos is the view that patients deserve high-quality healthcare, and patients' views and experiences are integral to successful improvement efforts. As such it employs Quality Health to undertake a robust and comprehensive survey of patients experience on an annual basis.

The Ward Accreditation Scheme within the Trust will continue to support improvements and to engage staff and empower leadership capability ensuring that we deliver the highest standards of healthcare for our patients.

The National Inpatient Survey key themes had been reviewed in full and have been scrutinised. There has been significant work undertaken by the CBUs, with the implementation of the five work streams of the Patient Experience Strategy, led by Lead Nurses and Allied Health Professionals, who provide monthly updates to the Patient Experience Sub Committee. Warrington and Halton Teaching Hospitals NHS Foundation Trust are focusing on the following themes as a result of the feedback in the survey.

- Admission to hospital – examining reasons why some patients have long waits to be admitted to a ward, this will feature as part of focus on flow workstreams ensuring that findings from the survey are linked into operational delivery.
- Noise at night – continued focus into why some patients experience high levels of noise from other patients at night. This will involve collaborative and multi-disciplinary quality improvement projects.
- Food and Hydration – Continued focus to review food quality, temperature, timing, and support for patients incorporating findings from the survey with the Independent Review of NHS Hospital Food report. recommendations.

3.9 Friends and Family

The NHS Friends and Family Test is an opportunity for patients to leave feedback on the care and treatment that they received at Warrington and Halton NHS Foundation Trust. The feedback will be used to review our services from the patients' perspective and enable us to drive improvements in care.

When patients visit our Emergency Department (ED)for treatment, or are admitted to hospital, they are asked to complete a short survey when they are discharged. This details how likely they are to recommend the ward/department or ED to friends and family if they needed similar care or treatment. The patient's response is anonymous, and they can post the paper survey into the confidential box on their way out of the ward or A&E. The boxes are emptied regularly to process the information and provide reports to the Ward Manager and Matron. Friends and Family Test (FFT) surveys now has increased functionality available for patients attending WHH supporting them to utilise the digital 'Patient Experience Surveys' link to complete their FFT in addition to paper surveys already in place. The benefit of utilising the digital solution includes the use of 'browse aloud' which is an accessibility tool to support people living with a visual or hearing impairment and allows for the survey to be transcribed into other languages or simplified utilising images as well as text. The digital survey can be accessed via the QR code on FFT posters across the Trust or by utilising the link on the paper copies.

If a patient is unable to answer the question, a friend or family member is welcome to respond on their behalf. Users are also asked to rate their responses, and this is translated into a rating which is reported through to the board of directors via the Quality Dashboard.

In accordance with National updates to FFT in 2020 the wording of the first question no longer asked about recommending services, instead this was replaced with the following: - 'We would like you to think about your recent experience when completing this form. Overall, how was your experience of our service?' Very good, Good, neither good nor poor, Poor, Very Poor, don't know. This change allows for more emphasis on the importance of using feedback and inclusion.

The Trust has in place an FFT contract in order to improve the process and increase the response rate e.g., text services.

Friends and Family scores 2019/2020 and 2020/21 are as follows:

*Suspended nationally for inpatient wards due to the COVID-19 pandemic, therefore no data is available for this period. A&E continued to collate Friends and Family Data via SMS text messages throughout this period with results detailed in the table below

	Inpatient 2019/20	Inpatient 2020/21	Inpatient 2021 / 22	A&E 2019/20	A&E 2020/21	A&E 2021/22
Apr	95%	FFT Paused	98%	82%	94%	79%
May	96%	FFT Paused	98%	84%	91%	78%
Jun	96%	FFT Paused	98%	82%	89%	77%
Jul	94%	FFT Paused	96%	82%	89%	73%
Aug	95%	FFT Paused	96%	83%	84%	70%
Sept	96%	FFT Paused	97%	78%	87%	72%
Oct	95%	FFT Paused	96%	78%	81%	68%
Nov	96%	FFT Paused	98%	77%	86%	73%
Dec	96%	FFT Paused	97%	78%	93%	75%
Jan	95%	98%	98%	81%	93%	75%
Feb	95%	94%	97%	81%	86%	71%
Mar	FFT Paused	97%		*	79%	

The ratings are published on both NHS Choices and in the Open and Honest publication which is published on the NHS England Trust websites.

3.10 Duty of Candour

The Trust monitors Duty of Candour at the weekly Serious Incident meeting held by the Clinical Governance team, chaired by the Deputy Director of Governance. Compliance with Duty of Candour is also reviewed at the weekly Executive Meeting of Harm chaired by the Chief Nurse, Deputy Chief Executive and continues to be reported monthly to the Patient Safety & Clinical Effectiveness Sub-Committee.

For each new Serious Incident (SI) investigation, a patient or family liaison officer continues to be appointed to provide support and advice. A stand-alone Duty of Candour Policy to support staff with the delivery of Duty of Candour to patients/families of those who have sadly been involved in an incident, resulting in harm has been ratified.

3.11 Staff Survey Indicators

The staff survey for 2021 has evolved to reflect the updated NHS People Plan which was updated in 2021. [1] Table **one** highlights the promises and themes that are reflected in the 2021 staff survey results.

Table One: People Promises and Themes in the 2021 Staff Survey

People Promise (PP) / Theme (T)	Subscore / Theme
We are compassionate and inclusive (PP)	• Compassionate culture • Compassionate leadership • Diversity and equality • Inclusion

People Promise (PP) / Theme (T)	Subscore / Theme
We are recognised and rewarded (PP)	N/A
We each have a voice that counts (PP)	• Autonomy and control • Raising concerns
We are safe and healthy (PP)	• Health and safety climate • Burnout • Negative experiences
We are always learning (PP)	• Development • Appraisals
We work flexibly (PP)	• Support for work-life balance • Flexible working
We are a team (PP)	• Team working • Line management
Staff engagement (T)	• Motivation • Involvement • Advocacy
Morale (T)	• Thinking about leaving • Work pressure • Stressors (Health and Safety Executive Index)
Data Source: NHS People Plan – published 2021: www.england.nhs.uk/ournhspeople/	

The most updated results from the 2021 NHS Staff Opinion Survey results for the themes of “We are Compassionate and Inclusive” and “We are Safe and Healthy” are as follows:

We are compassionate and inclusive

The Trust scored 8.49 for this theme overall which is higher than the comparison with the Acute Trust average of Trust’s utilising Quality Health as their survey provider of 8.05.

For question 14- Does your organisation act fairly with regards to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age the Trust scored 63% compared to the Acute Trust average of organisation’s utilising Quality Health as their survey provider of 55%. The Trust are above the national Acute Trust average of Quality Health Trust’s, however, recognises the importance of ensuring equity in relation to progression and promotion and has worked in collaboration with the Trust’s Staff Networks to develop 1:1 career coaching sessions and training opportunities to support individuals through their career progression. In addition, a reciprocal mentoring scheme has been implemented and supported across the organisation in partnership with Staff Network members. The organisation also has specific action plans in place aligned to the Workforce Race Equality Standard, the Workforce Disability Equality Standard and the Model Employer action plan to continue to improve this the experience of our staff in relation to acting fairly in terms of career progression or promotion irrespective of protected characteristic.

We are safe and healthy

In relation to harassment, bullying or abuse question 13b asks “how many times have you personally experienced harassment, bullying or abuse at work from managers? The Trust scored 12% which is a slight increase on the 2020 score but lower than the Acute Trust average of organisations utilising Quality Health as their survey provider which is 13%. The Trust recognises the importance of an inclusive culture and an environment where individuals feel safe within the workplace. To support improving this metric, a targeted action plan has been developed in partnership with Staff Side colleagues and members of our Staff Networks to implement a kindness, civility and respect campaign aligned to the new organisational value of “kindness”. In addition, the organisation has developed an implementation plan to working towards becoming an Anti-Racist organisation and has signed up to the Social Partnership Forum’s “Call to Action” in relation to bullying and harassment within the NHS. In addition to campaigns and visible commitments, policy levers such as the Grievance policy has been

refreshed to focus on enabling positive work environments which will be further enhanced with the implementation of the Line Manager development framework.

For question 13c – “In the past 12 months how many times have you personally experienced bullying, harassment or abuse at work from other colleagues? The Trust scored 19% which is an increase on the 2020 score but remains lower than the Acute Trust average with organisations utilising Quality Health as their survey provider of 21%.

12 Quality Academy

Bringing together our Quality Improvement, Knowledge and Evidence Services and Research, Development and Innovation teams together, the Quality Academy promotes innovation and delivers improvements in line with the Trusts quality priorities.

Objectives

Our Key priorities for the Quality Academy are:

- **To support the delivery the Clinical and Quality Strategies.**
- **Help to implement innovative ideas.**
- **Training in QI Methodology.**
- **Ensuring QI work is linked in with our quality priorities for the service/Trust to stop duplication and silo-working.**
- **Encourage innovation and increase R&D profile within and outside the Trust – maximising opportunities for patients to take part in research.**
- **Support to move toward best practice – benchmarking**
- **Become a beacon of exemplary practice on research.**
- **Support improvements alongside system partners**

Engagement

Key to ensuring that we are listening to our stakeholders and addressing what matters to them. The Quality Academy actively seeks, listens and acts on feedback received from our patients, the public, our staff and groups such as Governors, HealthWatch and Health Scrutiny Committees.

The Quality Academy work being undertaken with the Patient Experience and patient involvement agenda to ensure that the patient voice is integral to Quality Improvement. The Quality Academy also works with Workforce & Organisational Development, to ensure that staff engage in the agenda and are empowered and supported to make improvements in their work.

Quality Academy Showcase

Each year we hold our annual Quality Academy Showcase. The showcase presents the latest innovation, best practice, improvement and research. The teams in the academy work together with our internal and external partners to deliver the latest knowledge in innovation and improvement in healthcare. An event has taken place this year and a further event is scheduled on 11th July 2022. The event is a unique opportunity to discover the art of the possible, bringing teams together to deliver better outcomes for our patients as well as raising the profile of the Quality Academy and the services available.

Quality Improvement

The Quality Improvement Team has two main areas of focus: the leading of a number of Quality Improvement projects Trustwide and undertaking a QI capability building programme of work, increasing colleagues knowledge of the theory. This means that colleagues are confident and enthused about approaching opportunities in their work areas and confident in implementing improvements, using our main QI method for implementing change at WHH, The Model for Improvement.

Quality Improvement Projects overview

Falls Collaborative

The Falls Collaborative relaunched in April 2021 following a break in QI projects during the Covid-19 Pandemic. The baseline for the number of falls was 64.75 falls. The collaborative aim was to reduce this by 20% to 51.8 falls per month by March 2022. The current average is 50.1 falls per month, demonstrating that we are on target to achieve this aim.

This year we developed and launched a Trustwide Falls Change Package. This collated all the great work that Collaborative wards have completed and compiled them into 6 evidence based changes that wards are asked to implement in order to reduce the number of falls.

Pressure Ulcer Collaborative

The Pressure Ulcer Collaborative also restarted in April 2021 following the resumption of collaboratives after the Covid 19 pandemic. Working closely with wards, we also launched a Pressure Ulcer Change Package which was launched Trustwide in October 2021. Since this launch, the QI team has been working with all wards across the Trust to implement these changes.

Gram Negative Bloodstream Infections (GNBSI) Collaborative

Reduction of GNBSI has been identified as a 2021/22 Trust quality priority. Based on the learning from ward tests, a change package outlining evidence-based interventions will be developed in the next financial year for all wards to implement. Our aim to reduce hospital acquired GNBSI by 5% by the 31st March 2022 in line with national targets has been met.

Eight innovation wards are currently being supported to develop tests of change in five key areas identified for improvement:

- Hydration
- Oral care
- Continence care
- Catheter management
- Hand hygiene

We support wards with fortnightly joint walkarounds by the IPC and QI team, to prevent further delays in sharing best practice across the Trust. We are also developing a GNBSI prevention care bundle based on a combination of the best available evidence, alongside learnings from the innovation wards to date.

In addition, the UTI pathway has recently been revised and will soon be launched. We intend to provide targeted QI support to implement the new pathway on wards identified as having a high number of infections likely of urinary source.

Quality Improvement Projects (QIPs)

The Quality Improvement Register was established in 2019 to capture improvement projects that are being undertaken across the Trust and enable the QI Team to allocate the appropriate level of support to individuals/teams undertaking improvement work. 45 Quality Improvement Projects were registered in 2021/22.

Quality Improvement Capability Building Programme

A new WHH Quality Improvement Education Framework has been developed to ensure the Trust has a structured and strategic approach to building QI knowledge and capability within our workforce. The QI team is also in the process of increasing buy in through a new QI champion network to be set up across the Trust. A key component of this will be to recruit medics to improve engagement.

Since April 2021 the QI team has delivered new training to 203 staff members. Table 2 shows a breakdown of the courses and number of staff who have successfully completed them. A monthly schedule of training dates for the next calendar year has been advertised.

QI Training Staff Numbers

Course	Number of staff
QI Foundation	132
QI Practitioner (3-day programme)	6
Preceptorship – Introduction to QI	65
Total	203

3.13 Local Quality Initiatives

Improving quality provides an opportunity to deliver better outcomes. There are many examples at Warrington and Halton Teaching Hospitals NHS Foundation Trust that show that even relatively small-scale quality improvement initiatives can lead to significant benefits for patients and staff. The section below details some of the positive work that we have achieved in 2021/2022.

Support for International Nurses

The Trust developed an Objective Structured Clinical Examination and support booklet to help international nurses to fully prepare for their clinical examination assessments. The learning and resources prepared were shared with the Mid Cheshire Collaboration as best practice.

Nursing Times Awards

Ward A7 and the Acute Care Team collaboration were shortlisted for the Nursing Times Awards 2020 Team of the Year.

HSJ Awards

The Trust were finalists for the HSJ Awards for the Urgent & Trauma Care initiative for introduction of the Thoracic Injury Pathway.

Stroke garden

The Trust opened a new Stroke therapy garden to support patients on the Stroke Unit. The garden is used by patients and families and was funded through WHH Charity fundraising, donations and supported by Sellafield Ltd and Warrington Lions Club.

PEWS testing

The Trust was successful in becoming a pilot site for the introduction of a National Paediatric Early Warning Score - SPOT. The PEWS inpatient trial was successfully piloted between April and September 2021

Employer Recognition Scheme - Silver award 2021 - Proudly serving those who serve

The Trust is one of thirty-six organisations from across the North West of England that have been awarded Silver under the Ministry of Defence Employer Recognition Scheme for their support to Defence and the wider Armed Forces community. The Employer Recognition Scheme was launched to reward employers who support Defence People objectives and encourage others to do the same. This includes employing serving and former members of the Armed Forces community and demonstrating flexibility towards training and mobilisation commitments for Reservists and Cadet Force Adult Volunteers.

Post Anaesthesia Care Unit (PACU)

Prior to the Covid-19 pandemic, patients requiring elective surgery who were deemed to have a greater perioperative risk were booked for a postoperative critical care bed on the Warrington site, which is the main Trust site with ITU and ED. This bed was not guaranteed depending on critical care occupancy and dependency, and often led to late cancellation of patients. During the Covid-19 pandemic and the increased pressure on critical care beds, it was imperative that an alternative to critical care was available to provide a safe level of care for this cohort of patients and facilitate the Trust's elective recovery plan. The Trust was keen to utilise the Halton Elective site as a 'green pathway' for elective surgery with the addition of a PACU to increase the number of patients who could be safely managed there. The Associate Chief Nurse for Planned Care developed a Standard Operating Procedure (SOP) for PACU with input from key members of the multidisciplinary team.

The PACU was opened in 2021 and has enabled effective care to be provided for these patients supporting the Trust's elective recovery. The Trust also won the Cheshire and Merseyside Continuous Improvement Award in 2022 for the PACU.

Sharing best practice in Infection Prevention and Control

The triage tool for Covid used in our Emergency Department was recognised by NHSE/I as best practice and share across the North West Region.

Bereavement Garden

The Trust opened a remembrance garden, created as part of its COVID-19 legacy. The area is a quiet, peaceful and reflective space for staff, patients, bereaved relatives and members of the community to visit and remember.

The garden features an array of flowers, trellises and seating areas with wooden benches and was designed by a local landscaper on a previously unused and rather unloved patch of grass between the new Habab Training Centre and the old K23. At the centre of the garden is a beautiful stone birdbath that was donated by the family of the late Tony Nicholson, who sadly passed away last year in the ICU with COVID-19. The Trust held a short ceremony to formally open the garden and some of Tony's family members attended the event, including his sister and brother-in-law Sue and Matthew Walker and his nephew.

As well as being a beautiful place for staff and bereaved families to visit and reflect, the Trust also recognises the value that this, in partnership with our Bereavement Service, adds to those who lose loved ones at the Trust's hospitals.

Ambulance Handover Times

The Trust's Emergency Department has featured in Hospital Handover Improvement as a case study outlining the quality improvement piece of work undertaken to improve hospital handovers from ambulances to the Trust's ED Team. The improvement work has been shared across the North West region with other Trusts as best practice, having consistently demonstrated an improvement in ambulance handover times.

Operating Department Practitioner (ODP) apprenticeships

The Theatres Team have been instrumental in bringing about an innovative new degree apprenticeship. The OPD Degree Apprenticeship concept came from a postgraduate certificate-enabled project at the Trust focussing on exploring the impact of professional apprenticeships in the peri-operative environment.

Using this experience, the Trust collaborated with other Trusts to enable the University of Bolton to devise and deliver the course. Each student is able to study alongside their practical work and is supported by an Educator within the department. The first cohort of the new BSc (Hons) Operating Department Practice (Degree Apprenticeship) at the University of Bolton have just completed their studies and are awaiting their pin numbers from the Healthcare Professional Council before becoming fully qualified ODPs.

Echo Training Programme

The Trust currently performs 6,000 echocardiograms annually across both sites, with a staff of six qualified Echocardiographers and one in training, with five Imaging Consultants who perform and support all modalities of echocardiography performed at the trust.

There is currently a national shortage of suitably trained and Accredited Echocardiographers across the NHS workforce. The National School of Healthcare Science (NSHCS), in collaboration with the British Society of Echocardiography (BSE) has developed a pilot pathway that will respond rapidly to the urgent workforce needs for Accredited Echocardiographers. The pathway is an 18-month, full-time integrated training scheme to deliver academic and workplace training leading to both a post-graduate certificate in Echocardiography and Level 2 BSE Accreditation in Transthoracic Echo. There are currently only two universities offering the academic portion of the ETP programme; Manchester Metropolitan and University of Newcastle, making the Trust's hospitals ideally situated for students on the programme.

The Clinical Leads for echocardiography recognised the value of the programme and applied to be a host training centre for the Echocardiography Training Programme (ETP). The application was successful, and the trainee application process will begin in Spring 2022, leading to one trainee arriving at the Trust in September 2022to train over 18 months to become accredited and potentially recruited by the Trust. The ETP is in its infancy and WHH are forward thinking in getting involved so early in the programme.

Newborn Life Support Course

The Resuscitation Council UK (RCUK) Newborn Life Support (NLS) course focuses specifically on the resuscitation of the newborn infant, teaching the essential practical skills and theoretical knowledge needed to best aid the newborn infant in an emergency. The course is intended for any healthcare professional involved in the delivery and care of the newborn infant. This includes nursing staff, midwives, paramedics, resuscitation officers and both junior and senior medical staff.

The Trust is one of only two centres in the Northwest that offers the NLS course. RCUK has only accepted 10 centres nationally to deliver the course in 2022. As WHH is only one of the handful of trusts able to offer a national qualification on resuscitation of the newborn infant, the trust is now considered to be a centre of excellence in resuscitation training and education on the national agenda.

Joint Advisory Group for Endoscopy (JAG re-accreditation)

JAG accreditation is awarded to high-quality gastrointestinal endoscopy services In February 2022 the Trust's Endoscopy Unit was inspection by the Joint Advisory Group for Endoscopy. The Trust received very positive feedback and was re-accredited.

HSJ Partnership Awards

The Trust was highly commended at the HSJ Partnership Awards 2022 for the Best Elective Care Recovery Initiative.

3.15 Performance against key national priorities

National Targets and Minimum Standards	Indicator	Target 2021/22	2021/22	2020/21
Infection Control	Number of clostridium difficile cases due to lapses in care	<= 27	6	0
	Number of MRSA blood stream infection cases	0	1	1
Cancer: 31 day wait from diagnosis to treatment	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%		95.60%
Cancer: 31 day wait for second or subsequent treatment	Anti cancer drugs	98%	**Cancer data is not available until beginning of May 2022**	100.00%
	Surgery	94%		98.53%
Cancer: 62 day wait for first treatment	From urgent GP referral (Reallocation position)	85%		72.55%
	From the consultant screening service	90%		91.94%
Cancer: 2 week wait from referral to date first seen	Urgent GP referral suspected cancer referrals	93%		88.56%
	Symptomatic breast patients (cancer not initially suspected)	93%		79.80%
Referral to Treatment within 18 weeks	Admitted patients with a clock stop		57.16%	58.35%
	Non-admitted patients with a clock stop		83.01%	81.47%
	Patients on an Incomplete pathway End of March position	92%	72.28%	70.14%
Access to A&E	Patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95%	72.76%	85.86%
Access for patients with a learning disability	The Trust provides self-certification that it meets the requirements to provide access to healthcare for patients with a learning disability	N/A	YES	YES
Cancelled operations on the day for a non-clinical reason **	Number of Cancellations not offered a date for readmission within 28 days	0	13	54

	Patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital	<= 2%	0.47%	0.42%
	Patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not readmitted within 28 days		17.76%	54.21%

** These figures are subject to change

3.16 Quality Report request for External Assurance

This not required for 2021/22

Annex 1: Quality Report Statements

Statements from Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees and other stakeholders 2021/22 are presented within this document unedited by the Trust and are produced verbatim.

The statement will be included on receipt from the CCG

Statement from Warrington and Halton Clinical Commissioning Groups

The statement will be included on receipt from the CCG

Statement from the Halton Health Policy Performance Board

The statement will be included on receipt from Healthwatch

Statement from the Trust's Council of Governors

On the 05 April 2022, Governor N Holding - on behalf of the Council of Governors

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2021/2022.

The Quality Report is very detailed and thorough and assists the Governors in holding the Non-Executive Directors to account for the performance of the Board of Directors.

One of the Governors prime roles is to focus on quality. As part of the Council's governance structure, it meets regularly with the Chair of the Trust Quality Committee and the Trust Chair. At these meetings the Governors receive the latest performance information and have the chance to analyse it and raise questions. All Governors receive the Trust's dashboard monthly and can table queries to the CoG. The Governors have an observer at the Trusts Quality committee who reports to the CoG on the effectiveness

of the NED in the role of Chair of the Trusts Quality committee. All these activities have continued in a virtual format thereout the last year.

The formal public governor's council meeting programme is a small part of the governors' work in the trust. The Governors have several committees which they lead on, which allows them to bring information and views to the main council meeting. Other agenda items include updates from those committees and other topics of interest.

The Governors strongly support the emphasis on patient safety, patient experience and clinical effectiveness documented throughout the Quality Report. Patients, their relatives, carers, and the hospital's key stakeholders have all identified these as three areas of paramount importance.

For the coming year, the Governors agree with the priorities established. **The Patient Safety Priorities** relating to: Improving Sepsis screening and timely management. Waiting list management in line with national guidance and clinical priorities and Evidence a culture of Quality, Safety and learning aligned to National Patient Safety Framework. **The Patient Experience Priorities,** Implementation of the Trust Learning Disability and Mental Health Strategies. Nutrition and Hydration – To ensure that Patients have access to a choice of food and nutrition. Health inequalities addressed through Patient centred communications Finally, Governors see the **Clinical Effectiveness Priorities** regarding, Evidence a culture of Quality, Safety and Leaning across clinical services, "Get it right first time" clinical productivity programme to be implemented across all specialities to deliver enhanced quality and productivity. and to Strengthen the Discharge Process to improve the quality of discharge to home and community providers. as key areas for delivery of a better all-round patient path through the hospital.

The Governors are happy that the 2021/22 Quality Report provides data that is more meaningful, understandable, and clearer to all, the report shows indicating trends, and comparisons with the previous year statistics. For the coming year, the Governors will review the Quality Report quarterly.

Governors find the format and section headings helpful. The Quality Report contains considerable detail commensurate with the complex and diverse range of services provided by an Acute Hospital Trust. The Governors believe the Quality Report to be accurate. The graphs and accompanying explanations help the public and members to understand clearly the progress made in many areas of patient safety and patient care.

Governors encourage all Trust members, members of the public and others who are interested in our hospitals and their performance to read the Quality Report.

Statement from Warrington Healthwatch

Statement from the Halton Healthwatch

Annex 2: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2021 to date of signing this statement
    - Papers relating to Quality reported to the Board over the period April 2021 to date of signing this statement
    - Feedback from the Commissioners, Warrington Clinical Commissioning Group and Halton Clinical Commissioning Group dated **X/X/2022**
    - Feedback from Council of Governors dated 05 April 2022
    - Feedback from local Healthwatch organisations, Healthwatch Halton dated xxx and Healthwatch Warrington dated **X/X/2022**
    - Feedback from Overview and Scrutiny Committee dated **X/X/2022**
    - Feedback from Halton Borough Council dated **X/X/2022**
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated **X/X/2022**
    - The 2021 national adult inpatient survey under embargo until June
    - The 2021 national staff survey published – under embargo until June
    - CQC inspection report dated 24 July 2019

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Date…… Steve McGuirk **Chairman**

Date…… Simon Constable **Chief Executive**

[NB: sign and date in any colour ink except black]

Independent Auditor's Assurance Report to the Council of Governors of Warrington and Halton Teaching Hospitals NHS Foundation Trust on the Annual Quality Report.

Due to the COVID-19 global pandemic there will be no Independent Auditor's Assurance Report for this financial year.

Appendix – Glossary of Abbreviation and Definitions

Abbreviations	Definitions
Appraisal	Method by which the job performance of an employee is evaluated
Care quality commission (CQC)	Independent regulator of all health and social care services in England. They inspect these services to make sure that care provided by them meets national standards of quality and safety.
Clinical audit	Is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical commissioning group (CCCG)	Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Clostridium difficile (C diff)	A Clostridium difficile infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital. (CMCLRN) Cheshire and Merseyside Comprehensive Local Research Network
Commissioning for Quality and Innovation (CQUIN)	This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Friends and Family test (FFT)	Since April 2013, the following FFT question has been asked in all NHS Inpatient and A&E departments across England and, from October 2013, all providers of NHS funded maternity services have also been asking women the same question at different points throughout their care : "How likely are you to recommend our [ward/A&E department/maternity service] to friends and family if they needed similar care or treatment?"
Governors	Governors form an integral part of the governance structure that exists in all NHS foundation trusts; they are the direct representatives of local community interests in foundation trusts
Healthwatch	Healthwatch is a body that enables the collective views of the people who use NHS and social care services to influence policy.
Healthcare evaluation data (HED)	Clinical benchmarking system to support clinical experts in more effective management of clinical performance.
Hospital episode statistics (HES)	Is a database containing information about patients treated at NHS providers in England.
Hospital Standardised Mortality Review (HSMR)	Is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.
Information governance	Ensures necessary safeguards for, and appropriate use of, patient and personal information.
Mandatory training	The Organisation has an obligation to meet its statutory and mandatory requirements to comply with requirements of external bodies e.g., Health & Safety

Abbreviations	Definitions
	Executive (HSE), training is provided to ensure that staff are competent in statutory and mandatory
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
MSSA	Methicillin-sensitive *Staphylococcus aureus* (MSSA) is a bacteraemia caused by Staphylococcus aureus which is a serious infection associated with high morbidity and mortality and often results in metastatic infections such as infective endocarditis, which have a negative impact on patient outcomes
National confidential enquiries (NCEPOD)	The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients; undertaking confidential surveys and research; by maintaining and improving the quality of patient care; and by publishing and generally making available the results of such activities.
NHS Improvement	NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
National inpatient survey	Collects feedback on the experiences patients who were admitted to an NHS hospital in 2019.
National institute for health and clinical excellence (NICE)	Is responsible for developing a series of national clinical guidelines to secure consistent, high quality, evidence based care for patients using the National Health Service.
National institute of health research (NIHR)	Organisation supporting the NHS.
National patient safety agency (NPSA)	Lead and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
National reporting and learning system (NRLS)	Is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.
Never Events	Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS outcomes framework	Reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. To act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.
Open and Honest	North of England Trusts produces and publishes monthly reports on key areas of healthcare quality.
Palliative care	Focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.
Patient Reported Outcome Measures (PROMs)	Provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.
Payment by results (PBR)	Provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case mix.
Safety thermometer	Is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care?
Summary hospital-level indicator (SHMI)	reports mortality at trust level across the NHS in England using standard and transparent methodology.
Urinary tract infection (UTI)	is an infection that affects part of the urinary tract

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/69**			
SUBJECT:	**Finance and Sustainability Committee (F&SC) Chair's Annual Report 2021-22**			
DATE OF MEETING:	25th May 2022			
AUTHOR(S):	Terry Atherton, Non-Executive Director & Chair of F&SC			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			 ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1372** FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY - A failure to develop an affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits - A failure to garner ICS and NHSE support to progress the EPR business case - A failure to deliver Managed Convergence in line with emergent national policy and the ICS Convergence strategy (in development) RESULTING IN (sequentially) – a continuation of the Trust's challenges with the incumbent EPR, Lorenzo (as identified in the Strategic Outline Case), potential for a costly extension to the existing Lorenzo contract or the highly retrograde step of returning to paper systems as Lorenzo will be at end of life at or before the end of the tactical contract extension patient population and organisation, potential impact on patient care, reputation and financial position.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report seeks to deliver assurance to the Trust Board that the Finance and Sustainability Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision

RECOMMENDATION:	The Trust Board is asked to review the document and ensure it meets its purpose.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee
	Agenda Ref.	FSC/22/05/92
	Date of meeting	19th May 2022
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/22/05/92**			
SUBJECT:	**Committee Chairs Annual Report 2021-22**			
DATE OF MEETING:	19th May 2022			
AUTHOR(S):				
NON-EXECUTIVE DIRECTOR SPONSOR:	Terry Atherton, Non-Executive Director, Committee Chair			
EXECUTIVE SUMMARY:	This report seeks to deliver assurance to the Finance and Sustainability Committee that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: (please select as appropriate)	Information	Approval ✓	To note	Decision
RECOMMENDATION:	**The Finance and Sustainability Committee is asked to review the document and ensure it meets its purpose.**			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**			
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

SUBJECT	Annual Report of the Finance and Sustainability Committee 2021-22

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Finance and Sustainability Committee (F&SC) Annual Report which covers the reporting period 1 April 2021 to 31 March 2022.

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

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

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

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

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

Terms of Reference

The Committee's Terms of Reference were reviewed and approved by the Trust Board in November 2021 to ensure they continued to remain fit for purpose with amendments approved to:

Amendment to section 6- Core Attendees:

- Remove – Chief Information Officer
- Amend title of Deputy Director of Finance & Commercial Development
- Amend title of Director of Strategy & Partnerships
- Amend title of Executive Medical Director

Frequency of Meetings and Summary of Activity

In light of the COVID-19 pandemic, the meetings were held virtually via MS Teams and some agendas streamlined as appropriate.

Due to significant operational pressures, the Finance & Sustainability Committee scheduled to take place on Wednesday 19th May 2021, was cancelled. The following items were reviewed by me as Chair of the Committee and Anita Wainwright, Non-Executive Director and any questions raised and subsequent answer provided were shared with the Trust Board on 26th May 2021:

- Corporate Performance Report
- Additional Oversight of Capital Expenditure

- MIAA Capital Review progress report
- MRI Capital Business Case

All other items were deferred to the June meeting as appropriate, and the Trust Board received an update on the month 1 financial position within the IPR Board report on 26th May 2021.

The Committee met virtually 12 times during the year (an additional Extra-ordinary meeting took place on 14th October 2022). A summary of the activity covered at these meetings follows:

Reporting

In terms of reporting to the Finance and Sustainability Committee, the following key reports were submitted in 2021-22.

Pay Assurance

The Pay Assurance reports set out an overview of workforce FTE position across the Trust on a monthly basis throughout 2021/2022 and provided information to the Finance and Sustainability Committee information on compliance with processes in place to control pay spend including:

- Establishment Control Process
- Estimated Cost of Absence
- Medical Bank Rate Card Compliance
- Agency Rate Card Compliance
- Temporary Staffing Booking Lead Times

This paper also provided information to the Committee on the use of 'off-framework' agencies, administrative and clerical agency usage and sub-contractors. Other areas discussed included Waiting List Initiatives, vacancy rates, the cost of sickness and the possible implications of Vaccination as a Condition of Deployment (VCOD)

Performance

This Corporate Performance Report updates the Finance and Sustainability Committee on the progress of the Trust in relation to activity and performance related targets on a monthly basis.

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

- The Emergency Department and 4hr performance – At the end of the year the ED performance remained below the national standard of 95%; however, several actions are in place to support improvement.
- Ambulance Handovers
- Average Length of Stay
- Stranded & Super Stranded Patients
- Delayed Discharges
- Referral to treatment (18 week RTT)
- Cancer all standards.

Risks

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

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

- COVID-19 related risks
- EU Exit Transition
- Electronic Patient Record solution
- Recovery
- Capital planning
- Provision of effective digital services

Strategic Risk Register – During the year, one new risk was added and one risk was closed

Corporate Risk Register – During the year, one risk was closed and the rating of one further risk was reduced.

Finance

The Trust recorded an adjusted surplus of £0.2m which is slightly better than the breakeven plan. This adjusted surplus is the value which NHSE/I monitors the Trust against and was achieved.

The annual capital programme was £19.2m and the actual spend for the year was £19.15m, delivering an underspend of £0.05m.

PDC of £33.7m was provided in March 2021 to support the Trust in continuing to pay creditors promptly in line with guidance. The cash balance at the end of the year was £44.7m which will be utilised to fund the annual leave accrual, new EPCMS and delayed capital creditors.

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

Capital has been monitored through the year via Capital Planning Group and Finance and Sustainability Committee, with particular focus on schemes over £0.5m.

Over the last 12 months the Trust has continued to have regular meetings with NHSE/I where the financial position, forecast and capital have been discussed, reviewed, and challenged.

During the year the Committee received and reviewed the following:

- Dashboard setting out key finance and procurement metrics and performance
- Monthly, year to date and forecast financial performance
- Monthly, year to date and forecast capital expenditure.

- Monthly, year to date and forecast cash balances including short term cash flow.
- Draft Finance Strategy
- Review of aged debt and aged creditors.
- Monthly, year to date and forecast of COVID-19 expenditure and income
- Outcomes from Medical Stocktake review received April 2021.
- Updates on the Electronic Patient Care Management System (EPCMS)
- Cheshire & Merseyside Financial Position
- Monthly and year to date performance against the Better Payment Practice Code.
- Risks and mitigating actions to financial position.
- Updates on, Service Line Reporting and Reference Costs.
- Local system financial performance information.
- NHSI Updates.
- Digital assurance reports
- Medical Staffing Review

Approvals – delegated authority from Trust Board

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

- **19th January 2022** – Approval of the £0.363m underspend against capital schemes that had been returned to contingency and the OPTUS integration costs.

- **16th February 2022** – Approval of HR decoration and Accufit Testing schemes (£0.074m). Approval of the Schemes brought forward from 2022/23 of £1.362m and approval of the £1.194m underspend and slippage against capital schemes that had been returned to contingency.

- **21st March 2022** – Approval of a renal pump and plumbing scheme (£51k) and dental chair increase (£7k). Approval of Virtual fracture clinic software (£70k) and approval of £0.158m underspend and slippage against capital schemes that had been returned to contingency.

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

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

As a result of the COVID-19 pandemic, meetings were cancelled in April, May and December 2021, and again in January and March 2022.

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

Digital

The Committee continued to receive a monthly Digital Services report and maintain oversight of digital investments in line with the Digital Strategy.

Key areas of focus contained in the reports in the previous year have been:

- Updates on the Digital Programme
- Vendor Management
- Information & Business intelligence
- It Services
- Digital Compliance & Risk
- Digital Diagnostics
- eRostering
- Badgnernet Maternity Electronic Patient Record System
- Anti-Virus Protection
- Updates on the Electronic Patient Care Management System (EPCMS)

Other issues considered / Reviewed during the year

- In April 2021, the Committee supported the establishment of the Clinical Recovery Oversight Committee. The Committee is a temporary Committee established during the COVID-19 pandemic and is accountable to the Board to ensure triangulation of matters detailed above under the purview of the Quality Assurance Committee and the Finance & Sustainability Committee; and ensuring that the organisational risks are managed appropriately in line with professional and regulatory standards.

  CROC provided specific oversight and focus in relation to RTT, patient cancer pathways and diagnostics.

- June 2021 – The Committee received and considered a report on the indicative financial cost of harm.

- July 2021 – Received the conclusions and recommendations of the Medical Establishment review and established further oversight arrangements.

- September 2021 - Transfer of Maternity Services to the Trust

- December 2021 – Received and reviewed the Mersey Internal Audit Agency (MIAA) review of the WLI process in ENT

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

COVID-19 Monitoring

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

Issues Carried Forward/Escalated

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

- 4 hour performance
- RTT performance
- ED Plaza build
- Medical Establishment
- Ambulance Handovers
- Cancer Waiting times
- CIP Performance
- ERF Funding
- Super Stranded Patients

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

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

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

Summary

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

Terry Atherton
Chair of Finance and Sustainability Committee
May 2022

Finance and Sustainability Committee Attendance Record 2021-2022

	2021									2022			% attendance Excl, Deputy	% attendance Incl, Deputy
	April	May Ccl led	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March		
CORE MEMBERSHIP														
Terry Atherton, Chair, Non-Executive Director	√		√	√	√	√	√	√	√	√	√	√	100	100
Anita Wainwright, Non-Executive Director (until 31.12.21)	√		√	√	√	√	√	√	√				100	100
Julie Jarman, Non-Executive Director (from 01.01.22)										√	√	√	100	100
IN ATTENDANCE														
Andrea McGee, Chief Finance Office & Deputy CEO	√		√	√	√	√	A/D	√	√	√	A/D	√	82	100
Jane Hurst, Deputy Chief Finance Officer	√		√	√	√	A/D	√	√	A/D	√	√	A	82	100
Michelle Cloney, Chief People Officer	√		√	√	√	A/D	√	√	√	√	√	√	91	100
Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO	√		√	√	√	√	A/D	A/D	√	√	A	√	63	91
Alex Crowe, Executive Medical Director (until 30.11.21)	√		√	√	√	√	√	R	R	R	R	R	100	100
Paul Fitzsimmons, Executive Medical Director (from 1.12.21)									√	√	√	√	100	100
Dan Moore, Chief Operating Officer	√		√	√	√	A/D	√	√	√	√	√	√	91	91
John Culshaw, Trust Secretary	√		√	√	√	√	√	√	√	√	A	√	91	91
Paul Bradshaw (until Feb 22) Norman Holding (Mar meeting)	A		√	√	√	√	√	A	√	√	√	√	91	100
NED / EXECUTIVE / DEPUTY ASKED TO ATTEND														
Lucy Gardner, Director of Strategy (only when required)	ANR		A/ANR		√	√	√	√		√				
Anne Robinson, Deputy Medical Director	√			√				√						
M Garnett, Head of Contracts & Performance (1 item only)			√	√										
C Leather, Finance										√	√			
Zoe Harris, Director of Operations & Performance						√								
Carl Roberts, Deputy CPO						√								
Gregory King, Head of Financial Planning						√								
Tom Poulter, CIO						√	A	√		√				
John Goodenough, Deputy Chief Nurse							√	X/D			√			

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/70**	
SUBJECT:	**Infection Prevention and Control Quarter 4 Report**	
DATE OF MEETING:	25 May 2022	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first delivering safe and effective care, and an excellent patient experience.	√
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for now and the future.	√
	SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments, and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1207** Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident. **#1331** Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.	

EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection prevention and control activity for Quarter 4 (Q4) of the 2021/22 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. National healthcare associated infection (HCAI) reduction targets were published in July 21 and are as follows: - • E. coli bacteraemia ≤ 81 cases • Klebsiella spp. bacteraemia ≤ 23 cases • P. aeruginosa bacteraemia ≤ 4 cases • Clostridium difficile ≤ 44 cases • MRSA bacteraemia cases = Zero tolerance • MSSA bacteraemia cases – no threshold set In Q4 Trust apportioned HCAIs included: - • 10 E. coli bacteraemia cases with financial year total (FYT) 63 • 10 Klebsiella spp. bacteraemia with FYT 26 • 0 P. aeruginosa bacteraemia cases with FYT 3 • 15 Clostridium difficile cases with FYT 46 • 1 MRSA bacteraemia cases with FYT 1 (awaiting appeal) • 7 MSSA bacteraemia cases with FYT 29 Covid-19 cases were detected: - • 571 (0-2 days) with FYT 1364 • 102 (3-7 days) with FYT 162 • 75 (8-14 days – probable healthcare associated) with FYT 104 • 154 (15+ days – definite healthcare associated) with FYT 190 • 23 Covid-19 outbreaks in Q4			
PURPOSE: (please select as appropriate)	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to receive the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/05/125		
	Date of meeting	3 May 2022		
	Summary of Outcome	Submit to Board for assurance		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

SUBJECT	Infection Prevention and Control Q4 report 2021/22	Agenda Ref:	BM/22/05/70

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 4 (Q4) of the 2021/22 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) targets and the response to the Covid-19 Pandemic.

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

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

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

In July 2021 NHSE/I published quality requirements for Trusts to minimise healthcare associated C. difficile and GNBSIs, using 2019 calendar year data as a baseline. WHH HCAI thresholds are shown in table 1. Thresholds for 2022/23 are awaited.

Table 1: HCAI Thresholds for 2021/2022

HCAI	Reduction	WHH Threshold 2021/22
C. difficile	Minus 1 case	≤44
E. coli	Minus 5%	≤81
Klebsiella spp.	Minus 5%	≤23
P. aeruginosa	Minus 5%	≤4

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

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

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

2. KEY ELEMENTS

HCAI data

RAG rating of Trust performance for HCAIs by month is shown in Table 2. Breakdown by ward is included at appendix 1.

Table 2: HCAI data by month

Indicator	Threshold	Position	A	M	J	J	A	S	O	N	D	J	F	M	Total
C. difficile	≤44	Over trajectory	4	6	4	6	1	2	1	3	4	5	8	2	46
MRSA bacteraemia	Zero tolerance	Over trajectory	0	0	0	0	0	0	0	0	0	0	1	0	1
MSSA bacteraemia	No target	No target	4	4	2	1	4	1	3	3	0	5	1	1	29
E. coli bacteraemia	≤81	Under trajectory	9	6	8	4	6	4	4	5	7	4	3	3	63
Klebsiella spp. bacteraemia	≤23	Over trajectory	1	2	1	2	3	1	3	1	2	5	4	1	26
P. aeruginosa bacteraemia	≤4	Under trajectory	0	1	0	0	0	0	0	1	1	0	0	0	3

Clostridium difficile

All Trust apportioned cases undergo post infection review. Ribotyping of all hospital onset/healthcare associated and community onset/healthcare associated cases has not identified any links between Trust apportioned toxin positive cases. Cases are 2 over trajectory, however 3 cases were appealed to the CCG and were considered unavoidable. An additional 2 cases are awaiting appeal with the CCG.

Gram positive bacteraemia

1 cases of MRSA bacteraemia reported in Q4. The patient was admitted to another local Trust and is awaiting appeal with a view to reapportionment.

FYT figures for MSSA bacteraemia are shown in the table above. There is a mixture of likely primary sources (appendix 1), noting some are due to deep seated infections and not preventable. Supportive training has been provided to wards where cannula associated infections occurred and wider sharing of learning taken to Trust-wide safety brief.

Gram negative bacteraemia (GNBSI)

FYT figures for GNBSI cases are shown in the table above. The Trust is below threshold for all E. coli and P. aeruginosa bacteraemias. The likely primary source for the majority of GNBSIs is urinary tract.

The GNBSI Prevention Group meetings continue with phase one ward (A2, A4, A5, A6, A7, A8, B14, B19) and the Quality Academy. Areas of focus include: - hydration, continence management, reducing use of urinary catheters and improving care where required, hand hygiene (including patients) and urinary tract infection detection/management. The revised UTI pathway is scheduled to be launched in May 2022.

Comparative data for HCAI rates for with other Northwest (NW) Trusts, is included in appendix 2. The Trust has lower case numbers/rates for both MRSA/MSSA bacteraemia cases than both local Delivery System (LDS) partners. The Trust has flagged as a high outlier for C. difficile. Cases are comparable to previous years. E.coli bacteraemia cases are lower than 1 and comparable to the other LDS partner. Cases of Klebsiella are higher and an audit is in progress to identify learning from cases. Pseudomonas cases are significantly lower than both LDS partners.

Outbreaks/Incidents

Covid-19

Covid-19 cases were detected: -

- 571 (0-2 days) with FYT 1364
- 102 (3-7 days) with FYT 162
- 75 (8-14 days – probable healthcare associated) with FYT 104
- 154 (15+ days – definite healthcare associated) with FYT 190

- 23 Covid-19 outbreaks in Q4 with 32 for the FYT

Q4 saw an increase in patient admissions with Covid-19, compared to earlier quarters. Hospital onset cases by CBU and ward is shown in appendix 3. All cases detected ≥ day 8 of admission where there is no prior positive Covid-19 result in the last 90 days undergo root cause analysis (RCA). Point of Care testing in the Emergency Department is directing appropriate patient placement to Covid/non-Covid admission areas.

All activities continue in response to the Covid-19 pandemic including promotion of hand hygiene, use of personal protective equipment and social distancing. The programme of Fit Testing of FFP3 respirators has continued. Visiting has been reinstated with timed slots of 1 hour and 2 visitors per bed.

Trust compliance with the NHSE/I Board Assurance Framework (version 1.8) linked to the Code of Practice on prevention of Healthcare Associated Infections has been reassessed and submitted to Trust Board. An action plan has been developed to support minor gaps in assurance with progress made.

Twenty-three Covid-19 outbreaks were reported in Q4, associated with peaks in Covid-19 admissions. Root cause analysis investigations are in progress.

Next steps include: -

- Continue to provide and reinforce updates on Covid-19 IPC precautions
- Continue to review RCA findings from nosocomial cases
- Review and implement updated national guidance as it is published

Infection Prevention and Control Training

Training compliance by month is shown in Table 3. Overall compliance with Mandatory training was 87% at the end of February. Figures for March are awaited.

Table 3 Infection Control Training compliance

Infection Control Training	A	M	J	J	A	S	O	N	D	J	F	M
Level 1 – Non-Clinical	92%	91%	90%	89%	89%	89%	89%	89%	90%	89%	90%	
Level 2 - Clinical	82%	83%	83%	82%	83%	83%	83%	84%	85%	86%	83%	
Overall % of staff trained	**87%**	**87%**	**87%**	**86%**	**86%**	**86%**	**86%**	**87%**	**88%**	**88%**	**87%**	

The Infection Prevention and Control Nurses (IPCNs) have provided 2 virtual training sessions per week via Live MS Teams events to drive up compliance. Clinical Business Unit (CBU) with compliance below 85% have been directed to set improvement trajectories. Additional training sessions have been offered by the IPCNs to support the CBUs.

Environmental Hygiene

Good progress is being made by the task and finish group to implement the revised National Standards of Healthcare Cleanliness. Areas have been reassigned for cleaning category and wording of the Commitment to cleanliness charter has been reviewed to make it more patient/visitor focussed.

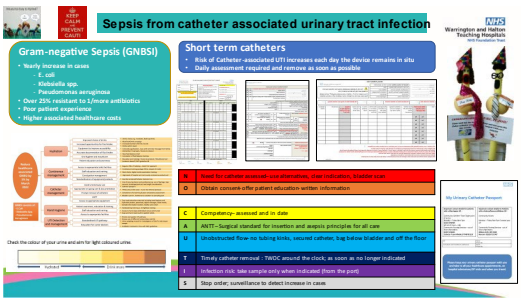
Antimicrobial Stewardship

From the Trust wide Antibiotic Point Prevalence Audit (March 22), an increased percentage of patients receiving antibiotics was identified. Improvements were noted in overall formulary compliance from 87.6% to 92.7% and a reduction in number of wards with less than 90% formulary compliance from twelve wards to five wards. The Antibiotic Ward Rounds introduced for A9 has shown improvements to 100% compliance with full audit details in appendix 4.

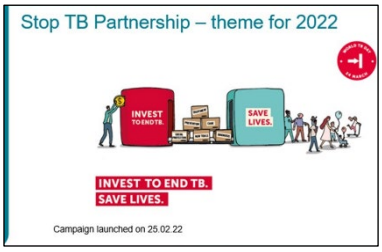
Awareness raising events

The Infection Prevention and Control Team carried out focussed awareness raising activity on: -

Antimicrobial Stewardship/Gentamicin and preventing urinary catheter associated GNBSI at Trust Wide Safety Brief in February.



Use of desktops and presentation at Trust Wide Safety Brief on World TB Day in March



3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. IMPACT ON QPS

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

5. MEASUREMENTS/EVALUATIONS

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

6. TRAJECTORIES/OBJECTIVES AGREED

HCAI	Reduction	WHH Threshold 2021/22
C. difficile	Minus 1 case	≤44
E. coli	Minus 5%	≤81
Klebsiella	Minus 5%	≤23
P. aeruginosa	Minus 5%	≤4

- One of the Trust's quality priority targets has been revised in line with the NHSE/I published thresholds to reduce healthcare associated GNBSIs by 5% by March 2022
- The zero tolerance to avoidable MRSA bacteraemia cases remains in place

Work streams will continue to:-

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

7. MONITORING/REPORTING ROUTES

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

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

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

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

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

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

8. TIMELINES

- 2021/22 FY

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

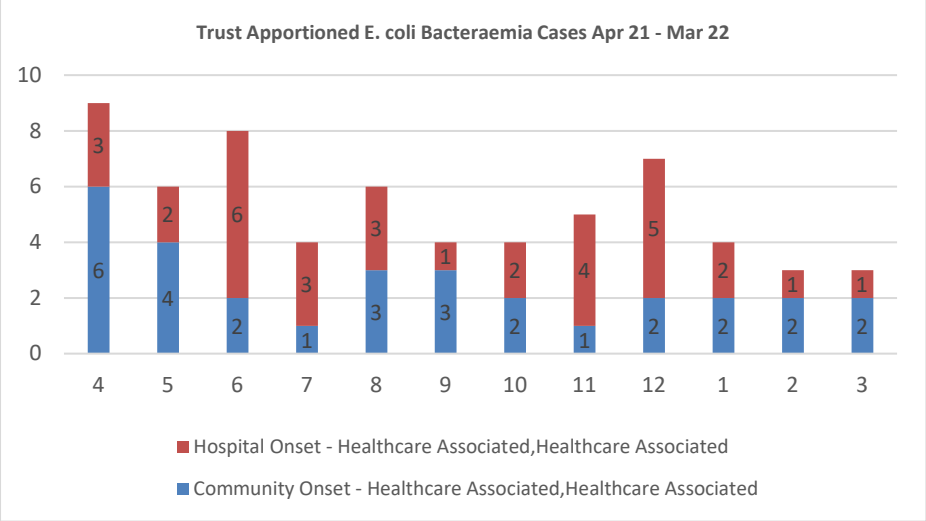
10. RECOMMENDATIONS

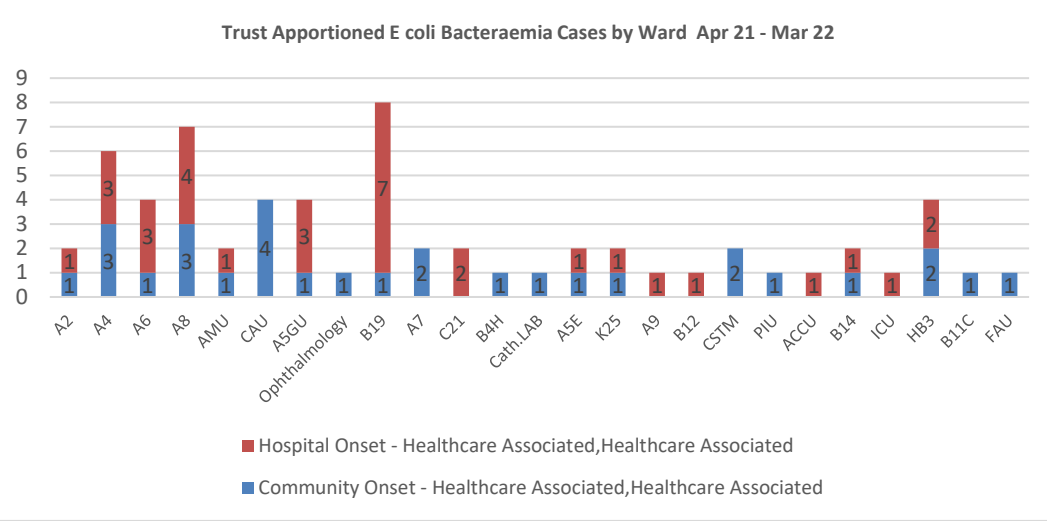
The Quality Assurance Committee is asked to receive the report and note the exceptions reported and progress made.

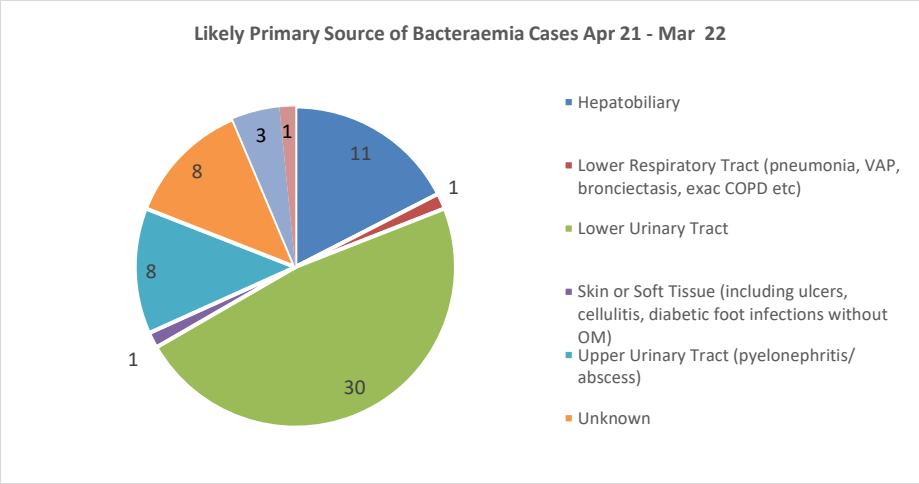
Appendix 1 Healthcare Associated Infection Data Apr 2021 – Mar 22

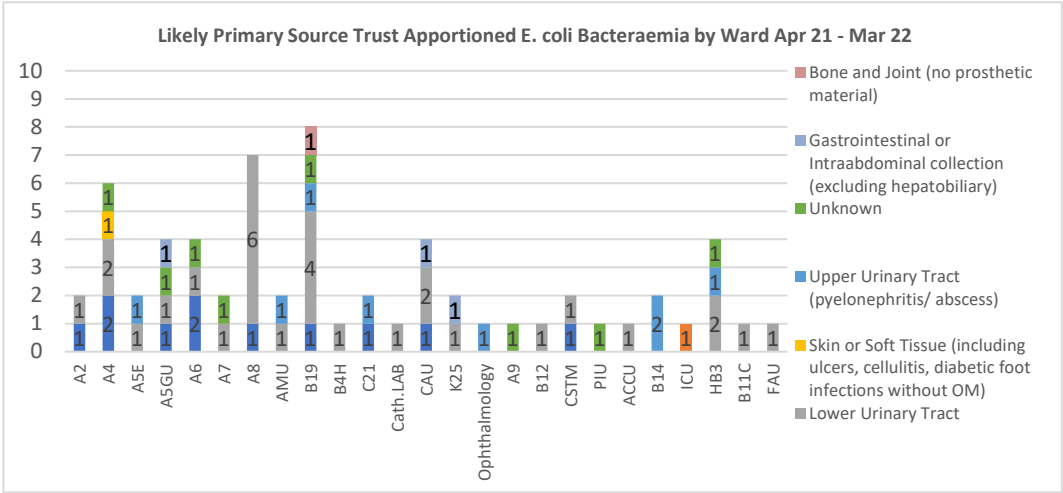
Threshold = 81 cases
FY Total = 63 cases

Gram Negative Bloodstream Infection: E. coli





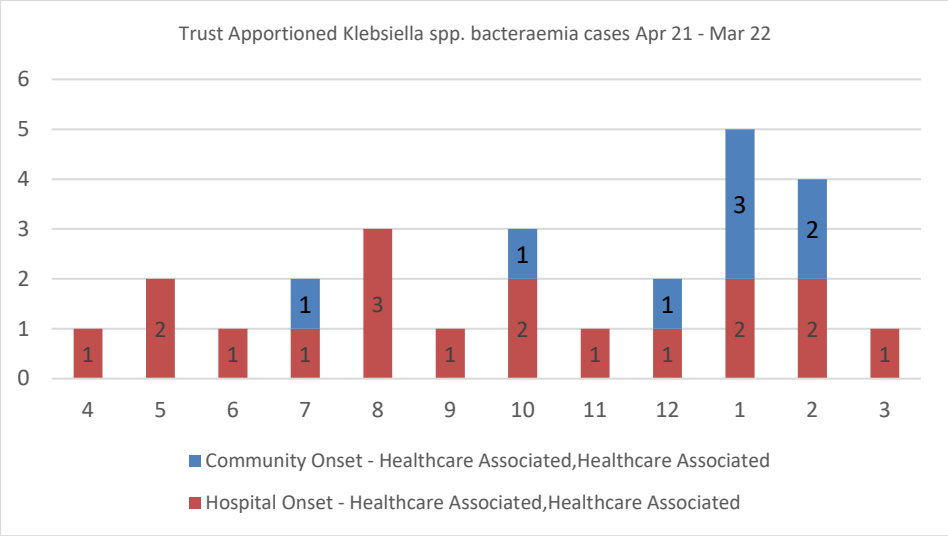


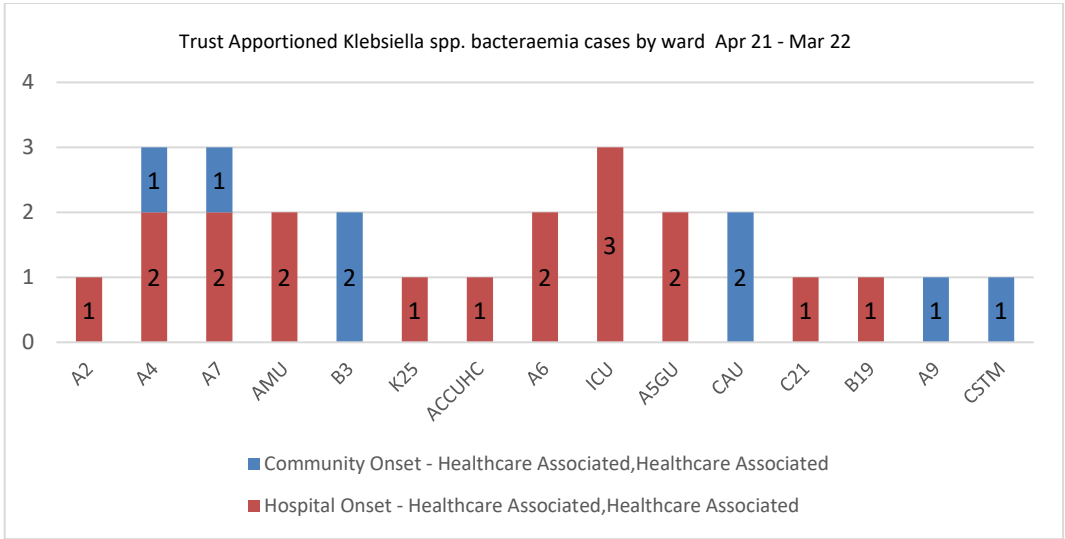


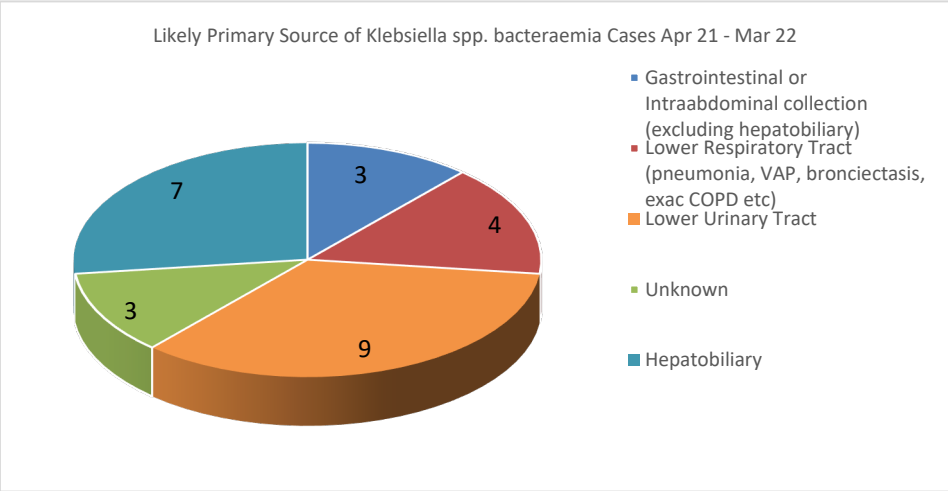
Warrington and Halton Teaching Hospitals NHS Foundation Trust

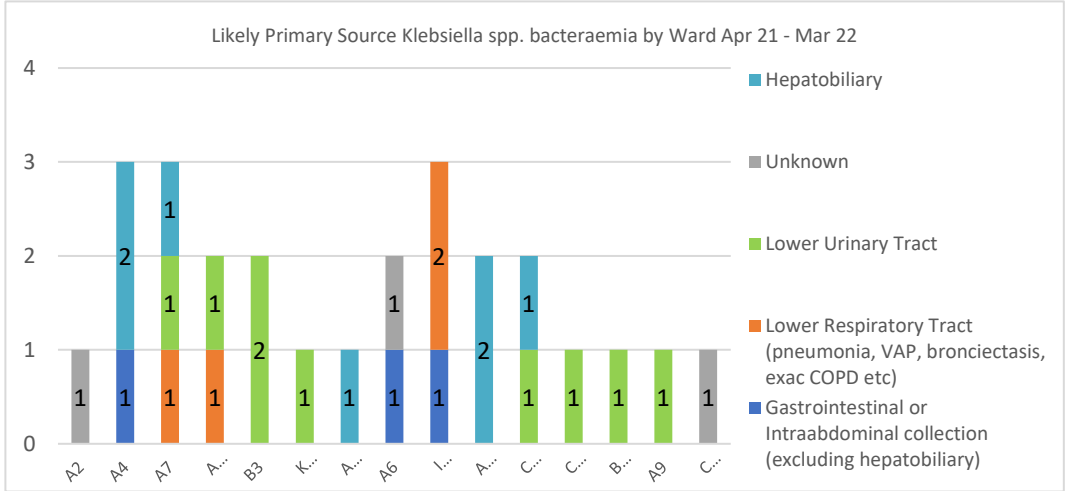
Threshold = 23 cases
FY Total = 26 cases

Gram Negative Bloodstream Infection: Klebsiella spp.





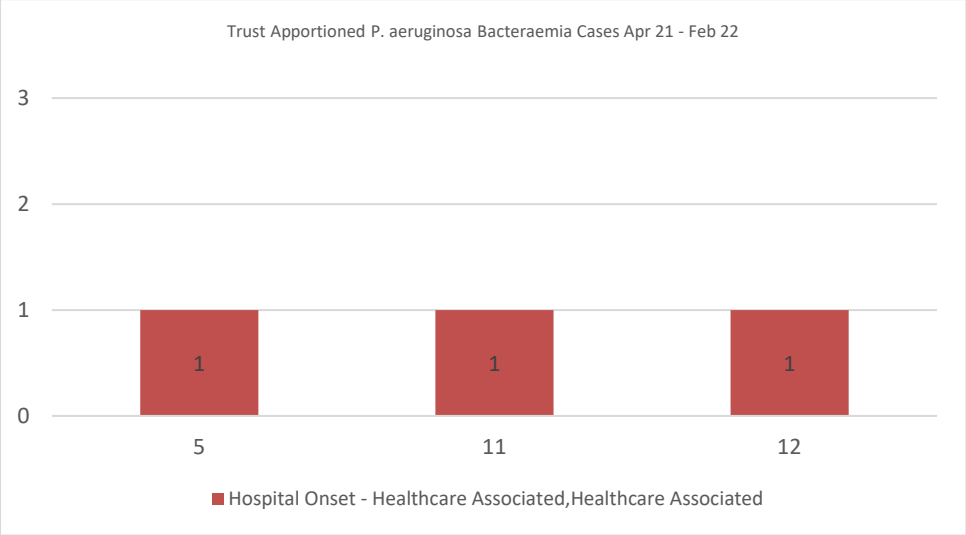


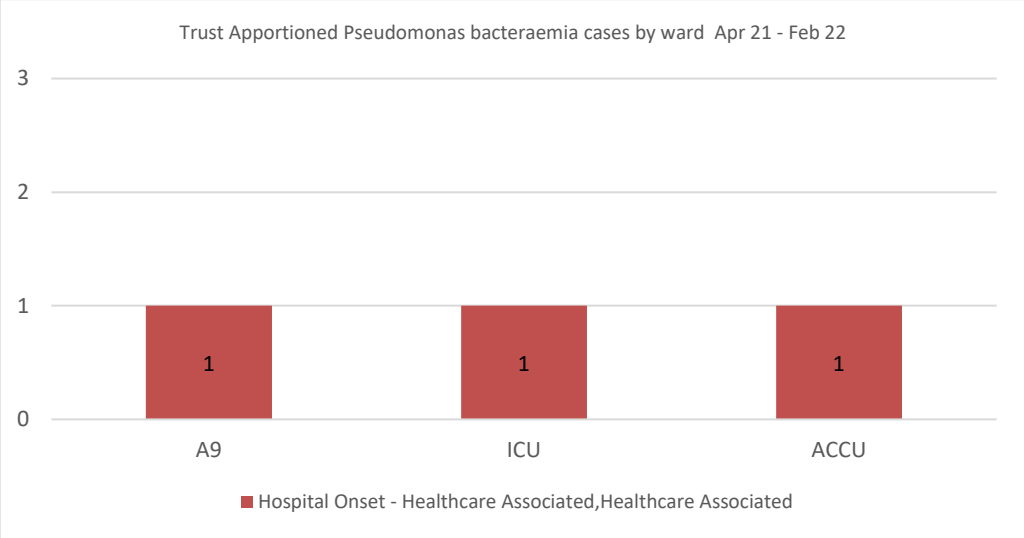


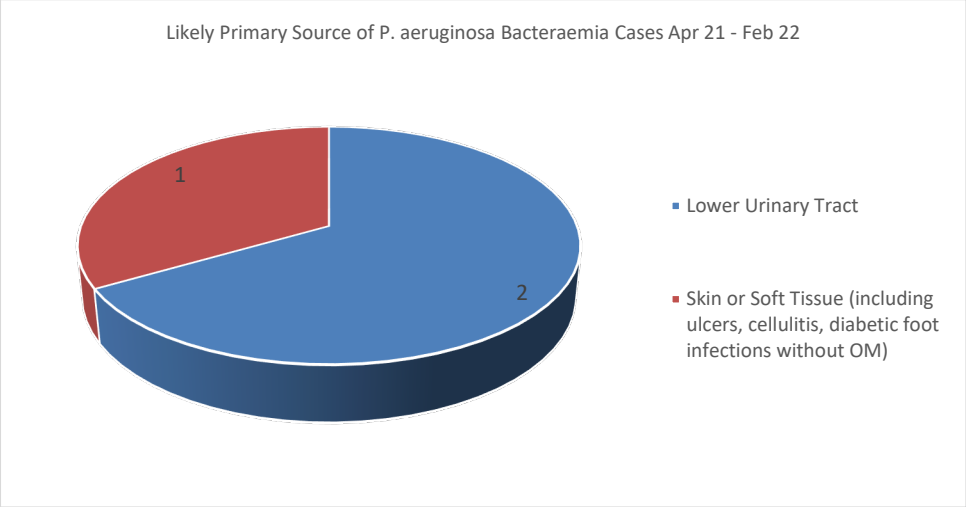
182 of 390

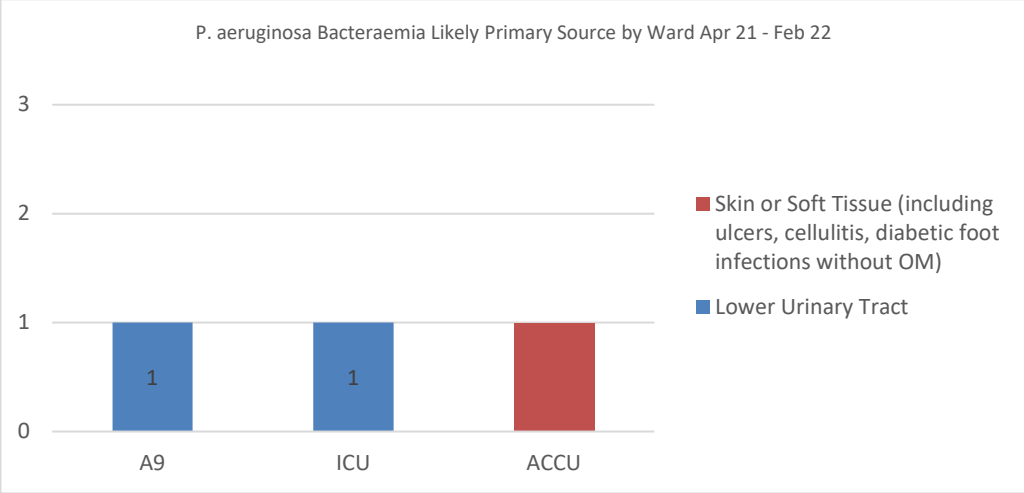
Threshold = 4 cases
FY Total = 3 cases

Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa)





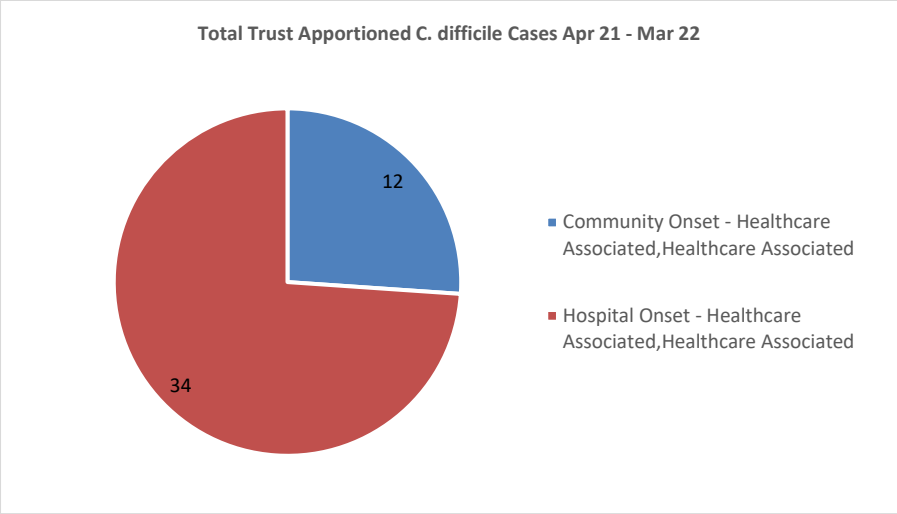


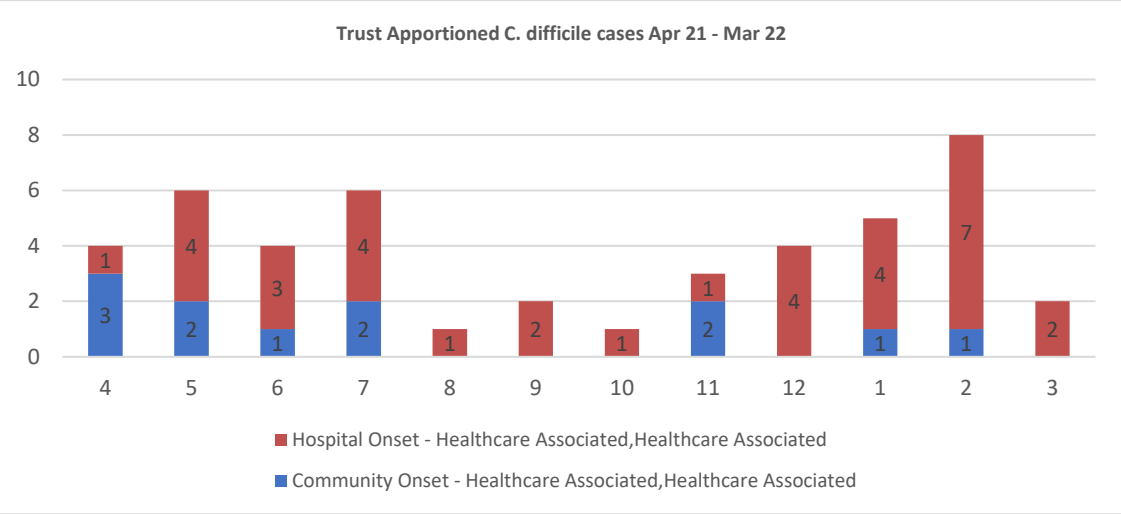


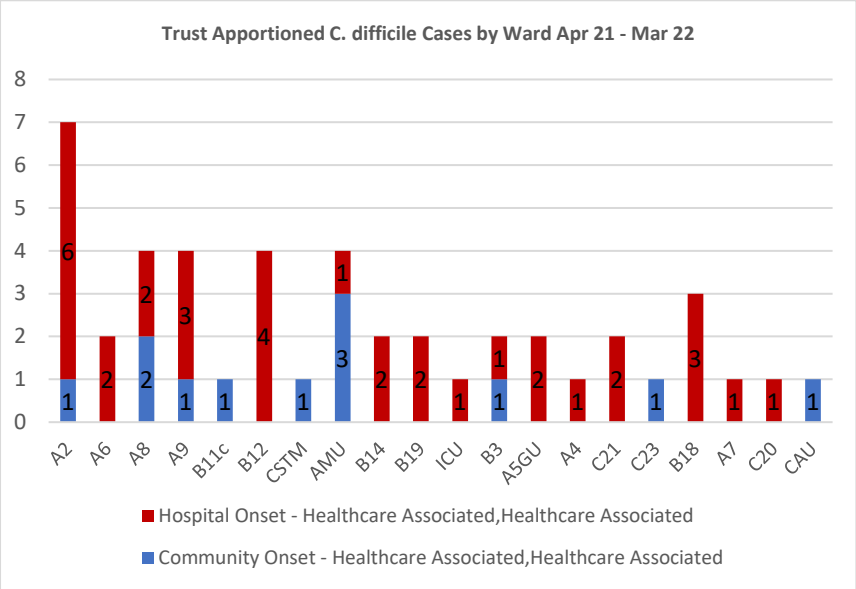
Clostridioides difficile (C. difficile)

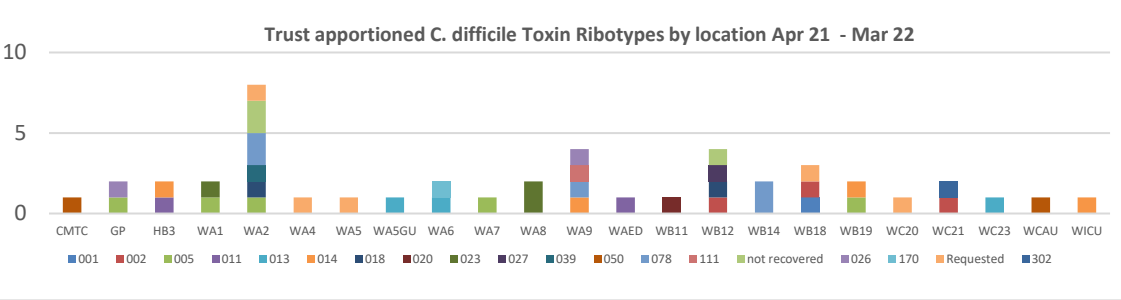
Threshold = 44 cases
YTD Total = 46 cases

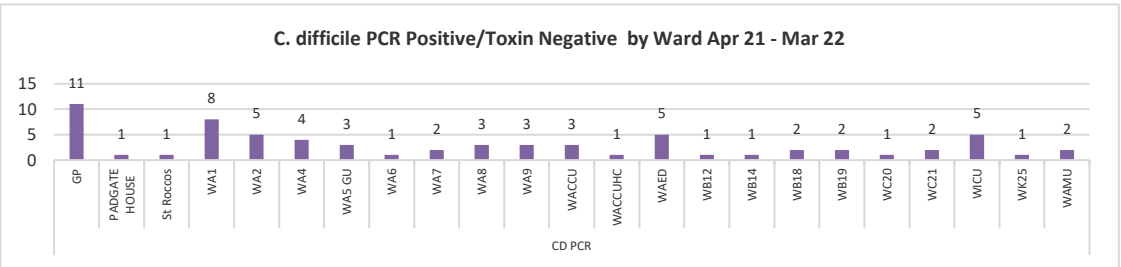
3 cases successfully appealed with CCG











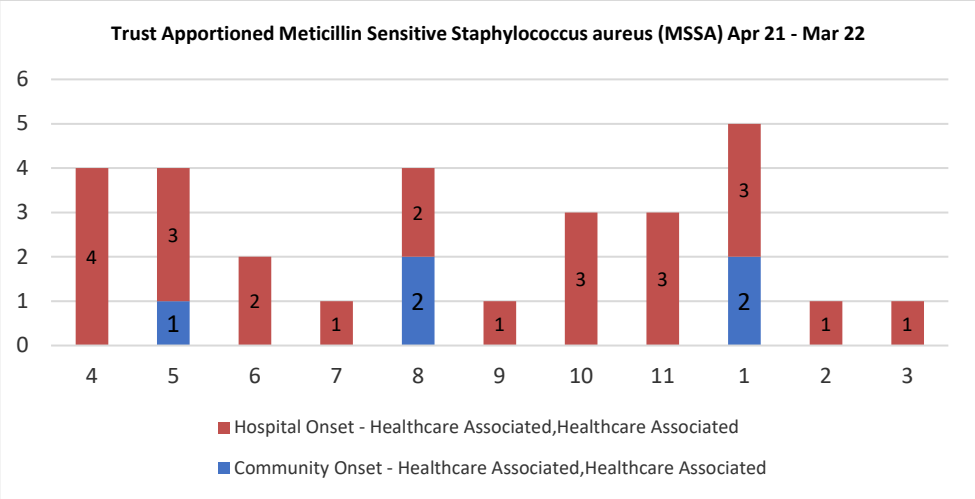
We are WHH & We are PROUD to make a difference

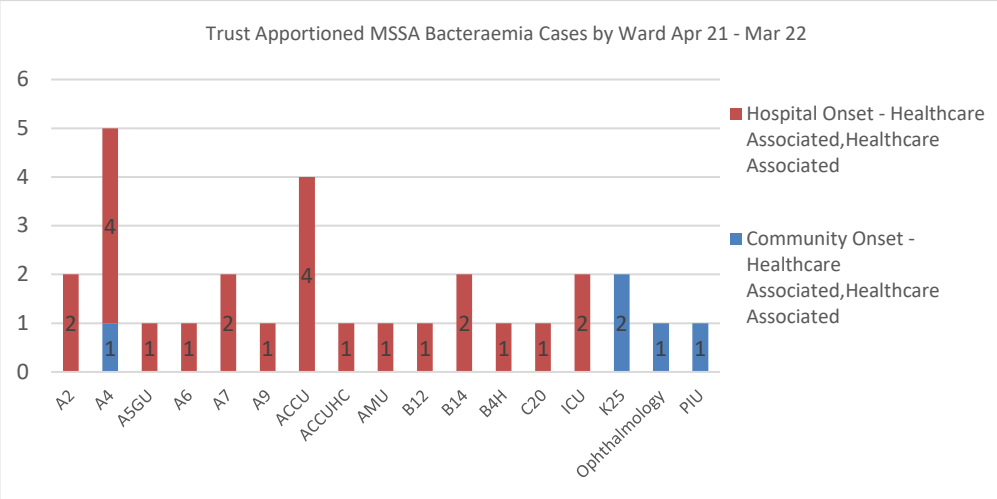
Warrington and Halton Teaching Hospitals NHS Foundation Trust

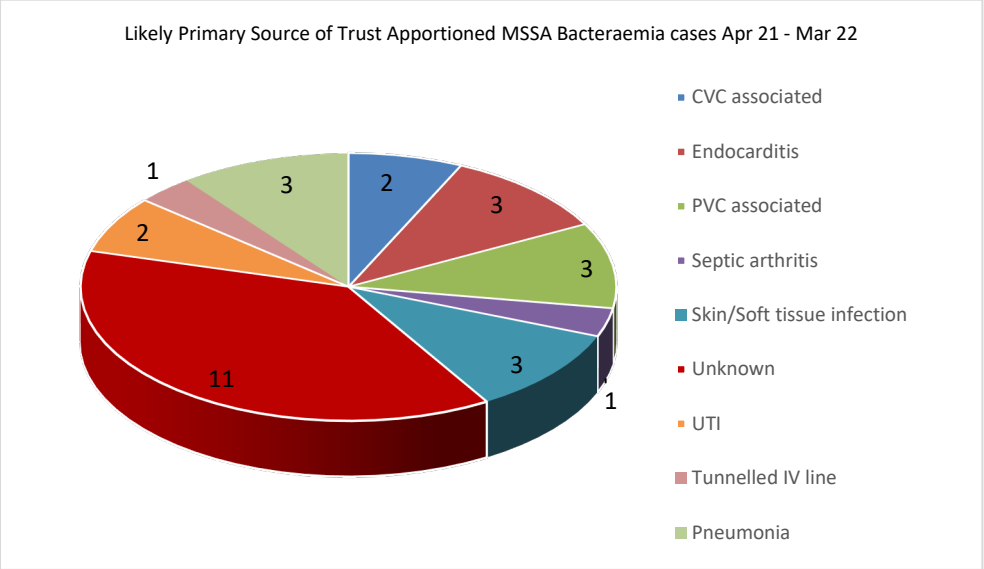
1 Community onset/healthcare associated MRSA Bacteraemia February 22

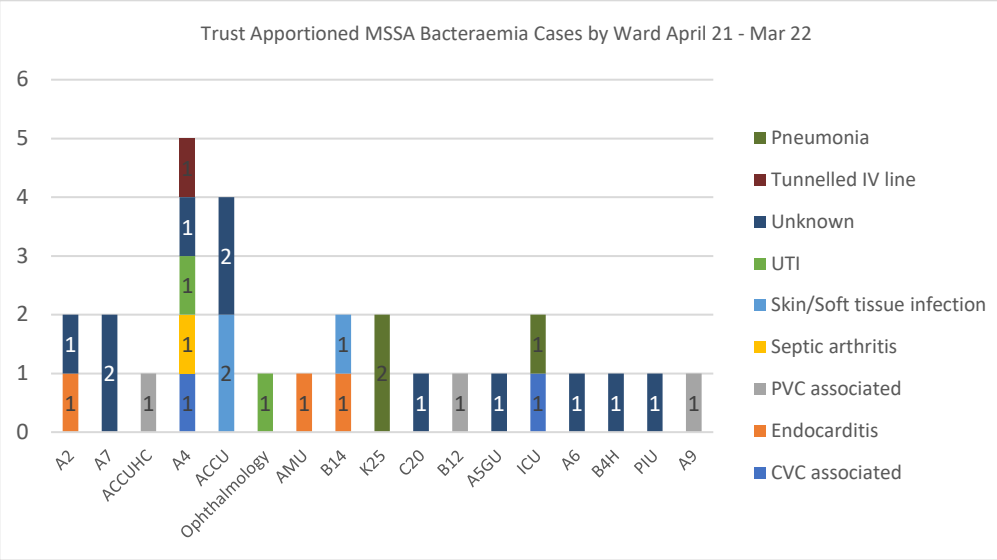
No Threshold set
YTD Total = 29 cases

Gram Positive Bloodstream Infection: Staphylococcus aureus









Appendix 2 Comparison of Healthcare Associated Infection Data Across the Northwest

E. coli annual tables: cases & rates by Trust

Organisation Name	March 2021 to February 2022	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	9	8.8	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	88	40.4	
BOLTON NHS FOUNDATION TRUST	63	34.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	38	28.8	
EAST CHESHIRE NHS TRUST	32	20.8	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	160	54.2	High (0.001)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	107	48.1	High (0.025)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	8	19.7	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	4	2.1	Low (0.001)
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	200	38.5	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	229	40.2	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	29	15.0	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	100	50.7	High (0.025)
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	133	26.4	Low (0.001)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	58	50.2	High (0.025)
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	88	34.7	
STOCKPORT NHS FOUNDATION TRUST	60	30.5	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	61	47.1	
THE CHRISTIE NHS FOUNDATION TRUST	31	59.9	High (0.025)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	15	63.1	
THE WALTON CENTRE NHS FOUNDATION TRUST	12	28.9	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	106	54.1	High (0.001)
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	**66**	**36.6**	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	56	24.2	Low (0.001)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	57	37.5	
North West	1810	35.4	

Klebsiella annual tables: Trust cases & rates

Organisation Name	March 2021 to February 2022	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	14	24.6	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	54	24.7	High (0.025)
BOLTON NHS FOUNDATION TRUST	10	5.1	Low (0.001)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	26	18.0	
EAST CHESHIRE NHS TRUST	5	4.9	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	55	18.9	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	31	11.5	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	4.9	Low (0.025)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	88	17.0	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	139	21.4	High (0.001)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	15	7.8	Low (0.025)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	31	17.3	
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	62	12.0	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	14	12.0	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	21	8.4	Low (0.001)
STOCKPORT NHS FOUNDATION TRUST	22	11.5	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	17	13.8	
THE CHRISTIE NHS FOUNDATION TRUST	20	40.3	High (0.025)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	10	45.4	High (0.025)
THE WALTON CENTRE NHS FOUNDATION TRUST	5	12.6	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	26	12.9	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	**28**	**15.7**	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	23	10.1	Low (0.025)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	17	11.5	
North West	735	14.8	

Pseudomonas aeruginosa annual tables: Trust cases & rates

Organisation Name	March 2021 to February 2022	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2	3.5	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	19	8.7	
BOLTON NHS FOUNDATION TRUST	2	1.0	Low (0.001)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	10	6.9	
EAST CHESHIRE NHS TRUST	2	2.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	5	1.7	Low (0.001)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	15	5.6	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	2.5	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	23	4.4	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	46	7.1	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	1	0.5	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	14	7.8	
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	20	3.9	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	7	6.0	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	13	5.2	
STOCKPORT NHS FOUNDATION TRUST	4	2.1	Low (0.025)
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	10	8.1	
THE CHRISTIE NHS FOUNDATION TRUST	14	28.2	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	2	9.1	
THE WALTON CENTRE NHS FOUNDATION TRUST	1	2.5	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	11	5.4	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	**4**	**2.2**	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	7	3.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	4	2.7	
North West	237	4.8	

MRSA annual tables: healthcare associated cases & rates by Trust

Organisation Name	March 2021 to February 2022	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	1.8	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	7	3.2	
BOLTON NHS FOUNDATION TRUST	2	1.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1	0.7	
EAST CHESHIRE NHS TRUST	1	1.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	2	0.7	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	1	0.4	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2	0.4	Low (0.025)
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	16	2.5	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	2	1.0	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	1	0.6	
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	7	1.4	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	2	1.7	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	2	0.8	
STOCKPORT NHS FOUNDATION TRUST	2	1.0	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	2	1.6	
THE CHRISTIE NHS FOUNDATION TRUST	0	0.0	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1	4.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	0	0.0	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	**1**	**0.6**	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	2	0.9	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	2	1.3	
North West	57	1.2	

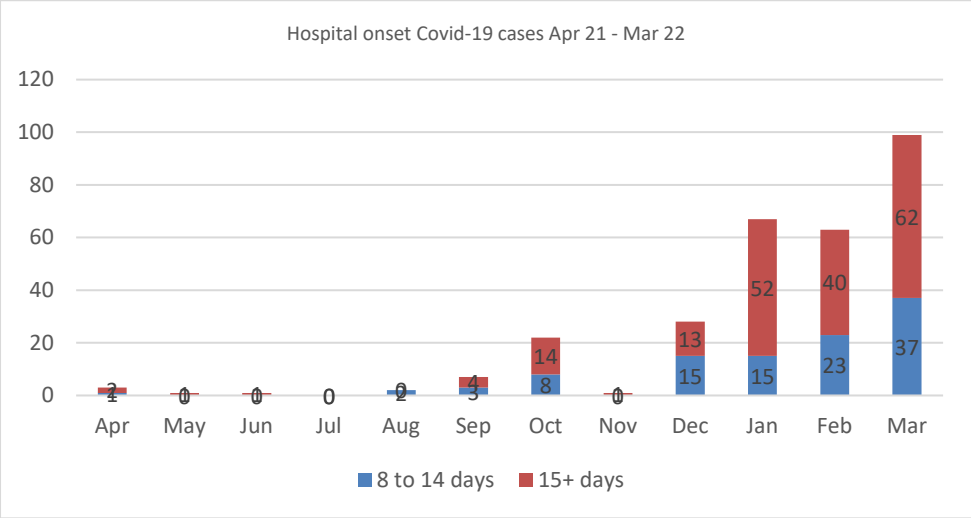
MSSA annual tables: Trust cases & rates

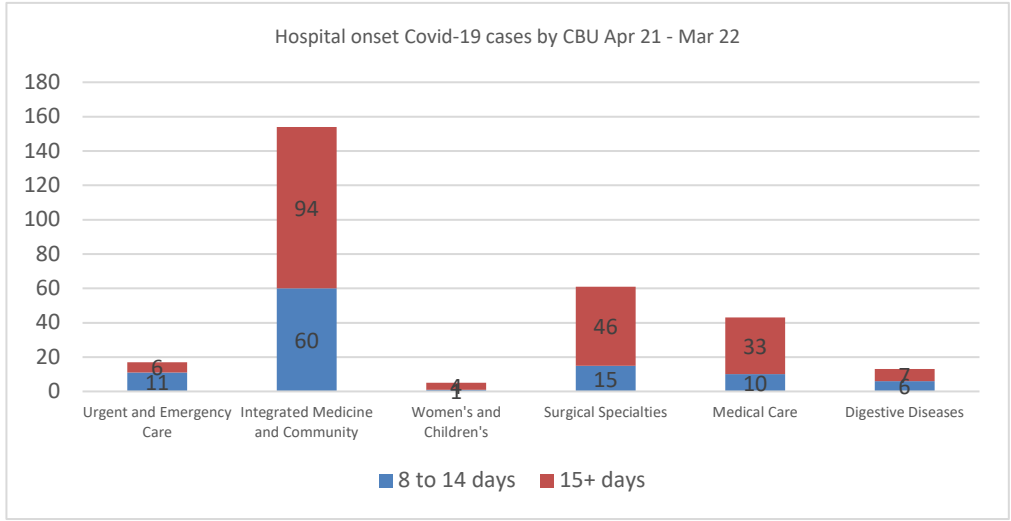
Organisation Name	March 2021 to February 2022	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	13	22.9	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	40	18.3	
BOLTON NHS FOUNDATION TRUST	34	17.3	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	21	14.5	
EAST CHESHIRE NHS TRUST	19	18.7	
EAST LANCASHIRE HOSPITALS NHS TRUST	55	18.9	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	39	14.4	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	10	24.7	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.7	Low (0.025)
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	89	17.2	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	133	20.5	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	17	8.9	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	30	16.8	
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	76	14.7	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	20	17.1	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	49	19.5	
STOCKPORT NHS FOUNDATION TRUST	21	11.0	Low (0.025)
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	15	12.2	
THE CHRISTIE NHS FOUNDATION TRUST	15	30.3	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	13.6	
THE WALTON CENTRE NHS FOUNDATION TRUST	11	27.7	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	31	15.4	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	**30**	**16.8**	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	30	13.2	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	31	20.9	
North West	833	16.8	

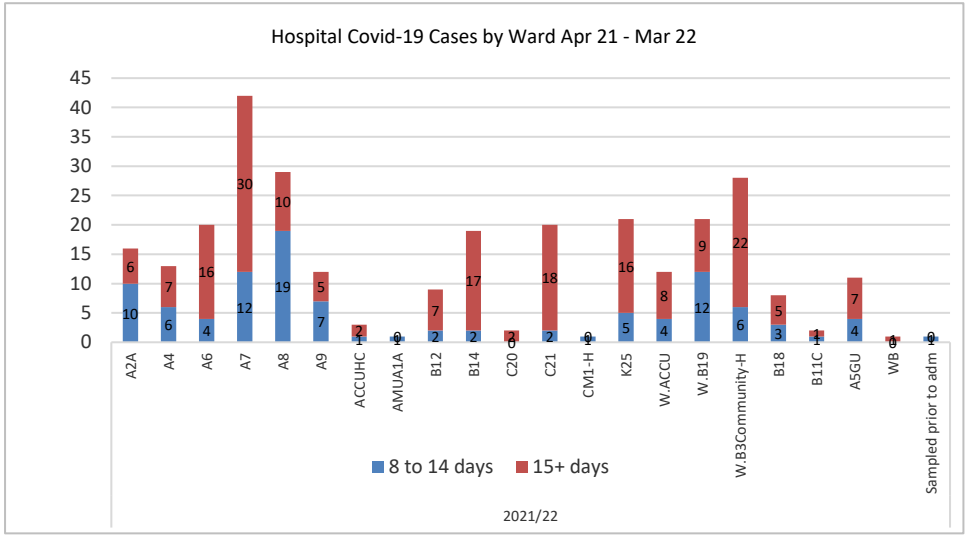
C. difficile annual tables: cases & rates by Trust

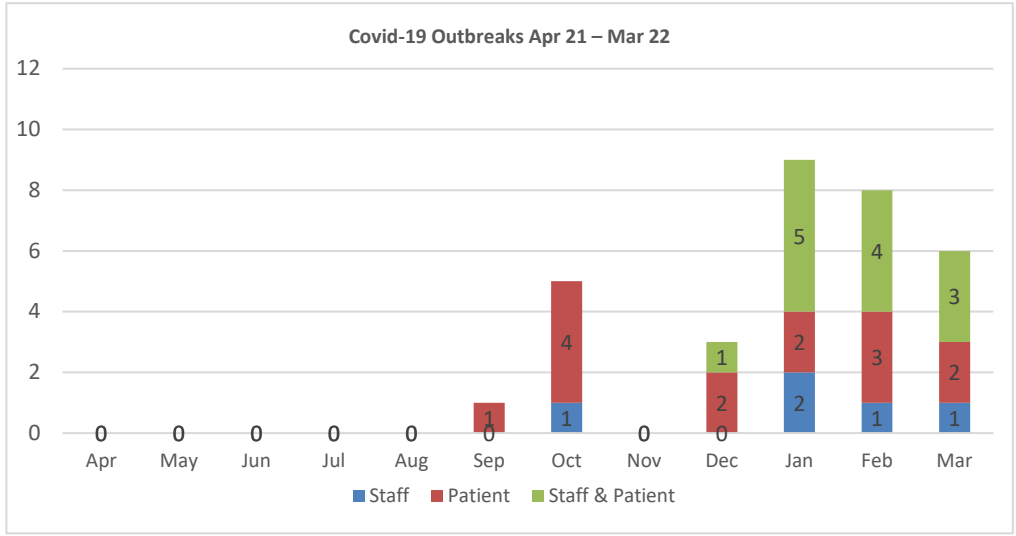
Organisation Name	March 2021 to February 2022	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	3	5.3	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	108	49.4	High (0.001)
BOLTON NHS FOUNDATION TRUST	83	42.2	High (0.025)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	54	37.4	
EAST CHESHIRE NHS TRUST	8	7.9	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	53	18.2	Low (0.001)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	127	47.0	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	7	17.3	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	132	25.4	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	201	31.0	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	34	17.7	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	55	30.7	
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	114	22.0	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	41	35.1	Low (0.001)
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	53	21.1	High (0.025)
STOCKPORT NHS FOUNDATION TRUST	69	36.0	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	45	36.5	Low (0.025)
THE CHRISTIE NHS FOUNDATION TRUST	41	82.7	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	17	77.2	High (0.001)
THE WALTON CENTRE NHS FOUNDATION TRUST	8	20.1	High (0.025)
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	86	42.6	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	**48**	**26.8**	**High (0.025)**
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	87	38.2	Low (0.025)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	56	37.8	
North West	1530	30.9	

Appendix 3 Covid-19 Cases









Appendix 4 Antibiotic Point Prevalence Audit

Antibiotic Prescribing Trust Wide Point Prevalence Report

March 2022

Jacqui Ward

Lead Pharmacist in Antimicrobial Stewardship

Introduction, aims and objectives

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

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

The aims and objectives of this audit were to;

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

1. Method

Data was collected on 15th & 16th March 2022 for all inpatients at Warrington Hospital and Halton Hospital site (encompassing the Nightingale Building and Captain Sir Tom Moore Building). All oral and parenteral antibiotics prescribed were included (topical preparations were excluded). Ward Pharmacists identified which patients were on antibiotics from their EPMA chart.

The data collected was:

Ward-specific:

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

Patient-specific:

- Antibiotic(s) prescribed
- Dose, route and frequency
- Indication documented in the notes/on the prescription chart
- Course length or review date documented
- Whether an allergy status was recorded on the electronic prescribing system
- Whether the antibiotic was compliant with the Trust antibiotic formulary.
- If the antibiotic was not compliant with the Trust antibiotic formulary, whether there was an appropriate reason for deviation documented. Appropriate reasons included the following:
    - Contraindication to formulary antibiotic (e.g. allergy)
    - Documented advice from Consultant Microbiologist
    - Culture and sensitivity result (current or previous) to suggest resistance to formulary antibiotic.
    - Risk factors for resistant organism
    - Failure of therapy recommended in guidelines (therapy escalation)

  - Recent exposure to first line therapy
  - No local guidance available
  - Continuation of therapy started in primary care/another Trust
- Was it the first antibiotic prescribed for the indication?
- If a review was undertaken, what the outcome was.
- If the antibiotic was oral, had it previously been stepped down from IV.

Exclusion criteria

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

2. Results

2.1 Antibiotic overview

Data was collected for 556 patients in total across the two sites on the days of the audit. 98.9% of all inpatient charts were screened. Across the two sites 193 (34.7%) patients were prescribed a total of 258 antibiotics. This is more than the previous quarter (Nov 2021) were 31% of patients were prescribed at least one antimicrobial. The number of patients audited has increased (556 vs 531) compared to the previous audit.

Table 1: Breakdown of patients audited across sites

	Warrington Hospital	**Nightingale Building**	**Captain Sir Tom Moore Building**	**Total**
% of Inpatients seen on days of audit	513/519 (98.8%)	26/26 (100%)	17/17 100%	556/562 (98.9%)
% of Inpatients seen prescribed antimicrobials on days of audit	190/513 (37%)	3/26 (11.5%)	0/17 Nil	193/556 (34.7%)
Number of antimicrobials prescribed on days of audit	255	3	0	258

Table 2: Antibiotic Overview by Speciality

Speciality	Number of patients on antibiotics	Number of antibiotics prescribed	% of patients with allergy status documented	% of antibiotics that were IV *	% of antibiotics that had a course length documented*	% of antibiotics with a documented indication *	% of antibiotics that were compliant with the formulary or otherwise appropriate*
Medicine	144	185	100	52	58	99	91.5
Gastro-enterology	7	10	100	44	33	100	100
Surgery	20	34	100	65	32	97	94
Women's & Children	9	11	100	82	73	100	100
Orthopaedic	7	8	100	50	33	83	83
ICU	6	10	100	70	30	100	100

* prophylactic antibiotics are excluded from this data

Figure 1. Antibiotic Overview by Speciality

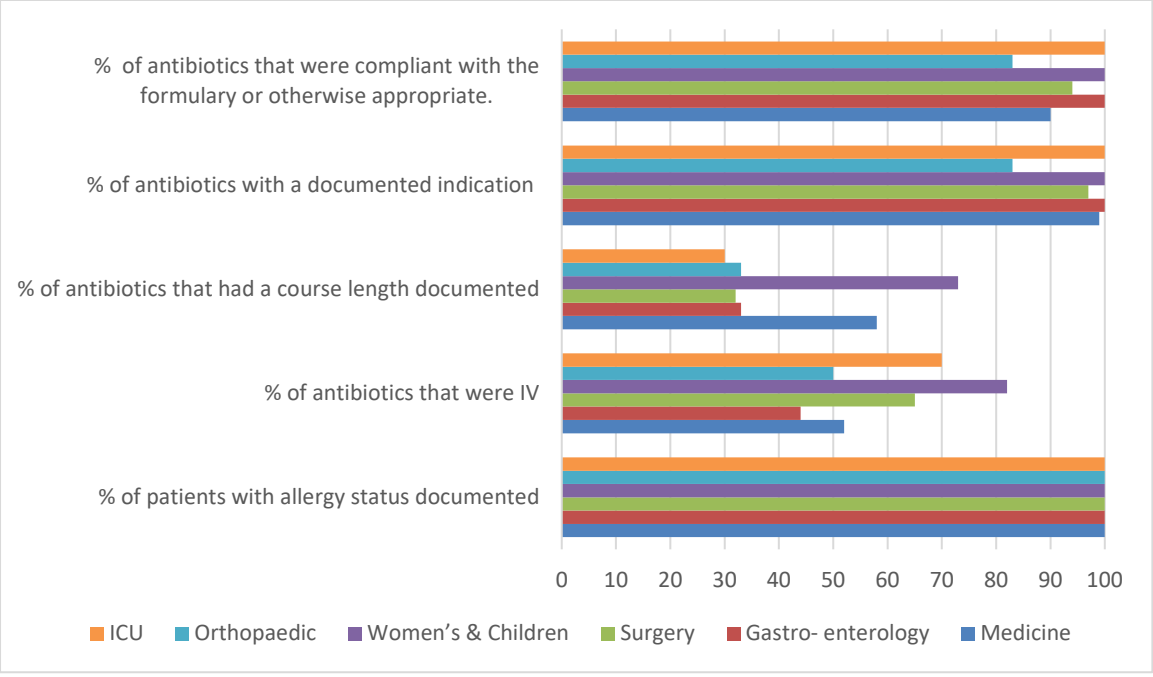


Table 3: Antibiotic Compliance with formulary by ward

Ward	Compliance Feb 2021	Compliance June 2021	Compliance Nov 2021	Compliance March 2022
A1	87% (13/15)	90% (9/10)	96% (25/26)	96% (22/23)
A2	87% (13/15)	94% (17/18)	78.5% (11/14)	100% (22/22)
ACCU ward	83% (5/6)	100% (9/9)	75% (3/4)	100% (14/14)
ACCU HDU	71% (5/7)	100% (6/6)	100% (4/4)	100% (3/3)
A4	79% (27/34)	96% (25/26)	79% (11/14)	80% (21/26)
A5 Elective	100% (1/1)	100% (1/1)	Nil antibiotics	100% (3/3)
A5 Gastro	100% (15/15)	100% (7/7)	84% (16/19)	100% (16/16)
A6	58% (7/12)	92% (12/13)	71% (10/14)	80% (4/5)
A7	94% (17/18)	73% (19/26)	80% (8/10)	95% (18/19)
A8	100% (24/24)	87% (13/15)	87.5% (14/16)	100% (10/10)
A9	85% (23/27)	75% (9/12)	83% (10/12)	100% (16/16)
FMN unit (B12)	75% (3/4)	100% (5/5)	100% (6/6)	100% (5/5)
B14	100% (5/5)	100% (2/2)	75% (3/4)	100% (3/3)
B18	92% (12/13)	Closed	87% (20/23)	83% (20/24)
B19	100% (12/12)	93% (13/14)	100% (5/5)	57% (4/7)
C20	91% (10/11)	67% (6/9)	75% (3/4)	100% (12/12)
C21	100% (7/7)	90% (9/10)	100% (6/6)	77% (10/13)
C23	33% (1/3)	100% (2/2)	100% (2/2)	100% (1/1)
K25	100% (1/1)	78% (7/9)	80% (4/5)	100% (2/2)
ITU	100% (19/19)	100% (11/11)	100% (15/15)	100% (10/10)
CAU	88% (7/8)	80% (4/5)	Nil patients	Not collected
Halton B3	75% (3/4)	100% (5/5)	100% (2/2)	100% (2/2)
Halton B4	50% (1/2)	Nil patients	Nil patients	No inpatients
CMTC	Nil antibiotics	0% (0/1)	100% (1/1)	Nil antibiotics
Paediatrics				
B10		No inpatients	No inpatients	No inpatients
B11		100% (5/5)	100% (7/7)	100% (9/9)
NNU		100% (11/11)	100% (4/4)	100% (2/2)

Wards with less than 90% compliance are highlighted in orange.

Antimicrobials prescribed for long term prophylaxis have been excluded from the above data.

3.Discussion

3.1 Patients prescribed antibiotics

Overall, 34.7% (193) of in-patients at WHH were prescribed antibiotics during the audit. This is an increase on the previous quarter, 31% in Nov 21.

3.2 Allergy status documentation

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

documented allergy. The audit picked up 1 patient who had a potential cross-sensitivity to the prescribed antibiotic. In this case the prescriber had clearly documented in the EPR that they had considered this risk and determined the benefit of treatment to outweigh the risk and discussed this with the patient who consented to trying the antibiotic.

3.3 Prophylactic antibiotics

10 patients were prescribed a total of 11 antibiotics for prophylaxis. 2 of these antibiotics were initiated during this hospital admission and both were on the direction of a Consultant Microbiologist for SBP prophylaxis.

3.4 Intravenous antibiotics

Of all prescribed antibiotics, 55% (135) were administered intravenously, this is consistent with the previous audit results which also determined that 55% of all antibiotics prescribed in November 2021 were administered intravenously.

In this audit women's and children had the greatest percentage of antibiotics (82%) prescribed intravenously; this is an increase on the previous quarter where 60% of antibiotics prescribed within this division were intravenous. Intravenous antibiotic prescribing has decreased within surgery (65% vs 89%), gastroenterology (44% vs 64%) and ICU (70% vs 100%) this quarter. Use within medicine has increased slightly (52% vs 46%) this quarter.

Within the other specialities intravenous antibiotics accounted for:

- 65% of all antibiotics within surgery,
- 70% of all antibiotics within ICU
- 44% of all antibiotics within gastroenterology,
- 82% of all antibiotics within women's & children
- 50% of all antibiotics within orthopaedics
- 52% of all antibiotics within medicine

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

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

98% (243) of antimicrobials prescribed had an indication documented in the EPR or on drug kardex. Having a documented clear indication is essential as it aids the ability of the person carrying out the next clinical review to stop, escalate or de-escalate antimicrobials as appropriate. For the purpose of this audit the 4 prescribed antimicrobials with no clear indication have deemed to be non-compliant. Antibiotics prescribed for prophylaxis have been excluded from this parameter.

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

3.5 Documentation of clinical review

93% (198/212) of antibiotics that had been prescribed for >72 hours had evidence of a clinical review. This is consistent with the previous audit back in November 2021. Antibiotics that were prescribed for long term prophylaxis were excluded from this parameter.

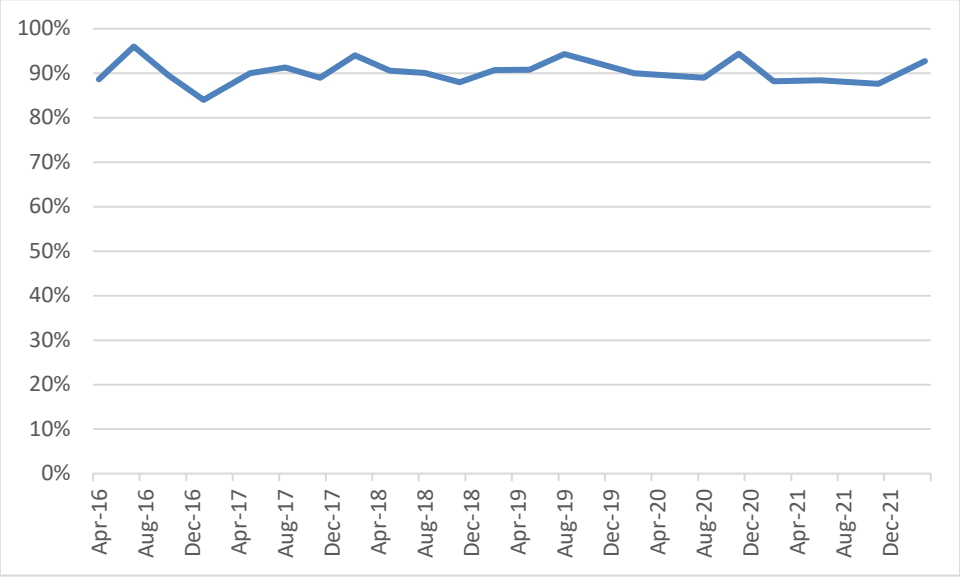
3.6 Documentation of stop date

53% (130/247) of antibiotics prescribed had a documented stop date. This is a decrease on the previous quarter where 58% of antibiotics prescribed had a documented stop date. Of those prescriptions with a documented stop date 32 prescriptions (25%) were for intravenous antibiotics and 98 prescriptions (75%) were for oral antibiotics. This audit shows that it is much more likely that a stop date will be added to an oral antibiotic when compared to prescriptions for intravenous antibiotics.

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

Compliance with the Trust antimicrobial formulary (or otherwise appropriate documented deviation) was 92.7% across the Trust, which is a significant improvement on the previous quarter were compliance was 87.6% in Nov 2021. **This is the first time in 12 months where we have been above the Trust's internal minimum compliance target of 90%.**

Figure 2. Compliance with the antibiotic formulary per quarter since April 2015



3.8 Non-compliance with the antibiotic formulary.

A total of 18 prescriptions were deemed inappropriate deviations from the formulary, examples can be found below.

- 4 prescriptions were deemed non-complaint because a clear indication for antimicrobial therapy could not be found in the EPR.
- 1 patient was commenced on oral doxycycline for aspiration pneumonia. This should be used in combination with metronidazole for aspiration pneumonia as anaerobic cover is required.
- Inappropriate use of co-amoxiclav, this is a restricted antibiotic across the Trust due to its increased association with Clostridioides difficile infection.
    - 83 year old patient was commenced on IV Tazocin for sepsis ? source, diagnosis later changed to CAP and antibiotics stepped down to oral with clinical improvement. The formulary would advise stepping down to oral amoxicillin plus clarithromycin with clinical improvement as per BTS guidelines.
- Non-formulary treatment of UTI's
    - Amoxicillin should not be used for empirical treatment due to high resistance rates locally.
- Inappropriate use of Tazocin.
    - 75-year-old gentleman commenced on IV Tazocin for suspected urinary infection – patient had recently completed a prolonged course of Tazocin (10 days) and had been stepped down to oral antibiotics following CMM advice. Treatment was escalated back to Tazocin as infection markers increased, patient remained apyrexial. At point of escalation in antibiotic therapy there was no discussion with CMM and no further microbiological testing.
    - Patient presented with frank haematuria – commenced on IV Tazocin. Indication not clear but if covering for urosepsis then IV gentamicin would be the first-choice antibiotic.
    - Patient commenced on IV Tazocin for chest sepsis/pneumonia.
- Doubling up of anaerobic cover. Patient was treated with IV Tazocin plus IV metronidazole for infective colitis. IV Tazocin provides good anaerobic cover, so metronidazole is not indicated
- Not formulary treatment of intra-abdominal sepsis with oral amoxicillin plus metronidazole.

3.9 Limitations

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

Recommendations

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

Key issues to address include:

- Ongoing assurance with Trust antibiotic guidelines and the need for clear documentation of an appropriate reason for deviation in the EPR.
- Achieve and sustain 100% indication documented in EPR.
- Improvement of documentation of course length or review date and review of antibiotics between 24-72 hours.
- CMM advice should be sought for patients who have received a prolonged course of broad-spectrum antibiotic therapy to ensure appropriate investigations and microbiological sampling is undertaken at point of antibiotic escalation.
- De-escalation of antibiotic therapy should be considered whenever a patient is reviewed and if not considered appropriate then the reason for this should be documented.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/71**	
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**	
DATE OF MEETING:	May 2022	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse Infection Prevention & Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	√
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	√
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments, and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1207** Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	

	#1331 Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	To provide the Trust Board with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to receive the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/05/126		
	Date of meeting	3 May 2022		
	Summary of Outcome	Submit to Board		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Infection Prevention and Control Board Assurance Framework Compliance Report	**AGENDA REF:**	BM/22/05/71

1. BACKGROUND/CONTEXT

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

This assessment tool (version 1.8) has been refined to reflect requirements specified in the Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021/22.

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

Legislative requirements relating to Covid-19 include: -

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

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

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

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

2. KEY ELEMENTS

Please see Appendix 1 for compliance assessment.

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. IMPACT ON QPS?

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

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

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

5. MEASUREMENTS/EVALUATIONS

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

6. TRAJECTORIES/OBJECTIVES AGREED

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

7. MONITORING/REPORTING ROUTES

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

8. TIMELINES

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

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10. RECOMMENDATIONS

- The Board is asked to note the report.

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Completed risk assessments			
Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: - based on the measures as prioritised in the hierarchy of controls, including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area - applied in order and include elimination; substitution, engineering, administration and PPE/RPE - communicated to staff	Risk assessments in place for all locations in the Trust Signage on room doors	Risk assessment formatting does not use hierarchies of control Communication of control measures	Revision to risk assessment in progress (draft submitted to IPC Silver Cell 31/01/2022) to provide risk mitigation measures in the order of elimination, substitution, engineering, administrative controls, and Personal Protective Equipment (including Respiratory Protective Equipment) Single page guidance given to all staff at CSTM building	
Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems	All risk assessments are approved via a robust Governance procedure at Tactical meetings			
If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	Nil derogation from national guidance			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	All completed risk assessments are reviewed by the Head of Safety and Risk			
If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	Risk assessments include RPE and other key items of PPE including eye protection			
Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services	Patients are allocated to wards based on speciality requirements	Learning from nosocomial Covid cases identified concerns about patient transfers	Operational and Patient Flow teams work cohesively to minimise patient transfers as far as reasonably practicable	
The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep. in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	- Chief Nurse/DIPC signs off data submissions - Sign off process in place for daily nosocomial SitRep - Daily data validation process for new admissions and inpatient Covid-19 tests prior to forwarding for sign off - BI reports are emailed daily to the Executive Team - RSV dashboards discussed at the IPC/Paediatric Surge planning meetings			
There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas	- Matron and IPC Walkarounds - Senior nursing team checks that action cards are being completed - Executive Team walkabouts			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	- Ward Accreditation with IPC reviewer membership - Challenge occurs at the following meetings: - Tactical - Silver IPC Cell - Quality Assurance Committee - Infection Control Sub-Committee - Senior Executive Oversight Group - Covid NED Group - Increased Microbiology support/ briefings delivered to medical cabinet - Surface wipes and alcohol-based hand rubs are provided for all non-clinical areas			
Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors)	PPE supply is monitored at tactical Group meetings PPE audit programme in place Health and Safety Team audit programme Signage is displayed on donning and doffing as an aide memoire for staff.			
The application of IPC practices within this guidance is monitored, e.g.: - hand hygiene - PPE donning and doffing training - cleaning and decontamination	Weekly hand hygiene audits Covid-19 PPE audits (for aerosol and non-aerosol generating procedures) are in place for all clinical areas	Centralised information on PPE training	UK HSA training videos are included in annual mandatory training programmes. Level 2 clinical training 85% at the end of December 2021.	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	Bimonthly review or sooner if updated Board meeting agenda Board meeting minutes			
The Trust Board has oversight of ongoing outbreaks and action plans.	- Information on outbreaks included in daily executive summary and discussed at the daily Senior Executive Oversight Group Meeting - Learning from Outbreaks included in Nosocomial Board Paper 01 2021 - Nosocomial learning action plan in place reviewed at Silver IPC cell meetings - Covid-19 RCA findings fed back to CBUs with drill down to individual ward learning September 2021 - Outbreak email circulation - Email showing locations where Covid-19 exposure has inadvertently occurred, and bays closed			
The Trust is not reliant on a particular mask type and ensure that a range of	Fit Testing programme in place and working to ensure all staff are			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
predominantly UK Make FFP3 masks are available to users as required.	successfully Fit tested against 2 types of mask, using Qualitative and Quantitative methods			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)	Task and Finish Group established with Action Plan in place for implementation. Progress will be included in IPC quarterly reports to QAC / Trust Board			
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Communications team are involved in changes and ensure information is cascaded and signage displayed			
Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Robust audit programme with timely feedback for corrective action as per the national cleanliness standards	Roles and responsibilities for cleaning Displaying star ratings and rectification if audit score is 3 star or less from a 5-star rating	Cleaning responsibilities framework in development as part of the implementation of the revised national cleanliness standards	
Increased frequency of cleaning should be incorporated into the environmental	Additional cleaning of outbreak areas including frequently touched surfaces			

Compliance assessment against version 1.8

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
decontamination schedules for patient isolation rooms and cohort areas				
Where patients with respiratory infections are cared for, cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	Chlorine based cleaning products are in use. Hydrogen peroxide Vapour is used following terminal cleaning by a Task Team trained in use of the equipment			
If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	- Alternative disinfectant used in CT scanning room.	- Specialist cleaning plan in place in the CT scanning room	- CT Manufacturer provided alternative decontamination guidance - Consultant Microbiologists and IPCNs included in discussions on alternative products to ensure effective against coronaviruses	
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Information on contact time is included in the decontamination policy			
A minimum of twice daily cleaning of: - patient isolation rooms - cohort areas - donning & doffing areas - 'Frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails - where there may be higher environmental contamination rates, including toilets/commodes particularly if patients have diarrhoea	- Twice daily cleaning in place - Ring the bell it's time for Clinell campaign - Domestic staff record when they have cleaned areas - Enhanced cleaning – all areas, including non-clinical, supplied with desk wipes			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	- Increased cleaning frequency in all public areas including toilets, communal spaces, lifts - Cleaning of workstations is included in the Environmental Action Plan - Domestic staff time cleaning activity when areas are vacant - Increased cleaning included in ICU Bioquell pod SOP - Review of guidance to reduce cleaning in low-risk elective procedure areas UKHSA review into IPC guidance - GOV.UK (www.gov.uk)			
A terminal/deep clean of inpatient rooms is carried out: - following resolutions of symptoms and removal of precautions - when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens)	- Terminal cleaning and decontamination polices in place including guidance on environmental disinfectant required to decontaminate the environment. Decontamination included in the Covid-19 policy - All policies are used in conjunction with any updates provided by COVID-19 national guidance			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
- following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)	- Terminal Cleaning Guidelines 2018 - Decontamination Policy 2019 - 4 additional HPV machines purchased and in use - CEO meeting and Chief Nurse/Deputy CEO and ADIPC meeting with domestic staff - Associate Director of Estates is a member of Silver IPC cell - Terminal cleaning standards sign off checklist - Ventilation Group and Ventilation Policy	Ventilation and air changes per hour in all areas is not unknown	Discussion on down time following areas where AGPs are performed based on air changes/hour where known and time extended in areas where mechanical ventilation is not available	
Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing, or repair equipment.	- Included in Decontamination Policy which incorporates single use and single patient use guidance - Cleaning monitoring audits - Decontamination audits - Policy and certification process to confirm cleaning prior to service inspection or repair			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	- Dynamic mattresses are cleaned off site by contractual arrangements - Green I am clean indicator tape for items cleaned/decontaminated at ward level			
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Robust audit programme with timely feedback for corrective action as per the national cleanliness standards			
As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance.	Theatre ventilation audits.	Trust-wide audit and Action plan required	Requirement for Estate overview discussed at Ventilation Group and plan in place to meet and agree requirement by 01 2022.	
The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer	Trust supported by an Appointed Authorising Engineer/Ventilation. Guidance sought on all capital projects with sign off of plans.			
A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways		Trust-wide audit and Action plan required	Requirement for Estate overview discussed at Ventilation Group and plan in place to meet and agree outcome of findings	
Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	'Give fresh air to show you care' campaign	As above	As above	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	Trial of alternative technology completed Products will be reviewed by the Ventilation Group to ensure fitness for purpose			
When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Discussion on air low takes place between IPC Team and Estates Team			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Arrangements for antimicrobial stewardship are maintained - previous antimicrobial history is considered - the use of antimicrobials is managed and monitored to reduce inappropriate prescribing to ensure patients with infections are treated promptly with correct antibiotic.	- Consultant Medical Microbiology daily Ward Round in Critical Care - Ward based Pharmacist support - Prescribing advice available by telephone (in and out of hours 24/7) - Pharmacist prescribing support on all inpatient wards - Infection Control Doctor presentations to Medical Cabinet - Formulary reviewed as evidence/ guidelines are updated	Point prevalence Audit scores in the region of 90%. Some wards have lower than 90% compliance for more than 1 quarter	Business case approved to strengthen stewardship resources Change approach to auditing to provide more meaningful data	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Antibiotic prescribing guidelines for COVID suspected patients have been published - Antimicrobial Management Steering Group Meetings - Quarterly - C difficile outliers ward rounds - Quarterly Point Prevalence audits with concerns discussed at Medical Cabinet and Infection Control Sub-Committee – Process being reviewed to Biannual audits with focus on areas with higher concerns			
Mandatory reporting requirements are adhered to, and boards continue to maintain oversight	- Mandatory reporting of HCAIs has continued - Data on HCAIs is included on the Quality Assurance Committee and Trust Board and Infection Control Sub-Committee Dashboards - DIPC reports HCAI data at Trust Board - Information on Data Capture System - Distribution of HCAI surveillance data weekly			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Annual PHE HCAI reports and monthly dashboards			
Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	- Infection control risk assessments completed on admission and updated in light of microbiology results - Electronic patient record alerting system - IPC Policies/guidelines - IPC on call service			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors	Risk assessment in place Compassionate visiting supported			
National guidance on visiting patients in a care setting is implemented	- Restricted visiting implemented 17 March 2020; Visiting fully suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020. Paper on visiting arrangements taken to SEOG		• Guidance regularly updated in-line with national guidance • Visitor risk assessments • Pre-visit symptom screening checklist • Visitor information leaflet • Family Liaison Officer team	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Visiting the dying guideline in place with training provided by the Palliative Care Team - Trust wide Communication via email on visiting restrictions then cessation - Environmental Safety Plan includes site lock down to restrict access - Compassionate visiting arrangements agreed for the following patient groups where close family and friends visiting may be admitted: - Patients in critical care - Vulnerable young adults - Patients living with Dementia - Autism - Learning difficulties - Loved ones who are receiving end of life care - Signage at entrances - Information on Trust website - FLOgrams - Trial wards agreed to re-introduce visiting week commencing 7 June 2021 limiting		• Virtual visiting/ iPad	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	numbers and visiting time period of 1 hour - Visiting permitted with booked and timed slot on Christmas Day and Boxing Day with control measures in place on symptom checks and where possible Lateral Flow Device Test (with negative result) - Visiting guidance updated to meet current national guidance – 2 visitors per patient, timed slots, for 1 hour			
Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	- Guidance on visiting in place - Maternity specific Guidance on birthing partner - Appointment scheduling system implemented to ensure social distancing isn't breached, particularly where there are concerns regarding ventilation/ low air change/hour - Visited restricted during outbreaks			
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with	Signage across the Trust including at entrances and in public toilets: - Face masks - Hand washing		Every action counts campaign signage – roll out plan in place	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
handwashing, wearing of facemask/face covering and distancing.	- Social distancing suspended signage from ceilings on all corridors and at entrances/exits - PPE/ mask stations located at entrances/exits alongside alcohol-based hand gels		Leaflets on face mask wearing provided January 2022	
If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM	PPE provided at all Trust entrances and entrances to wards			
Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	Visitor Risk assessment Sign-in sheet symptom checker			
Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	FFP3 Fit testing for visitors to ICU			
Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted C1116- supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Campaign posters received and roll out plan devised	Images of WHH staff selected for campaign use Wellbeing support area established	Roll out will be completed by January 2022	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	Triage tool and molecular Point of Care testing is in use in ED and Maternity. ED Triage tool includes a question on travel history Positive results are sent by text message to Infection Prevention and Control (IPC) Nurses, who review and put IPC advice in place. PCR testing is also undertaken on admission Respiratory SOP Infection Risk Assessment Lorenzo Symptom screening checklist Virtual Ward Pathways	Out of hours Cover for results from 10pm until am where POC test was negative, but PCR result is positive	To be discussed	
Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Senior staff triage in ED			
There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved	Compliance reviewed during outbreaks and at nosocomial RCA review meetings BI reporting systems shows swabs due to be taken daily. Daily oversight by senior nursing team to support compliance with admission, day 3 and day 5 testing Weekly testing stepped down 04/2022	Audit of compliance required		

Compliance assessment against version 1.8

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Virtual appointments where practicable - Temperature checking and symptom screening in place in OPD/ Vaccination centre			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Appropriate infection prevention education is provided for staff, patients, and visitors.	IPC Mandatory training programme Signage for visitors and support provided by staff on duty			
Training in IPC measures is provided to all staff, including: - the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and - the correct technique for putting on and removing (donning/doffing) PPE safely.	Fit Testing programme UK HSA training videos shown during mandatory training sessions Aide memoire posters on donning and doffing are displayed in all clinical areas			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	Hand hygiene technique is displayed on all soap dispensers PPE/swabbing Champions (58), training and cascaded roving training on donning and doffing of PPE Training for Helping Hands staff IPC Team out of hours advice IPCN and Consultant Microbiologist Departmental visits to provide support			
All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	Mandatory IPC Training package			
Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	PPE audits in place Concerns identified are addressed at the time of audit Increased auditing schedule during outbreaks			
Gloves are worn when exposure to blood and/or other body fluids, nonintact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	Standard precautions and PPE guidelines			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	- Hand air dryers not in place in clinical areas - Access to hand hygiene facilities (stock of liquid soap, hand gel and paper towels is included in the auditing template - Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan - Hand towel dispensers have been installed and waste collection schedule put in place			
Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Guidance on social distancing re-enforced			
Staff understand the requirements for uniform laundering where this is not provided for onsite	Guidance included in Uniform Policy and Covid-19 PPE booklet. Scrub suit provided for use in place of uniforms which are laundered by the Trust			
All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of	SOP in place for testing staff and or household members	Staffing absence due to Covid-19	Staffing meetings held throughout each day to ensure safety in inpatient areas Absence monitoring at Tactical Group meetings	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
the symptoms (even if experiencing mild symptoms) in line with national guidance.	HR process in place for reporting to Line Manager and Occupational Health In-house testing is promoted for timey availability of results SOP in place for Lateral Flow Testing prior to return to work in line with revised guidance COVID-19: management of staff and exposed patients or residents in health and social care settings - GOV.UK (www.gov.uk)	Some staff use external testing resulting in delay in result turn around time	In-house testing is promoting – including for household members	
To monitor compliance and reporting for asymptomatic staff testing	LAMP testing compliance data monitored at Tactical Group meetings	Uptake low approximately 450 staff	Uptake encouraged at trust wide Team brief, DIPC promotional video	
There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Consultant Microbiologist presentations at Tactical Group meetings. Local prevalence data included in Tactical Group agendas BI reports with UpToDate position Datix reporting of hospital onset case, Outbreak reporting as per the NHSE/I HOCI SOP Regional benchmarking using the Cheshire and Merseyside Nosocomial pack			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	ULHSA CCDC attends Infection Control Sub-Committee Silver Infection Control Cell meetings chaired by the DIPC All Covid-19 positive results are communicated by text alert to the IPCNs. Patient records are flagged, and IPC advice documented			
Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	IPC Team monitor incidence and report outbreaks via the web-based reporting system in line with the NHSE/I northwest HOCI SOP Datix reports are completed for all hospital onset cases and where an Outbreak is declared. RCA investigations are completed and reviewed to identify learning and harm. Where concerns are identified regarding harm, referral is made to the Governance Team for further review. PowerPoint feedback reports on learning from incidents shared with each CBU for 2020/2021			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Patient information leaflet circulated in January 01/2022 promoting use of face masks for in patients Signage on display advising use of face masks	Some patients exempt from face mask use and some patients decline National restrictions on face mask use lifted on 27/01/22 for public spaces	Communication circulated on 27/01/22 that use of Face masks in healthcare settings remains in place Clear curtains between inpatient beds	
Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	Symptom screening on arrival at clinics Pre-attendance advice not to attend if symptomatic.			
Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Appointment scheduling to avoid cross over of Covid/non-Covid patients			
Patients are appropriately placed i.e., infectious patients in isolation or cohorts.	Monitoring of Covid testing for patient placement Isolation Policy Isolation of Immunosuppressed Patients Guidelines Side room audit tool Additional side room capacity created with pods inserted in	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- ED x1 - ICU x5 - B18 x4 Additional side rooms created on Wards - A2 - A3 - A6 - A9 - C21			
Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	Environmental action plan Clear curtains			
Standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	SOP for respiratory/non-respiratory pathways and PPE requirements Standard IPC precautions Guidelines IPC audit programme in place IPC Mandatory training programme			
The principles of SICPs and TBPs continued to be applied when caring for the deceased	Care of deceased patients' guidelines			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Testing is undertaken by competent and trained individuals.	Training on swabbing technique provided verbally and by video Competency assessment tool launched Training provided on use of point of care molecular testing equipment UKAS accredited laboratory with Quality Control checks in place			
Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance	Swabbing SOP in place covering day of admission, day 3, day 5, weekly thereafter if previous results negative, symptomatic, pre-admission elective and discharge screening Quadplex testing (Influenza A/B RSV – in addition to Covid-19) for patients presenting with respiratory symptoms Legionella and Pneumococcal antigen testing	- RCAs identified some routine samples are being missed -	- Daily senior nurse oversight to ensure compliance - Electronic systems support identification of patients who have not been screened as per routine testing protocol - Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	
Staff testing protocols are in place	Staff testing SOPs Asymptomatic / Symptomatic – including for household members Asymptomatic LAMP testing in place for staff	Low uptake of staff LAMP testing	Uptake encouraged at trust wide Team brief, DIPC promotional video	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available	Monitoring at Silver IPC	Reporting frequency	Request made for regular reporting.	
There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	- LION BIS used to monitor testing in line with guidance and follow-up of omitted tests on admission/ day 3 /day 5/ weekly from day 5 - Documentation of IPC advice on receipt of positive results - RCA requests for cases ≥ day 8 of admission, with monitoring system in progress - Daily data validation process for Sit Rep signoff and external reporting - IPC Team Spreadsheet with RCA follow up of all cases ≥ day 8 of admission			
Screening for other potential infections takes place.	Other routine admission screening (CPE, MRSA, VRE) in place			
That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	All patients being admitted to the Trust have Covid admission tests taken in ED using point of care (Abbot ID Now) testing and PCR swab Point of Care Testing supports ED and inpatient placement			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
isolation: approach following updated government guidance)				
Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Included in mandatory IPC training. Level 2 compliance eat the end of December 2021 = 85%	Some CBUs with less than 85% training compliance	IPCN offer to provide additional training sessions	
A fit testing programme is in place for those who may need to wear respiratory protection.	Fit Testing programme is in place.			
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: lead on the implementation of systems to monitor for illness and absence. Infection prevention and control board assurance framework - facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce - lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 - encourage staff vaccine uptake.	Outbreak meeting discussions on exposed staff Datix reports on workplace exposure incidents	Review of updated guidance published 17/01/22 COVID-19: management of staff and exposed patients or residents in health and social care settings - GOV.UK (www.gov.uk)		
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	Covid-19 SOP			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Powered Hoods are offered as an alternative where it has not been possible to fit close fitting face masks Only EN 149:2001 compliant masks are accepted as fit for use for Aerosol Generating procedures			
Staff who carry out fit test training are trained and competent to do so.	Programme of Fit Testing in place which is only carried out by trained Fit testers An accredited Fit2Fit company or the Department of Health virtual training provided staff training			
All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	- Programme of Fit Testing in place - Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021 - Programme of Fit Testing continues with an ambition to ensure staff are Fit Tested against 2 types of FFP3 respirators. Data on 08/10/2021 - Total Number on Database: 3848 - Total Number passed on at least 1 current supported mask: 2422			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
urgent/emergency care pathways as per national guidance.	- Senior Nurse presence 7 days per week 8am-8pm to support staffing management - Planned elective areas have designated teams, who are not moved to any other area in the Trust - Where it is necessary to move staff between different areas to support patient safety, this is discussed with the Infection Control Team. - This cross over has not occurred between Elective and Emergency Care pathways			
Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	- Risk assessment in place to reduce risk - Agile working policy includes home working - Staying Covid-19 secure signage listing mitigation in place			
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	- Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place - Data reported to Tactical meetings - Staff self-Isolation SOP in place from 08/2021 to enable staff to return to work, if they meet a			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 05 2022

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	risk assessed criteria from non-household Covid-19 contact - HR advisors support wellbeing meetings for long-term absence			
Staff who test positive have adequate information and support to aid their recovery and return to work	- A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce - The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) - Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical - Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and when required - Retesting is in place as appropriate and is set out in Staff Testing SOP - Occupational Health e-mail to staff and their manager with return-to-work guidance	- Test and Trace Service hours of operation	- Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action	

APPENDIX 2 Action Plan for IPC BAF 05 2022

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
Criterion 2 Provide and maintain a clean and appropriate environment								
1	A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	**May 22**		Requirement for discussion on audit findings at Ventilation Group and plan to agree actions	ADE	IPCT	Site audits completed	
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance								
Criterion 4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.								
Criterion 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								
2	Audit of compliance with routine patient testing protocols in line with Trust approved hierarchies of control risk assessment and approved	**May 22**				Informatics	BI report on testing provides information on tests outstanding for completion.	
3	Prioritisation patients with excessive cough and sputum production for placement in single rooms whilst awaiting testing.	**May 22**					Patients are prioritised based on risk assessment by mode of infection transmission	
Criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection								
Criterion 7 Provide or secure adequate isolation facilities								
Criterion 8 Secure adequate access to laboratory support as appropriate								

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
4	Revision to pre-admission PCR / Lateral Flow Device testing.	**May 22**					Proposal to implement on the day Lateral Flow Device testing for day case surgery Halton ward B4 and both site Endoscopy Units.	
Criterion 9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections – Nil Concerns								
Criterion 10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection								
5	All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	**May 22**		Continuous Fit Testing Programme				

RAG Legend	
Action not commenced	
Action in progress	
Action completed	

Key Personnel	
ACNs	**Associate Chief Nurses**
ADIPC	**Associate Director of Infection Prevention and Control**
ADG	**Associate Director of Governance**
AMD	**Associate Medical Director**
CBU	**Clinical Business Managers**
CMM	**Consultant Medical Microbiologists**
DCN	**Deputy Chief Nurse**
DCOO	**Deputy Chief Operating Officer**
DCPO	**Deputy Chief People Officer**
DD HR	**Deputy Director of Human Resources and Organisational Development**
IPC Admin	**Infection Prevention and Control Administrator**

Completed actions

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
1	Revise risk assessment templates to NHSE/I hierarchies of control template	Feb 22	Feb 22		HW	IPCT	Approved at Tactical meeting 04/02/22	
2	Role out of revised Risk Assessments	Apr 22	Apr 22		HW			
Criterion 2 Provide and maintain a clean and appropriate environment								
3	Trust wide audit of ventilation systems and gap analysis against national guidance	Mar 22	Apr 22	Discussed at Ventilation Group. Further meeting required to agree scope of assessment.	ADE		Audits conducted by the appointed Authorising Engineer Ventilation	
4	Strengthening of stewardship resources	Mar 22	Mar 22	Business case in progress to strengthen stewardship resources, Change approach to auditing to provide more meaningful data	CMM	LPAMS	Hot topic 21/02/22 at Trust wide Safety Brief Business case approved	
5	Implementation of the Supporting excellence in infection prevention and control behaviours	Feb 22	Feb 22	Roll out plan approval	ADIPC		Campaign materials rolled out Trust wide	
6	Improve compliance with LAMP testing	Mar 22	Mar 22	Revise introduction plan Communication strategy to improve uptake including CEO led team brief June 2021 Discussion on importance at Outbreak meetings	CPO	CBU Triumvirate Leads	LAMP testing ceased 31/03/22	

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
7	Consider daily testing of COVID-19 negative patients when there are high nosocomial rates should consider testing daily.	Feb 22	Feb 22	Increased testing in wards during outbreaks	CMM		Outbreak case detection	
8	Prompt tracing of Covid-19 contacts where this occurs	May 22	Apr 22	Publication approval reference: C1630 – isolation of Covid-19 contacts no longer required if asymptomatic	CMM/ ADIPC		Covid-19 exposed contact letter updated Completed as far as reasonably practicable	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/72**	
SUBJECT:	**Learning from Experience, Quarter 4**	
DATE OF MEETING:	25 May 2022	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The following report provides an overview of the Learning from Experience Report. The information within the Learning from Experience report is extracted from the Datix system and other Clinical Governance reports for Incidents, Complaints, Claims, Health & Safety and Clinical Audit related to Quarter 4, 2021/22.	

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

RECOMMENDATION:	The Board of Directors is asked to note the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/22/05/124
	Date of meeting	May 2022
	Summary of Outcome	Noted for assurance
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Experience, Quarter 4	AGENDA REF:	BM/22/05/72

1. BACKGROUND/CONTEXT

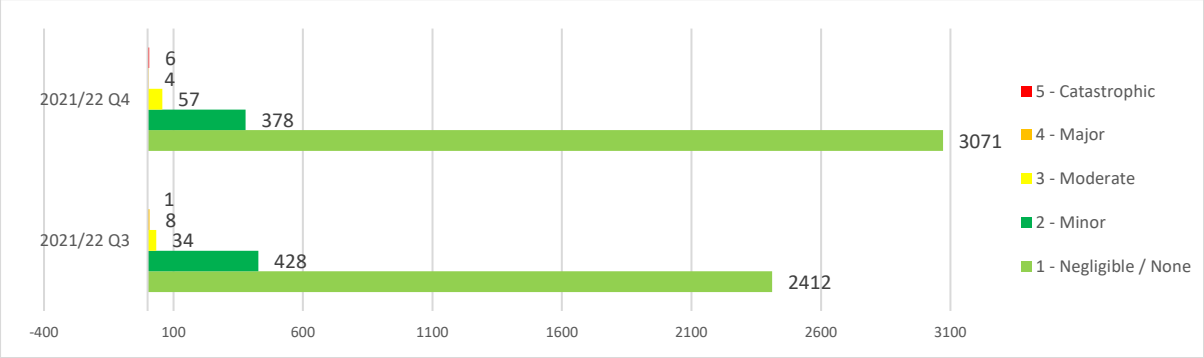
This report relates to the period 1st January to 31st March 2022 (2021/22 Q4). It contains a quantitative and qualitative data analysis (using information obtained from the Datix risk system) of incidents, complaints, claims, health & safety and clinical audit. The report includes a summary of themes, trends and key findings identified in Quarter 4 with specific recommendations to support learning across the organisation.

2. KEY ELEMENTS

a. Learning from Incidents

Reporting Position

There was a 22% positive increase in incident reporting across the Trust in 2021/22 Q4 (2883 in 2021/22 Q3 vs 3516 in 2021/22 Q4). The number of no harm incidents reported increased by 27% in Q4, increase in incident reporting likely linked to increased attendances / operational pressures. Incident reporting is within normal variation.

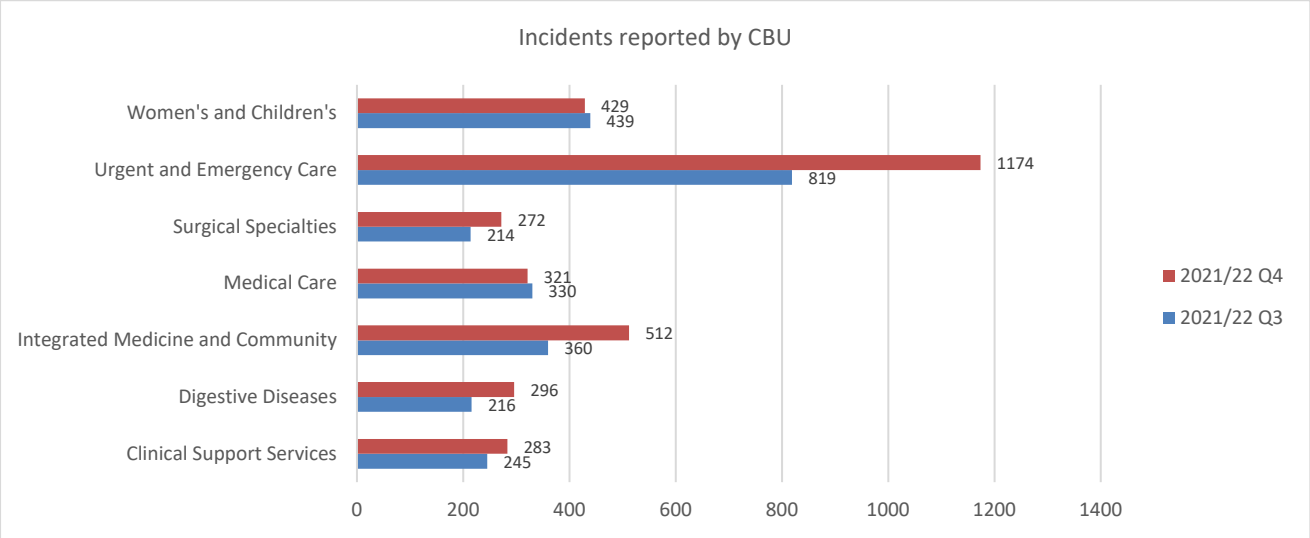


The above graph shows that six incidents were deemed as catastrophic in Q4. 4 were deemed as major. 57 were deemed as moderate and the rest minor or negligible. Compared to Q3, 1 incident was deemed catastrophic, 8 were deemed as major and 39 were deemed moderate. However, it is important to note that incidents should not be defined only by their grade and should be investigated on the learning that is identified as per the serious incident framework 2015.

Incidents reported per CBU

There was an increase in the number of incidents reported from the previous Quarter, demonstrating a positive reporting culture. A total of 3287 incidents were reported across the 6 CBUs and Clinical Support Services in Quarter 4, this has significantly increased from 2623 when compared to Quarter 3. This demonstrates a positive reporting culture with the increase a likely result of increased operational pressures.

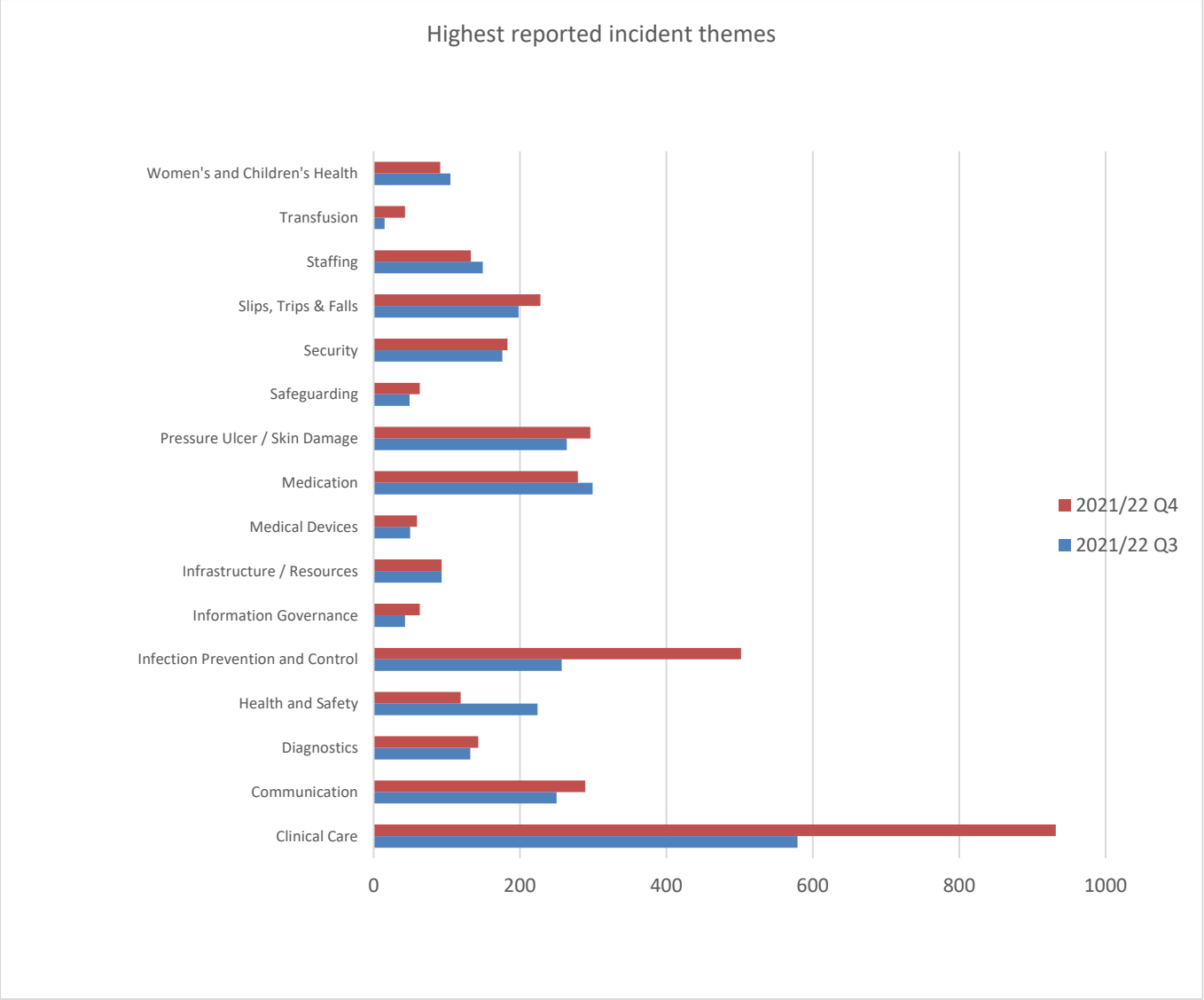
In Quarter 4, Urgent and Emergency care reported the highest number of incidents (1174), this was also the case in Quarter 3 (819), themes include delay to assessment and time to treatment reflecting the challenges of increased activity being experienced nationally. Of those reported in Quarter 4, 98% of these were minor or negligible harm. This demonstrates that the Urgent and Emergency Care CBU is promoting a culture of positive incident reporting. Integrated Medicine has significant increase in incident reporting in Q4 (514) compared with Q3 (360) there has been a focus to improve reporting culture in Integrated Medicine due to a decrease in reporting in Q3 from Q2. Women's and Children's CBU has reported 429 incidents in Quarter 4 when compared to 439 in Q3. This is a decrease of 2% but is still within statistical control. In order to improve reporting culture further, the report to improve campaign continues to be shared on a weekly basis Trust wide with CBUs via the governance managers. The governance managers also offer a daily prompt to all CBUs when reviewing incidents. In addition, bespoke Datix training will be offered by the senior administrator for Datix over the next Quarter. A weekly drop in governance session has been established to support any additional training needs. A rolling agenda item has been added to the CBU Governance agenda to highlight the reduction in reporting to those areas noted.



Types of Incidents being reported

The number of incidents reported relating to clinical care, infection prevention and control and communication increased in Q4 ,1759 compared to 1045 in Q3. Incidents reported relating medication and staffing decreased in Q4, 490 compared to 601 in Q3.

As per the below graph, incidents relating to clinical care continue to be the most commonly reported at 932 and 96.67% of these incidents were minor or negligible harm. Figures relating to clinical care incidents reported in Quarter 4 (932 reported, 96.67% minor or negligible harm) and also those reported in Quarter 3, 21/22 (579 reported, 96.71%), evidence a positive reporting culture.



Incident Themes

In Quarter 4 there has been an increase in the **number** of clinical care incidents reported (61%) with no increase in harm noted. The governance team have been feeding back to CBU's through governance meetings aspects of clinical care which include 12 hour breaches (378), delay in treatment (128) and delay in assessment (95).

There has been a continued increase in the number of infection prevention and control incidents reported (37.4%) with no increase in harm noted. This is indicative of the on-going work of the Infection Prevention & Control Team in fostering a culture of continued vigilance across the organisation and incident reporting when there is not. In order to support this on-going piece of work, the Quality Improvement Team have developed a Gram-Negative Bloodstream Infections (GNBSI) collaborative. The aim of this collaborative is to reduce healthcare associated GNBSI by 5% by March 2022 and will focus on hot spot areas as noted within the Datix system. Reduction of GNBSI has been identified as a 2021/22 Trust quality priority. A change package outlining evidence-based interventions will be developed in Quarter 1 2022/2023 (revised due to operational pressures), for all wards to implement, it is ongoing at present. Work is also in progress to update and develop relevant trust wide policies and training.

Serious and Concise Incidents closed within Quarter 4

There were 18 Serious Incidents closed within Quarter 4.The highest reporting areas for SI's are:

Area	Number	Findings
Birth suite	2	1. Maternity Closure – SI as per LMS guidance 2. Maternal death
B18	2	1. Delay in diagnosis 2. Fall
ED	2	1. Delay in assessment (adequate treatment provided) 2. Delay in reviewing blood results when patient left the department

Subcategory	CCS	DD	IMC	SS	UEC	WAC	Total
Aggressive Behaviour by Patient / Relative	0	1	0	0	0	0	**1**
Category 3 - Hospital Acquired	0	0	0	1	0	0	**1**
Complication of Procedure	0	1	0	0	0	0	**1**
Delay in Assessment	0	1	0	0	0	0	**1**
Delay in Diagnosis	1	1	0	0	0	0	**2**
Delay in imaging	1	0	0	0	0	0	**1**
Failure to follow policy / guideline	0	0	0	0	1	0	**1**
Fall from bed or trolley	0	0	1	0	0	0	**1**
Inadequate Pre-op assessment	0	1	0	0	0	0	**1**
Lack of Nursing / Midwifery Staff	0	0	0	0	0	1	**1**
Medicines stored incorrectly / unsecured	0	0	0	0	1	0	**1**
Radiology results – reporting discrepancy	1	0	0	0	0	0	**1**
Reportable Ward / Unit Closure	0	0	0	0	0	1	**1**
Sub-optimal Treatment / Care	0	1	0	0	0	0	**1**
Unanticipated Admission > 37 weeks - low chord ph	0	0	0	0	0	1	**1**

Unstageable Ulcer - Hospital Acquired	0	1	0	0	0	0	**1**
Witnessed fall to floor	0	0	1	0	0	0	**1**
Grand Total	**3**	**7**	**2**	**1**	**2**	**3**	**18**

There were 20 concise incidents closed within Quarter 4,.

Learning from Incidents and Assurance

The Associate Director of Governance and the Patient Safety Manager continue to attend the CCG meetings in order to present Serious Incidents alongside the Investigating Officer. This enables feedback and assurance in real time through broad discussion with health partners. The Serious Incident Review Group is chaired by the Chief Nurse of the CCG, who has commented that the meeting is proving successful in providing appropriate assurance to the CCG. In addition, the Director of Governance and Quality presents at the Clinical Quality Focus Group any themes and trends and offers assurance to the CCG with learning actions identified.

Following the Root Cause Analysis (RCA) investigations of these incidents, the following themes were identified, and actions implemented. In order to measure the success of the learning, complaints, PALS, incidents and risk are monitored on a weekly basis to ensure a downward trend of the specific learning points noted below or timely escalation where required.

Patients appointments not received due to human factors
There were two RCAs that related to patients who had been lost to follow-up due to human factors, these occurred in Breast Surgery and Radiology. On one of the repots a change in process had already been put in place on 1st April 2021 due to bringing reporting back 'in house' and therefore we completed audits to ensure no further patients had been missed.

Inadequate Documentation
7 of the RCAs completed in Quarter 4 found that documentation errors or omissions were root causes or direct contributory factors in the incidents. In order to address the documentation omissions identified in the Digestive Diseases RCA, whereby comfort rounds and body maps were incomplete, a pressure ulcer collaborative was commenced within the CBU, and a test of change implemented through link nurse involvement. Device checklists have been implemented and rolled out across the Trust. This supports the monitoring of patient skin when devices are in use and key areas to monitor. There have been no other RCAs noted within the quarter relating to this trend, but this is monitored centrally via Governance and any on-going trend will be highlighted.

Orthotic Applicant/Orthopedic Devise Chart

Teaching Hospitals NHS Foundation Trust

ORTHOTIC APPLIANCE/ORTHOPAEDIC DEVICE OBSERVATION CHART

Type of Appliance/device ..... Reason for Application .....

Date of Application..... Duration for which appliance to be worn (or date to be removed) .....

Skin integrity under orthotic/orthopaedic device to be checked 4 hourly and if the patients position changes. Orthotic appliances need to be loosened t check all areas in contact with the brace and must be removed and reapplied if all areas cannot be checked with the brace in situ (contact Orthotics if training or further advice required). If orthopaedic device cannot be removed ensure that all visible skin is checked.

Date	Time	Pressure areas checked intact? (Insert comment if not intact)	Pads Changed? Y/N/NA	Comments	Name of Registered Nurse	Signature
	07:00					

There were two Women's & Children's RCAs relating to maternity unit closures. One of the issues identified in the investigation was that children and midwifery guidance does not give clear instruction in relation to when a trust is nearing full capacity. This should result in internal escalation, however, there was no proforma to capture actions taken to address amber concerns from the Maternity Divert Policy such as a higher patient dependency than staffing ratio and skill mix. It was therefore felt that there was no clear communication and decision log when in amber status and what proceeding actions were taken. The actions taken were the introduction of a Maternity Escalation Flow Chart to support staff decision making.

Pressure Damage A6 and A4:

The contributory factors within both of these RCA's was that care, comfort and repositioning charts were not completed accurately or timely in order to closely manager this Tissue Viability are working closely with the ward areas to provide additional support and training needs.

One of the reports showed that there was a lack of regular removal of an orthotic device to monitor pressure deterioration an action which was implemented and now in place is a Trauma nurse skin review under orthotic devices on the daily trauma ward round as an additional action to check to document findings.

Communication

8 out of the 18 RCAs found issues identified with communication between teams. The first RCA was a patient who had been sent in by the General Practitioner awaiting surgical review. A decision was made that as the patient was clinically well and had stable physiological observations, it was unlikely that there would be any intervention that night therefore the patient could be discharged home with the plan to bring the patient back to the surgical clinic and re-list for surgery. The patient went home but did not have his bloods reviewed which later showed he was septic. There was no communication between teams who the patient was under and be reviewing bloods taken on that attendance. As a result of this urgent blood test results should be reviewed before patients are discharged from the ED. When it is clinically appropriate to discharge a patient without all blood results being available, it is the responsibility of the Clinician requesting investigations to review the results and act on them promptly or to formally hand over this task and document this in the clinical record.

Another report which relates to communication was a patient that had a pre-operative assessment and deemed not fit for surgery. This information was not communicated to the patient or booking team to cancel the theatre slot. The patient attended for theatre. Due to the team pre-printing the anaesthetic records the most up to date information was not on the preoperative assessment therefore the Anaesthetists were not aware he had been cancelled. As a result of this there is a robust and auditable Standard Operating Procedure being completed in Q1 2022/2023 for cancelling unfit patients from theatre lists.

Breast:
An RCA in Breast related to patients lost to follow-up, after a consultant had left the Trust. There was no clear process in realigning the Consultants caseload. 212 patients were reviewed 6 patients were identified that had not been seen, no harm to any of these 6 patients was identified following review. The RCA identified missed opportunities to ensure that patients within this group were allocated. As a result of this incident, there is formalised escalation processes between the appointments team and the CBU's to ensure information is being escalated and shared with the relevant staff. This SOP is audited on a monthly basis.

Safety Alerts

WHH uses the daily safety brief to share learning on a wider scale, these are shared Trust wide via communications, and noted as pop-ups on computer screens and shared at daily staffing huddles. The below table provides examples of Safety Alerts issued by the Trust via the daily safety brief following incidents that occurred or were investigated in Quarter 4:

Subject	Detail	Date issued
The benefits of requesting via ICE	The laboratory would encourage the use of ICE where possible when requesting Pathology tests, as the potential for human error is reduced when compared to using manual paper request forms. **Action:** The alert was shared via the daily safety huddle starting on 18th February 2022 with an action to for all Divisional Clinical Governance Leads, Clinical Leads, Consultants, Divisional Head of Nursing, Matrons, Ward Manager and Heads of Departments please print off the risk Alert and ensure this is communicated to your staff within your areas of responsibility as part of all communication briefings **Assurance:** We will know that this communication has had the desired impact by monitoring the number of incidents relating to this.	18/02/22
Safe disposal of sharp	The inappropriate safe disposal of sharps can lead to unexpected sharps injuries. Incidents/injuries often occur as a result of a used sharp being disposed of inappropriately by not placing it into a sharps container immediately after use **Action:** A communication has been issued to give staff instruction on what action they must take to ensure they are acting in line with Trust policy and to keep themselves, their colleagues, and patients safe. All Clinical Governance Leads, Clinical Leads, Consultants, Head of Nursing, Matrons, Ward Manager and Heads of Departments were asked to print off the Safety Alert and ensure this was communicated to staff within their areas of responsibility as part of all communication/health and safety briefings	24/03/22

	Assurance: We will know that this communication has had the desired impact by monitoring the number of incidents reported relating to this issue.	
Importance of identifying patches when completing daily body maps and confirming the patch is prescribed	There has been an incident where a patient's buprenorphine patch was not removed when the prescription was discontinued and remained in place for 4 weeks before it was identified at the Care Home after discharge. **Action:** A communication was shared with staff to share with their teams to ensure this becomes daily practice. **Assurance:** We will know that this communication has had the desired impact by monitoring the number of incidents and complaints reported relating to this issue.	29/03/22

Never Events

Never Events from this Quarter

There was 1 Never Event opened in Quarter 4 that was reported on 24th March 2022. This remains the same as Q3, where there was 1 Never-Event opened or closed. Following the never event, an urgent Executive led debrief panel was arranged by the Director of Governance to ensure that actions were undertaken promptly.

The patient attended for an Ultrasound injection of the shoulder prior to MRI scan, where their right side was injected rather than their left side. The error was only identified after the injection had been performed.

Duty of Candour

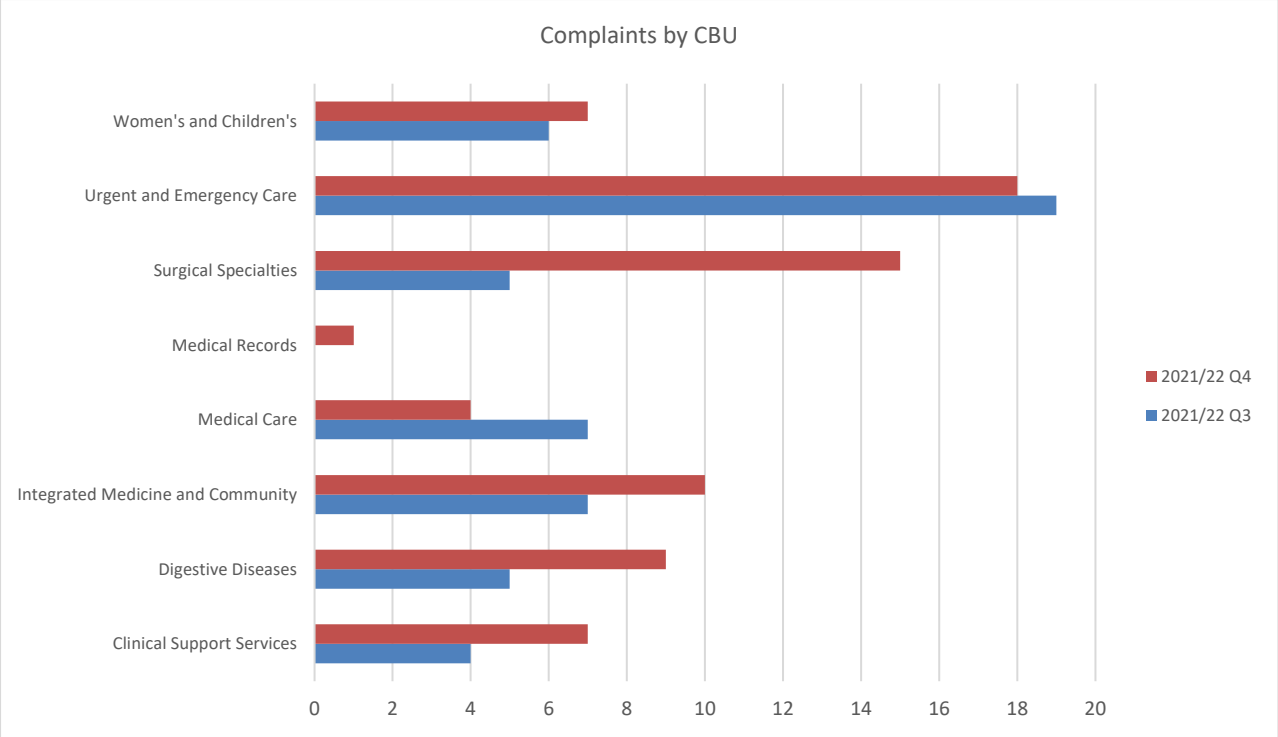
Whilst the Trust maintains its position of 100% compliance with Duty of Candour.

b. Learning from Complaints and PALS

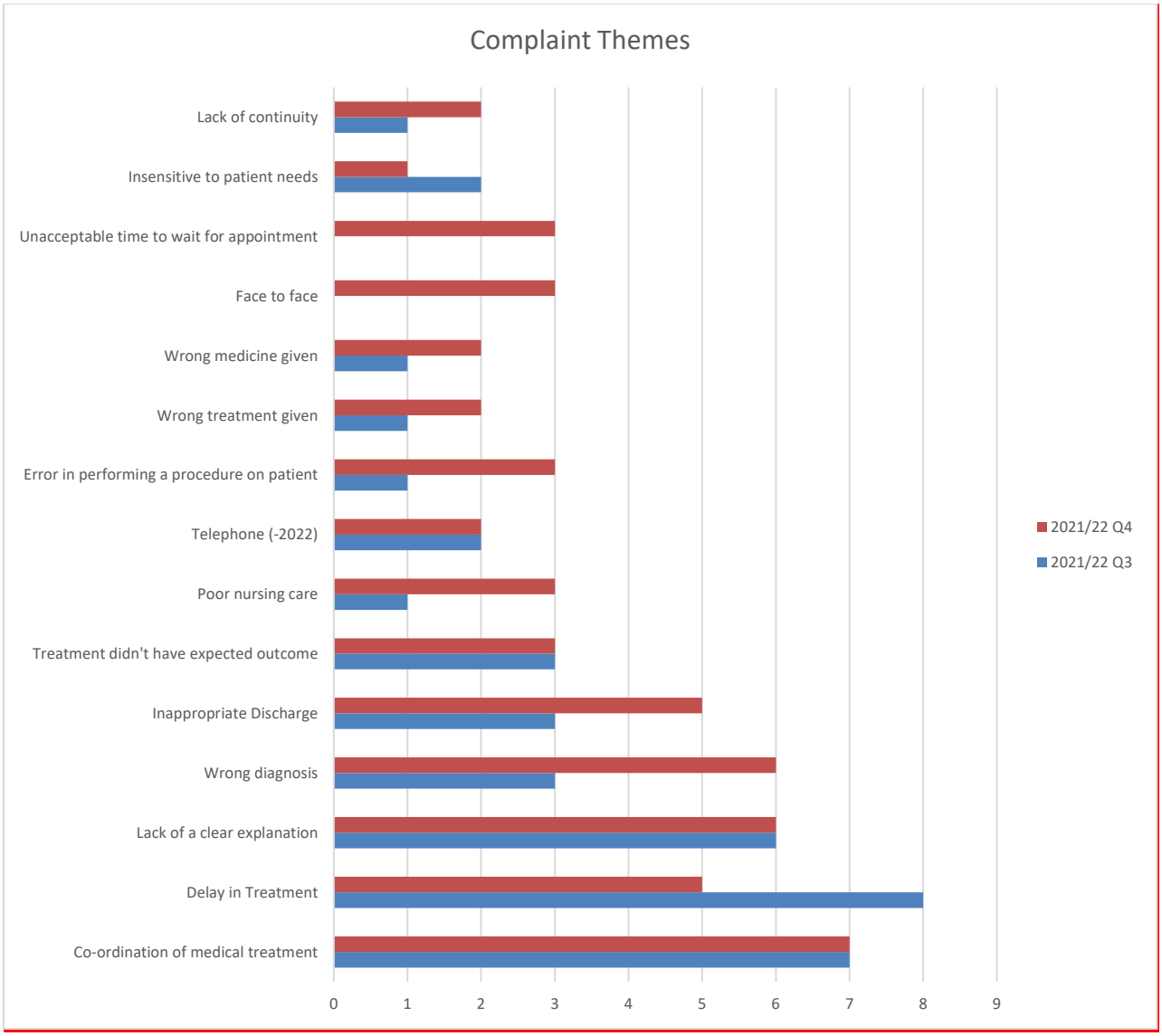
Complaints

Complaints received

As per the below graph, there was a 36% increase in complaints opened Trust-wide in Q4 (52 in Q3 versus 71 in Q4). The themes of the complaints received were reviewed which confirmed that there was no particular areas of concern. Although there was an increase between the Q3 and Q4 figures (52 in Q3 versus 71 in Q4), this is still a significant decrease from the same Quarter in 20/21, where 121 new complaints were opened. The themes of the complaints received are demonstrated in the graph further below. Surgical Specialties reported an increase in the complaints received. Urgent and Emergency Care saw no change in complaints received while Medical Care had a decrease in the number of complaints received.



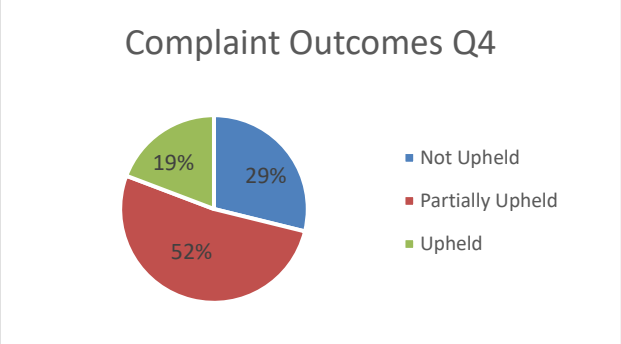
The themes of complaints received in Q3 vs. Q4 are outlined within the below chart. Clinical Treatment remains the most common theme of complaints received. This category of complaints includes alleged delayed or misdiagnosis and delayed treatment. The number of complaints relating to this theme have increased from 29 in Q3 to 38 in Q4. This is triangulated with the themes noted within incidents.

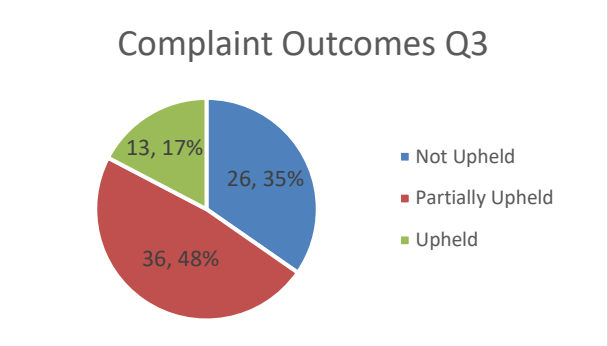


Complaints closed

There was a decrease in the number of complaints closed in the Trust in Q4 (75 in Q3 versus 52 in Q4) however all were closed within timeframe. The below pie charts demonstrate the outcomes for complaints closed in Q3 vs Q4. In Q4 a greater percentage of complaints were not upheld (26.35% in Q3 vs. 29% in Q4), indicating that the care and treatment provided was appropriate despite challenges that are being experienced operationally.

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





Responsiveness
All specialties have responded to complaints within timeframe in Q4. The Trust had a target to respond to 90% of complaint on time and in Q4 the Trust continued to achieve 100%. The Trust continues to have 0 breached complaints and there are no complaints over 6 months old.

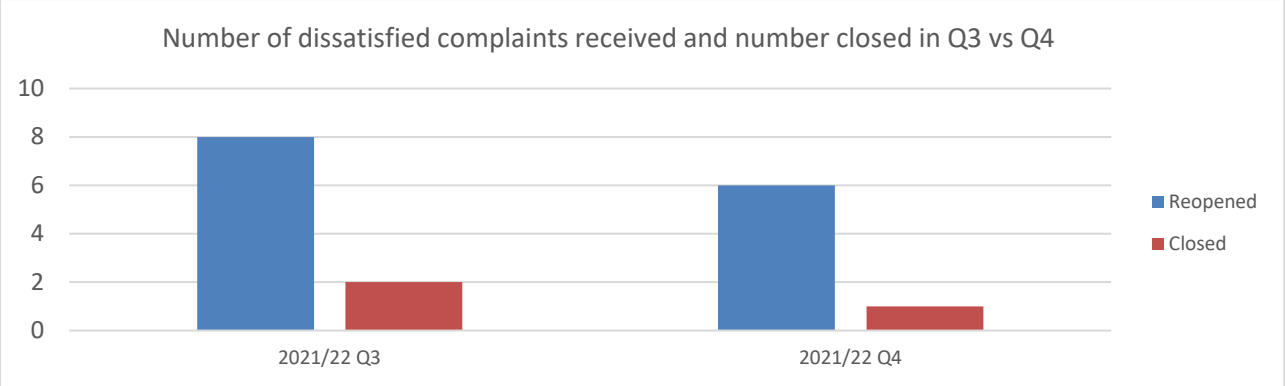
Complainants continue to be offered the opportunity to attend a meeting with the appropriate team to facilitate meaningful discussion as an initial measure – this approach facilitates wider learning and understanding. It is also noted that fewer complainants return with further questions or expressions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

Actions resulting from Complaint investigations
The following table provides examples of complaints raised in Q3, and the actions we took in order to address the concerns raised and improve our processes. For further assurance a complaints position with learning is provided quarterly to the Quality Assurance Committee. The Chairman also holds a monthly complaint meeting where a CBU or speciality will present a complaint, the lessons learnt, and actions implemented.

You Said….	We Did….
A complainant raised concerns regarding communication within the ED. The patient is a member of the deaf community and was not offered any support. Patient was also left without treatment for a protracted amount of time.	Ensuring, where appropriate, alerts are added to patients' electronic records. Ensuring patients who are deaf are advised of support that is available to them whilst in ED
Complainant has raised concerns regarding her treatment in: the Accident and Emergency Department, Gynaecology Assessment Unit and Early Pregnancy Unit. Concerns include: appointment delay and waiting room experience.	Decision made to redesign entrance to EPAU to avoid patients suffering miscarriages using same corridor as ante natal patients
The complainant has raised concerns over staff attitude whilst attending the Ophthalmology department.	Had a wider discussion at sub committee around Trust values and importance to wear face coverings

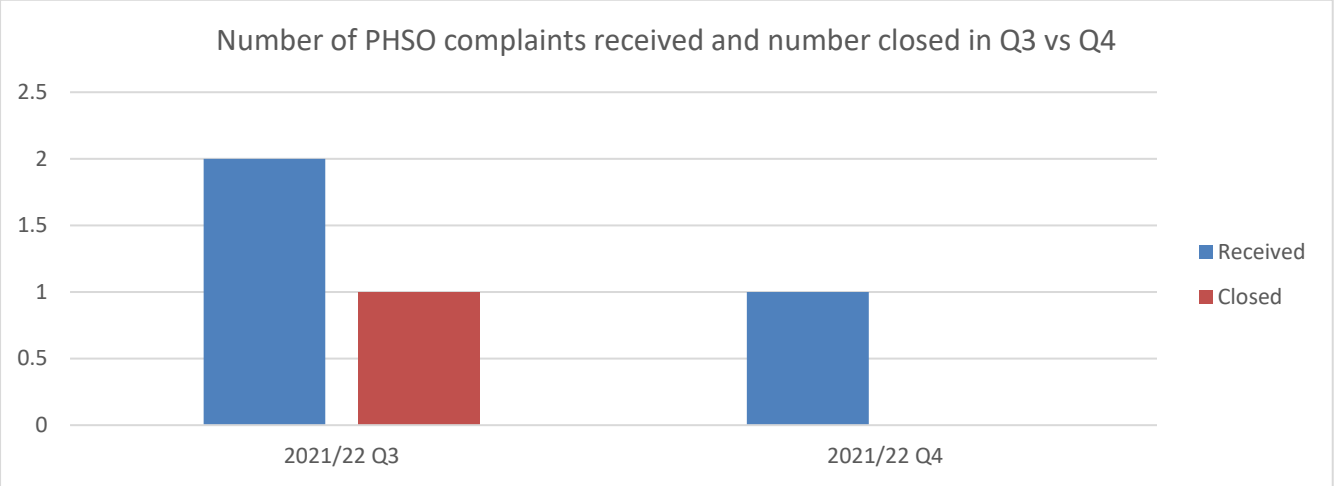
Dissatisfied Complaints

The below graph demonstrates the numbers of dissatisfied complaints received and closed in this Quarter vs. the previous Quarter. The Complaints Team is continuing to work with the CBUs to improve the quality and detail of the complaint responses to reduce the number of dissatisfied complaints. Fewer dissatisfied complaints were received in Q4 than Q3.



PHSO Complaints

The number of PHSO complaints received within Q4 remained low. PHSO complaints continued to be dealt with in a timely manner. There have been no PHSO complaints closed within Q4 as the investigations being undertaken by the PHSO have not yet concluded.



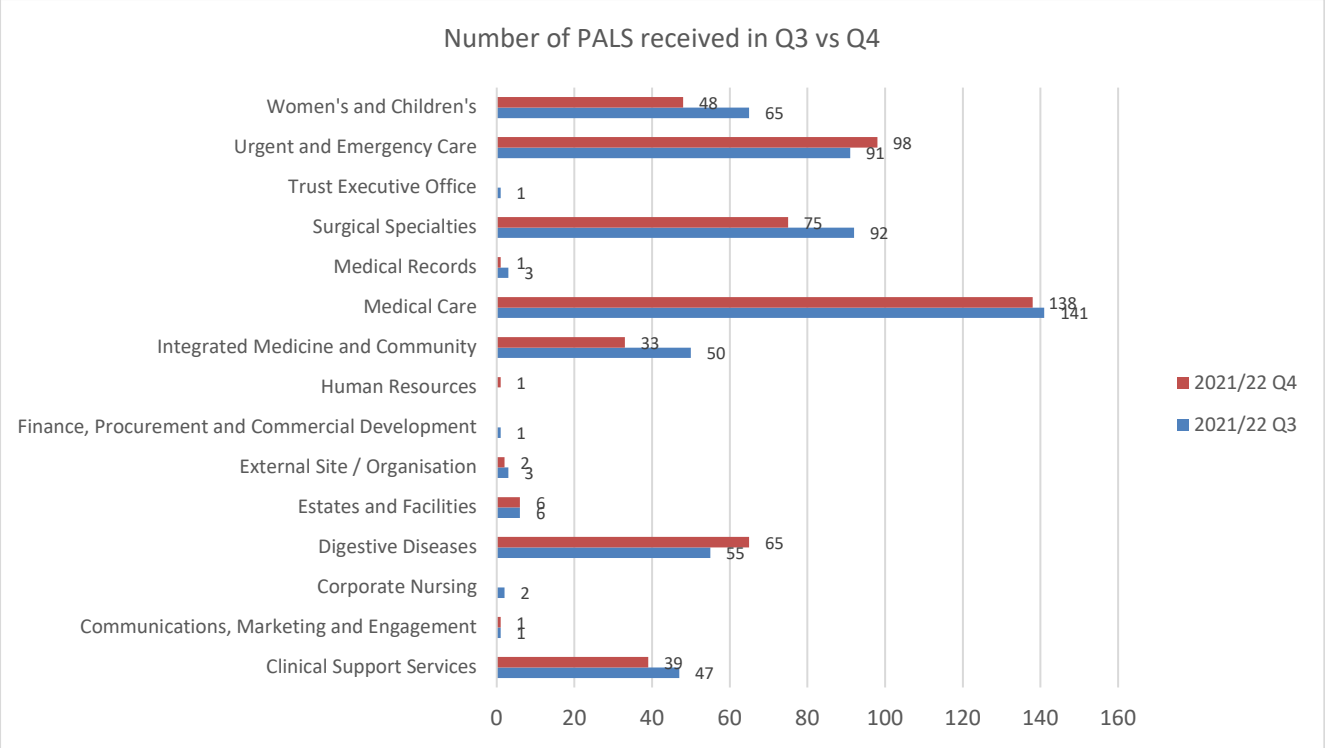
PALS

PALS received

There were 507 new PALS received in Q4, a decrease from the 558 received in Q3. The below chart demonstrates the breakdown of PALS received for each service.

PALS closed

In Q4 we closed 523 PALS cases, compared with 576 closed in Q3. The below chart demonstrates the breakdown for PALS closed for each service.



PALS relating to the Digestive Diseases CBU saw the biggest increase in cases closed in Q4, with 65 cases closed, compared with 51 closed in Q3. The increase is due to an increase in PALS received within the quarter and also due to the CBU working to ensure that all PALS cases are closed within the Trust's 3 working-day turnaround period. That the number of complaints closed for Digestive Diseases in Q4 is considerablly that the number of PALS received (9 complaints vs. 65 PALS) demonstrates that the CBU is able to effectively deal with concerns and queries quickly and informally.

Actions resulting from PALS cases

You Said….	We Did….
A patient's wife raised concerns in regard to the accessibility of the general office at Halton for patients in wheelchairs.	The concerns were shared with Associate Director for Estates and Facilities. A visit was undertaken to the general office to review the accessibility and it was identified that changes could be made to make the general office more accessible. Arrangements have been made for an auto-close system to be fitted to the doors of the office, so that doors remain open so that patients do not have to struggle to open the doors.

c. Learning from Claims

<u>Clinical Claims</u>

Clinical Claims Received

There were 26 clinical claims received in Q4. This is a increase from Q3, where 17 clinical claims were received.

Clinical Claims Closed

49 Claims were closed in Q4, 15 of which were with damages (totalling £3,192124,12) (excluding the costs of instructing Trust solicitors) this includes 1 claim which settled with periodic payments. This is not a concerning feature as the number of claims remain stable. Damages were higher in Q4 than Q3 as more claims were closed and the values of the claims closed were higher on average than the previous quarter.

Clinical Support Services	£400,000.00	1
Radiology	£400,000.00	1
Digestive Diseases	£147,500.00	3
Endoscopy	£40,000.00	1
Gastroenterology	£100,000.00	1
Urology	£7,500.00	1
Surgical Specialties	£245,101.30	7
Vascular	£21,621.30	1
Ophthalmology	£14,000.00	1
Orthodontics	£32,000.00	2
Spinal Surgery	£112,980.00	1
Trauma & Orthopaedics	£27,000.00	1
Urology	£37,500.00	1
Urgent and Emergency Care	£1,649,522.82	3
Acute Medicine	£20,000.00	1
Emergency Medicine	£1,000.00	1
General Medicine	£1,628,522.82	1
Women's and Children's	£750,000.00	1
Obstetrics	£750,000.00	1
Grand Total	£3,192,124.12	15

Non-Clinical Claims (Employee Liability/Public Liability)

Non-Clinical Claims Received

There were 7 non-clinical claims received in Q4. This is an increase of 5 from Q3. The learning from these will be provided once they have been closed.

Non-Clinical Claims Closed

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

Improvements and changes arising from Claims

Following claims investigations for claims closed in Quarter 4, the following themes were identified, and actions implemented. In order to measure the success of the learning, complaints, PALS, incidents and risk are monitored on a weekly basis to ensure a downward trend or appropriate escalation in relation to the themes of the specific learning points noted below. A claims report is provided to each CBU meeting. In addition, there is a clinical claims review group that is attended by various clinicians. A newsletter is also produced which highlights key themes for learning.

Failure in delay of diagnosis of breast cancer

Within Q4, a claim was closed where it was determined that there was a delay of diagnosis of breast cancer in or around June 2015 leading to aggressive treatment including chemotherapy, right

mastectomy and axillary node clearance and radiotherapy. In response to this there was immediate review of systems for relying on handwritten scan reports in the New Patient Breast clinic and the system for storing these. Reflective learning by Consultant Radiologist and Consultant Breast Surgeon. There has been no trend noted in terms of delays in diagnosis in the breast speciality.

Perforation of the bowel during an endoscopic examination

A claim was settled where a patient suffered a perforation of the bowel in 2019 during an endoscopic examination and the patient later passed away. In response to this, advice from another specialty should be taken into account when planning further management of a patient in order to ensure adequate decision making, this has been shared at specialty mortality and morbidity meetings by gastroenterology governance lead. The operating endoscopist must have a comprehensive knowledge of all investigations before undertaking an invasive procedure. This has been shared at specialty mortality and morbidity meetings by gastroenterology governance lead. Remove request for inpatient colonoscopy from ICE and replace with inpatient referral to gastroenterology. The Gastroenterology Governance lead to contact ICE as an immediate action to amend the advice

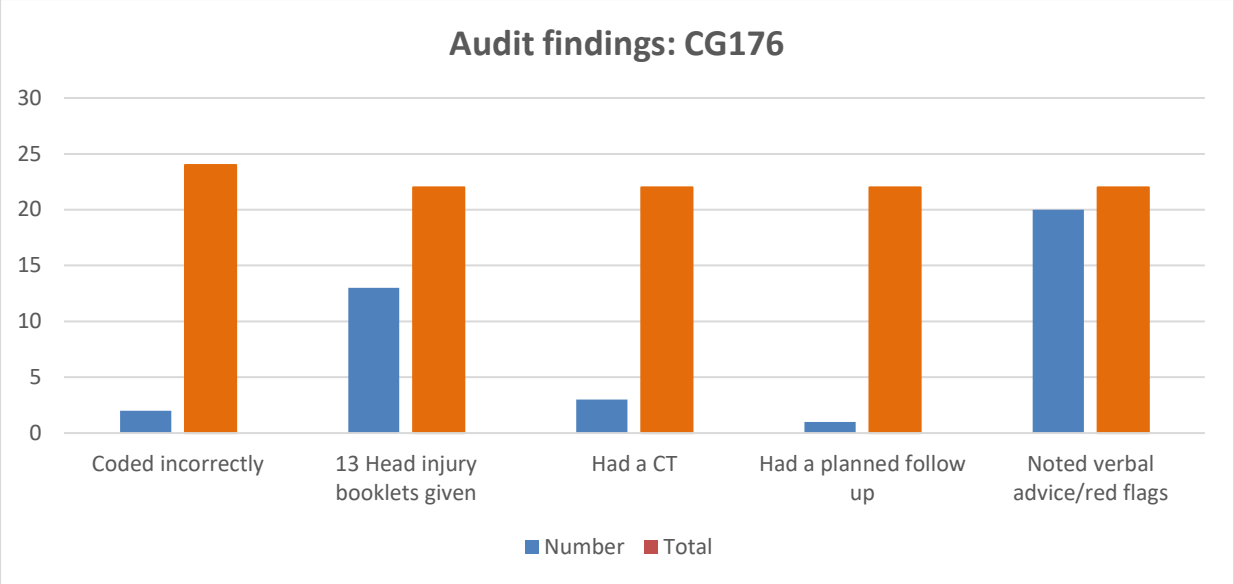
Delay in treatment eye condition resulting in detached retina

The Trust settled a claim whereby there was a delay in treatment of an eye condition resulting in detached retina in 2018, allegedly due to incorrect advice given during telephone call (no note of call at hospital). The patient required further surgery. Following this, Ophthalmology now have a system called Medisight, which is a full EPR system. The standard practice is to create a "note" on medisight against a patient's clinical record for any record of a discussion between patient/family member/other professional. This forms part of the patients' clinical records and has a robust audit trail with the individual recording the note and date this was recorded. The benefit of the EPR is that it is readily accessible for all clinicians to make a quick note on the patients clinical file in real time.

NICE Guideline - CG176: Head Injury: assessment and early management.

Over the last 12 months (1st March 2021 - 28th February 2022) 5219 patients attended either Warrington or Halton Hospital and were discharged with a head injury as one of their diagnoses. An audit was undertaken on 24 case notes – 2 for each month, one from Warrington and one from Halton.

The results are summarised in the graph below.



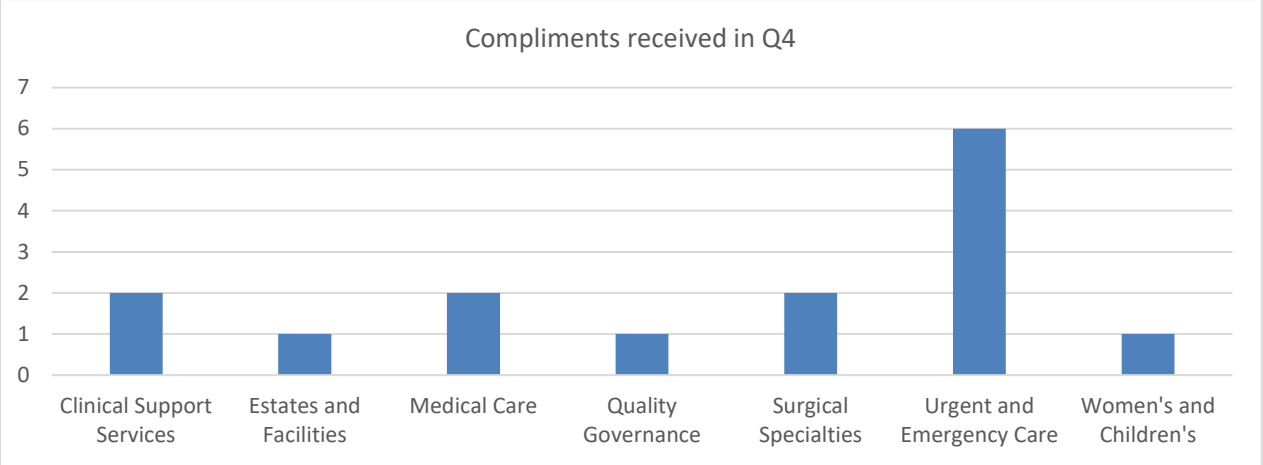
- 2 out of 24 were coded as head injury incorrectly and therefore they were removed from the analysis of results. These were both patients who were seen at Warrington Hospital.
- 13 out of 22 notes said a head injury booklet was given. Of these, 7 were given in Halton Hospital and 6 were given in Warrington Hospital.
- 3 out of 22 patients had a CT scan prior to discharge.
- 1 out of 22 had a follow-up planned prior to discharge.
- 20 out of 22 had verbal advice/reg flags discussed written in notes.

NICE Guidelines

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. New and updated best practice guidelines and updated guidelines are published regularly and the Trust measures compliance against the recommendations. In Q4, 59 applicable guidelines were sent to leads to assess compliance, of these 41 have been completed and 18 are still within timeframe for completion. The Trust's current compliance is 91.22% against a target of 90%.

d. Learning from Compliments

A positive safety culture is one where compliments are fed back to staff in the same way that investigations are. Compliments are a really useful tool for the Trust to be able to identify what areas are working well. In Q4 the Trust received 15 compliments, this compares with 7 compliments which were received in Q3.



It has been identified that compliments are often received within letters of complaint, whereby the patient or relative will take the time to acknowledge the positive impact of staff members involved in their care. The Head of Complaints has discussed the importance of logging these compliments with the Complaints and PALS staff at the 9th February 2022 team meeting and will continue to monitor the logging of compliments on a monthly basis to ensure the numbers received are being accurately captured. This positive feedback is also shared with the CQC.

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

A Patient Safety Summit is being planned for June 2022. This learning with guest speakers will be available to Trust employees but also to GPs as partners in health. This will include work around civility saves lives, human factors, court of protection and learning disabilities.

e. Learning from the CBUs

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

Medical Care

We found….
A patient's relative rang the ward to explain her husband was discharged the previous day and Along with his TTO'S there was multiple other medications that belonged to another patient. Indicating the TTO'S were not checked before discharge or the previous patients medication was still in the pod so they have all been put into a bag.
We Acted….
• Discussed with staff at safety brief the process of checking TTOS correctly to ensure any mistakes are rectified prior to patient being transferred and ensuring they are all correct as per discharge summary.

- When under pressure to complete discharges staff need to be extra vigilant

Integrated Medicine & Community

We found….

A male patient with learning disabilities was becoming increasingly difficult to provide care for but there was no formal Mental Capacity Assessment performed. The patient required restraint and was very strong and determined so Security were called to assist with the patient. Staff were unsure of what their rights were with regards to using any clinical holds and were inexperienced in this action.

We Acted….

- Print and display a clinical holds policy for the ward to help support staff
- Check all areas MCA book have a sticker to advise send to Lancashire House
- Contact the family and ask what they would like to be in place for any future admissions
- Discuss with the family what they would like to be implemented for the patient and discuss commencing a carers passport for the patients sister (advocate)
- Remind all staff of the importance of reporting any incident during which a restraining hold has been used to include clear traceable patient identifiers.
- There are plans to implement a carers passport, any patients admitted with a carer / advocate who may be staying for extended periods of time to support the patient should be asked what they require to provided that support and what they would like from the clinical area

Clinical Support Services

We found….

An ultrasound thyroid request converted to NM thyroid scan by radiologist, hand written on a paper request. Administration person requested a NM parathyroid instead. Due to shortage of isotopes at the time request not vetted properly and put on planned to be done. Patient arrived for scan, ID, details checked and confirmed by another radiographer. The patient knew she was for a scan of her neck and happy to proceed. Scan preformed and then it was discovered this patient should have had a NM thyroid scan. Highlighted to Radiologist and clinical lead. Errors occurred in each part of the chain, 3 radiographers read the request, unfortunately the patient received this incorrect scan, systems are being changed to try and ensure this wont happen again.

We Acted….

- The effective dose from the unintended examination is equivalent to 2 years of natural background UK radiation and is associated with an increased lifetime cancer risk of <0.05%. This is not reportable to the CQC.
- The CQC were informed of this on 4th March 2022 and have stated they will class the submission as a voluntary notification and will not require a report.
- The patient was informed of the incorrect scan- not as a formal duty of candour.
- A meeting took place with the nuclear medicine team to make all staff aware of the incident and to be vigilant as regards the details of scan type/clinical information.
- With immediate effect the NM team will not automatically process any referrals which have been changed by a member of the clerical team (with the exception of scans for pulmonary embolus which are converted from CT to NM by a Consultant Radiologist).

- In the nuclear medicine team between 8.30 and 11.00am each day there will be a dedicated member of staff vetting requests, booking appointments and checking the requests for the following day.

Urgent & Emergency Care

We found….

Patient attended the Emergency Department with a knee injury that had occurred three weeks previously. The patient was assessed and treated as an Anterior Cruciate Ligament (ACL) injury however following a referral to fracture clinic was found to have a fracture and not an ACL injury. The patient required surgery that was more complex due to the delay in diagnosis as the fracture had healed. The patient also developed a blood clot (DVT - Deep Vein Thrombosis) in her leg which was identified following her initial outpatient appointment.

We Acted….

- All clinicians to be aware of need to follow guidelines and x-ray where indicated via safety brief and governance newsletter
- Ottawa guidelines for knees/ankles and feet to be included in teaching for nursing staff requesting x-rays
- Trauma and Orthopaedics to be tasked with reviewing time to fracture clinic appointment to ensure timely access**.** Virtual fracture clinic will be introduced early 2022

Surgical Specialities

We found….

Young fit patient with complex wrist fracture admitted for surgery. Due to delay in arranging surgery then the fracture had partially healed in a poor position. Contact was attempted by the team to arrange surgery date but unsuccessful and contact not documented. This procedure proved to be a very difficult operation and additional assistance was required from colleague during procedure. Incident had potential for poorer outcome due to delay.

We Acted….

- Consider electronic trauma system
- All communication to be documented on electronic patient record
- Update ambulatory trauma policy to include if patient is uncontactable within 72 hours, then contact patient in writing.
- To discuss options of reducing patients awaiting surgery at the next speciality meeting.
- Consultants to directly liaise with waiting lists in relation to priority of urgency patients

Digestive Diseases

We found….

Incident reported stating “Patient with Type 2 diabetes found to be in DKA.”
A rapid incident review was held to discuss the incident.
The patient would have usually been on oral diabetic medication which was not prescribed on admission as the patient was unwell and needing a variable rate insulin infusion. The patient had a bowel obstruction and required urgent emergency surgery. The Diabetic Nurse explained that the VRII appears

to be discontinued just as the patient goes to theatre. Post theatre there doesn't appear to be any oral or VRII medication

We Acted….

- A rapid incident review was held to discuss the incident.
- The ward manager has shared the diabetic policy with staff and sign to say have read and understood this. Lessons learnt from the incident were shared with the ward staff.
- The digestive diseases clinical director has communicated to clinicians to ensure medications are reviewed regularly for diabetic patients.
- From the level of the patients' blood sugar readings, they were slightly elevated at 12.2mmols at its highest. Policy is if has a BM is above 12mmols then check ketones plus had previous ketones. Patient had 2 readings overnight above 12 and ketones were not checked. Staff are to be reminded of the diabetic policy and ensure trust standard training is up to date.

Women's & Children's

We found….

A baby was born with hemolytic disease of the newborn and needed to be transferred to a specialist unit for treatment. Baby has since recovered. The mum was Rhesus negative blood group and had become sensitised during pregnancy (meaning that she had developed positive antibodies for the disease during pregnancy), which is a rare event.

We Acted….

- The process in the laboratory has been strengthened to ensure all women who have positive antibodies in pregnancy, require regular follow up; if there is a high level of antibodies, the laboratory will refer blood samples for more in-depth analysis.
- awareness has been raised with the Obstetricians and Midwives around the significance of women who have positive antibodies and the follow up that would be required.
- The laboratory reports have been updated to include the detail relating to the cause for the positive antibodies and the follow up required.

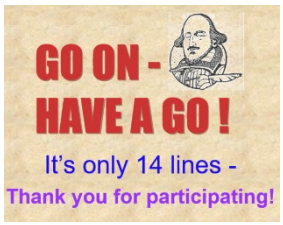
f. Learning from our Staff

Saying Thank You

The Extranet has been updated to include the "You Made a Difference" nomination form. We want to know how Team WHH has made a difference. You can nominate an individual or a team for going the extra mile. Anyone can make a nomination using our simple online form, and nominations will be taken to a panel for judging.

There will be a monthly 'You Made a Difference' award winner, and all winners of the monthly 'You Made a Difference' award will be put into the annual Thank You awards special category of "You Made a Difference Winner of the Year".

Sonnets on the Extranet



In order to encourage creativity and reflection, staff are now able to submit a sonnet to be uploaded to the Extranet. These are short poems, which staff can use to reflect their thoughts and feelings on certain topics. There are currently three sonnets, written by Trust staff, on the topic of covid. Sonnets can be submitted for uploading by emailing: whh.organisationdevelopment@nhs.net

Bright Spots

The Bright Spots section is within the daily Trust-wide Safety Brief and is an opportunity to recognise the efforts of our staff and thank them for their hard work.

g. Learning from Patient Experience

Review and action based learning from CQC Surveys:

- Focused workstreams for food, nutrition and hydration based on learnings from patient experience surveys – including Nutrition and Hydration week 'hot topic'.
- Communication with patient relatives on wards – trials in wards of additional communication lines to improve communication and updates with relatives.
- CQC Mock Inspection reviews are identifying learning from survey actions including noise and light at night, patient information, communication regarding wait times and first impressions.
- Learnings shared through internal meetings, sub-committees and 'Topic of the Month' for April 2022 with patients and staff.

Continued focus on learning from patient experiences:

- Continued use of digital stories to drive improvement – learnings utilised from MDT ward based stories and complaints and PALS and presented across the Trust.
- Focused meetings with Community Partners and engagement at Patient Experience Sub-Committee and Patient Equality, Diversity and Inclusion Sub-Committee to listen and learn from community experiences at WHH.

Reintroduction of patient visiting across inpatient areas with feedback from PALS considered to ensure patients are supported with communication and wellbeing.

h. Learning from Clinical Audit

National Audits

Cardiac rhythm management and ablations

Summary:

Cardiac rhythm management (CRM) is the treatment of arrhythmias (heart rhythm disorders). The term 'CRM' is often used to describe treatments based on implanted electronic devices such as pacemakers and defibrillators.

Results:

Data completeness was greater than 95%. Centre activity recorded was as expected, Operators are consistently doing more than the minimum requirement of pacemaker implantation per year, 100% compliance with NICE (TA324 and TA 88).

Table 10: Pacing in sinus node disease

Eligible PPM Implants	No. meeting guidance	% meeting guidance	% not meeting guidance	% indeterminate
20	20	100	0	0

NICE TA88: Dual chamber pacing in AV block

The 5.2% documented as not meeting guidance likely represents patients who were in atrial fibrillation for whom a dual chamber device is not appropriate. The audit dataset does not capture this.

No action plan for improvement required.

Assurance rating (using Trust assurance rating matrix):

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

Local Audits

DNACPR Audit 2021

Summary:

Warrington & Halton Hospitals NHS Foundation Trust (WHHFT) has utilised the Adult Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) Policy and associated documentation since October 2013. The internal audit of the uDNACPR process has been in place since this date. A specific audit form is included in the uDNACPR policy. The aim of the audit is to produce data which establishes levels of compliance with the uDNACPR Policy in use in WHHFT from January 2021 up to and including December 2021.

Results:

Recommendation:

	Compliance Scores				
Standard	Yes	No	N/A	Total	Compliance RAG
1. Are there clear patient details?	120 100%	0 0%		120	100%
2. Have the date and time of the decision been completed?	118 98%	2 2%		120	98%
3. Has the reason for the decision been documented?	118 98%	2 2%		120	98%
4. Has the person been consulted/informed of the decision?	63 93%	5 7%	52	120	93%
5. If the person lacks capacity has the relevant other been informed?	66 93%	5 7%	49	120	93%
6. Is there evidence of discussion (Confirm in Lorenzo/electronic notes)?	109 91%	11 9%		120	91%
7. Is the record clearly dated, timed and signed correctly, including GMC number?	119 99%	1 1%		120	99%
8. Has the form been completed and/or verified by a consultant?	111 93%	9 8%		120	93%

Recommendations:

Key successes: In all areas the data displays a greater than 90% level of compliance. This would indicate that the forms are being completed correctly.

Areas for improvement:

Current sampling requires 10 uDNACPR forms to be audited per month. The auditor would like to increase this number to 20/month (or the total number of completed forms received per month if less than 20) and randomly sample forms from the wards, along with those returned to the Resus. Department to increase levels of assurance.

i. Quarterly Learning Piece

International Women's Day

On 8th March 2022, International Women's Day took place and this was observed by the Trust. Learning was shared around gender bias and staff across the Trust were encouraged to reflect on themes including a gender equal world, free of bias, stereotypes, and discrimination.

Women compromise nearly half the global population and have a significant impact on the health of their families and communities. Gender bias can be a result of sexism and misogynistic practices.

Dr Rita Arya, Associate Clinical Director, Women's Health, shared a Good Morning Message (GMM) which focused on the care being provided to women at our Trust. Dr Arya outlined the vital improvements being made at WHH in relation to women's health.

j. Workstreams for Quarter 4

Action Planning

On review of the actions arising from RCAs and complaints investigations in Quarters 3 and 4, the Head of Complaints, PALS and Legal Services and the Patient Safety Manager have identified that action planning across the CBUs is not consistently S.M.A.R.T (Specific Measurable Achievable Realistic Timed). In the next Quarter, the Complaints and Patient Safety Teams will work in collaboration with the Governance Managers to implement S.M.A.R.T action plan training and a toolkit, to help action planners and owners set and complete meaningful actions. This will be monitored via the Quality Assurance Committee. Initial discussions into what the training package and toolkit are expected to achieve have taken place in Quarters 3 and 4 this workstream is progressing in Quarter 1.

Complaints Monitoring and Improvement

The Head of Complaints, PALS and Legal services is working with the Trust's Learning and Organisational Development Team to roll out a structured formal complaints training package. The aim of these will be give staff in the CBUs information around how to handle concerns at first contact to reduce the number of formal complaints, and to look at how formal complaints and PALS can be responded to, to give the best outcome for our patients and their families. This also facilitates learning in real time.

Formal complaint responses continue to undergo close scrutiny through the complaints and senior Governance Team to review the quality of the responses. Where appropriate, the Complaints Team will continue to encourage staff to seek to resolve complaints via telephone conversations or local resolution meetings with complainants.

The Complaints Quality Assurance Committee (QAG) continues to meet monthly, focussing on a different CBU each time. These meetings are an opportunity for the Chairman to review the Trust's complaints position, and for CBUs to reflect and feedback upon the quality and detail included within their responses. The QAGs held in Quarter 4 focussed on Women's & Children's, Surgical Specialities and Clinical Support Services.

Complaints Satisfaction Service Questionnaire

This workstream has progressed in Quarter 4 and the questions for the questionnaire are currently with the Director of Governance for approval. The Questionnaire will be available in both a physical and electronic format so that it is accessible to more service users. The Questionnaire is expected to go live in Quarter 1. The information gathered from this survey will enable the Trust to understand what works well, and what can be improved, to better support our patients and families through the Complaints process. A sample of the questionnaire findings will be available in the next reporting period with learning identified and included in reporting to the Quality Assurance Committee.

Welcome Booklet

The Patient Experience Team are in the process of redesigning the Trust's "Welcome to our Hospitals" booklet. This booklet provides information for patients, relatives and carers on what to expect from their hospital stay, from admission to discharge. It provides key details around topics including mealtimes, visiting and infection control. The booklet is being redesigned in collaboration with the Digital Communications Team, Complaints & PALS Team and Clinical Teams from each of the CBUs and seeks to address questions commonly asked by patients and relatives. This workstream was paused due to the rise of the Omicron variant, however, is scheduled to recommence in Q1 of 2022/23. This will allow for directives such as visiting to be updated in relation to Covid-19.

Staff involved in incidents – Survey

This workstream has progressed in Quarter 3 and the questions for the questionnaire are currently with the Director of Governance for approval. The survey is expected to be rolled out to a sample group of staff in Quarter 4 to gain initial feedback on the survey itself. The findings of this survey will assist the Governance Team in the delivery of training for RCA investigators and will also help us to better support staff involved in incidents.

Hotline Phone

In Quarter 1, the Director of Governance, the Associate Director of Governance, the Head of Complaints, PALS & Legal Services and the Patient Experience Team will establish a Hotline phone service, that will give patients and their families access to a senior member of staff to resolve concerns in real-time. This is intended to provide prompt resolution to concerns as they are occurring and reduce the number of PALS and formal complaints received thus enhancing patient experience and patient safety. Initial meetings have already been undertaken with Patient Experience and an options paper is being created to be reported at the next Patient Safety Sub Committee.

Junior Doctor Incident Training

The patient safety manager has been completing junior doctor training to support the understating of governance and how incidents are managed and progressed. During these sessions incidents are pick out to discuss, on occasions the junior doctors have pick out scenarios and completed a presentation these for discussion. The feedback received from these sessions is that they are informative and bring about positive discussion identifying workstreams where we can learn and work together to improve patient care. These sessions will continue in Q1 2022/2023. Below is example of presentation slides.

Mock Inquest Sessions

On 31st March 2022 a mock inquest learning session took place with the support of Hill Dickinson solicitors. This included a 20-minute power point presentation presented by Hill Dickinson followed by a mock inquest session, complete with senior members of Trust staff acting as witnesses. The session was well attended by Junior Doctors from FY1 to ST4 level. The aim of the session was to introduce staff to the inquest process. Feedback from the session was that staff had found the session to be very informative. Further sessions will be arranged later this year for nursing and medical teams.

3. RECOMMENDATIONS

The Board of Directors are asked to note the report.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/73**	
SUBJECT:	**Report from Digital Board – 11th April 2022**	
DATE OF MEETING:	25 May 2022	
AUTHOR(S):	Tom Poulter, Chief Information Officer	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. to the existing Lorenzo contract or the highly retrograde step of returning to paper systems as Lorenzo will be at end of life at or before the end of the tactical contract extension	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Digital Board met on the 11th April 2022. Below is a summary of papers received from key stakeholders. The following assurance status for key delivery areas was noted: **Digital Programme** Substantial Assurance **Vendor Management** Moderate Assurance (Dedalus) **Information and Business Intelligence** Substantial Assurance **IT Services** Substantial Assurance **Digital Compliance and Risk** Substantial Assurance **Electronic Patient Record** Substantial Assurance **Clinical Safety and Risk Review** Substantial Assurance **Digital Diagnostics** Moderate Assurance **Digital Maternity** Substantial Assurance	

	eRostering Moderate Assurance **Items to escalate to Trust Board:** • Anti-virus protection is currently operating at a reduced level on the PACS system • Dedalus notification that Lorenzo will be replaced by ORBIS U • The outcome of the EPCMS procurement exercise has not yet been confirmed • The Badgernet Maternity EPR system go live 3rd May 2022			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to XXXXX			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee		
	Agenda Ref.	FSC/22/04/65		
	Date of meeting	20 April 2022		
	Summary of Outcome	Noted for assurance		
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Digital Board Update – April 2022	AGENDA REF:	BM/22/05/73

1. BACKGROUND/CONTEXT

This report provides an update on the programmes of work in Digital Services and Digital Analytics, with the latest assurance assessment on each work area in scope. The minutes of the April meeting of Digital Board are attached as an Appendix to this report for reference.

2. KEY ELEMENTS

1.1 Digital Programme
Substantial Assurance

One project completed since last report to FSC - Virtual Clinic Consultation Software Procurement .

Attend Anywhere' were the successful bidders following full procurement with Cheshire and Merseyside – 15 Trusts will share costs across a 2- year contract. 4 projects are green status, and 9 projects are on amber status.

The DOG group last met on the 5th of April. The focus of the meeting was Fraxinus Projects (Elective Recovery) – Assurance for Digital Board that new functionality has been imbedded at other Trusts and change management, configuration and implementation are the requirements and focus for WHH.

Programme Planning – Assurance for Digital Board that Programme Planning for this financial year is underway with current focus on;Resource Planning – within the ePR team and digital colleagues PID development for each project Benefits capture and monitoring for projects and optimisation

1.2 Vendor Management
Moderate Assurance (Dedalus)

Dedalus are planning the removal of support by Microsoft of its Silverlight application framework, this is a significant piece of work. One Ed is progressing well, user acceptance test environment on track to be delivered by 3rd May. Still awaiting update on the CCN a meeting with the Trust's is planned for the 13th of April 2022. Go live is scheduled for the 6th of June. Dedalus colleagues have been on site this week working with ePR team and have tested various performance functions, feedback is the Silverlight issue is causing the performance issues and performance should improve once the Silverlight browser has been modernised.

1.3 Information and Business Intelligence
Substantial Assurance

Statutory reporting remains a challenge due to frequent new and changing requirements from NHS Digital, CIPHA and other external agencies.

One of the Senior Information Analysts is acting up for 6 months, without backfill for their role, in effect the temporary loss of one post. A Principal Information Analyst from the BI team will be leaving the team at the beginning of May 2022, recruitment is under way.
The latest Corporate Information and BI deployments/developments include:

- Specialty Demand and Discharge Pending Consultant report
- Capacity and Demand datasets
- Theatre datasets
- UEC SITREP – 111 First activity
- Outpatient Dashboard - PIFU updates
- Red to Green daily compliance report
- Ward round daily compliance report

1.4 IT Services Update
Substantial Assurance

Five projects completed since last Digital board**.** IT received a total of **2936** Service Desk calls. First time fix via telephone handled activity 61%. To ensure we have full Infrastructure compliancy and protection against Cyber attacks we are required to patch all network Infrastructure. All of March's change requests have been completed, except for 1 pending CAB approval currently on hold and 2 CAB pending following approval. 1048 Service desk calls come via email, 37% of the overall activity which is currently not reported on. IT are looking at options to automate email activity assign it to the correct team and category. SLA's now provided in Digital board reporting these include IT service desk, 2nd line desktop support, 3rd line network support and 3rd line datacentre support.

1.5 Digital Compliance and Risk
Substantial Assurance

The National Cyber Security Centre (NCSC) has urged organisations in the UK to bolster their cyber security resilience in response to malicious cyber incidents as a result of the ongoing situation in the Ukraine.

The Trust vulnerability score has risen by 8 points but has settled down by 2 points to a score of 36, due to newly found vulnerabilities in Microsoft Edge, Google Chrome Adobe Flash Player and Reader CareCERTs - There was no new High CareCERT reported last month by NHS Digital.

1.6 Electronic Patient Care Management System
Moderate Assurance

Dedalus Orbis U announcement; EPCMS Project Board recommendation that Dedalus is contacted to stand them down form the procurement before w/c 18th April; the procurement is in its concluding stages; a meeting is being arranged with the ICS Executives requesting confirmation on their endorsement of OBC V3. There is a reduction in the costs compared to the market research, that was done as part of OBC V2; the ask now for the capital costs is less than 50% of the internally generated capital depreciation level- this is looking much more likely that this can be accommodated and potentially not needing CDEL cover.

1.7 Clinical Safety and Risk Review.
Substantial Assurance (for Lorenzo)

1 PAN which was a low risk for the Trust.

1.8 Digital Diagnostics Programme
Moderate Assurance

No representation in meeting due to sickness, no update reported from CAMRIN network perspective.

1.9 Digital Maternity
Substantial Assurance.

Project timeline: activity focussed upon preparation for go-live – assurance, training, go-live support.

- Clinical focus areas: assuring clinical safety, stepping up communications activity, completing training on schedule.
- Operational focus areas: establishing floorwalker support during go-live, completing SOPs for business processes, planning the central Control Room function for go-live coordination.
- Digital focus areas: disaster recovery planning, completing testing, planning the technical activities needed in advance of go-live.

Additional meetings scheduled to oversee progress and provide rapid escalation and decision making.

1.10 RIS Procurement.
No representation in meeting.

1.11 eRostering Programme
Moderate Assurance

The objective of workforce development Medical e-Rostering Level of Attainment (LoA) 1 is to achieve 90% utilisation across all clinical workforce by 31 March 2022.

Level of Attainment (LoA) – We have achieved 94% of substantive clinical workforce using e-rostering for medics so far, NHSE/I confirmed that it is not a requirement to include locums in this % (please note there is in excess for 200 locums working in the Trust). We are still working towards 5 AHP areas.

Clinical Workforce Group (Allied Health Professionals (AHPs)) – 5 areas have been identified to on board at this stage – Radiography, Orthoptics, Physiotherapy, Dietetics and Therapy.

351/343 licences are currently in use across 11 specialties. Initial workshop on 7th April to start work on Specification for eRostering for procurement purposes.

1.12 Regional "place" Digital Programmes (Warrington Together & One Halton)

A workshop session was held last Friday to help provide a new digital plan for Warrington Together. WHH is leading the Warrington together plan, a second session will be held in a month's time.
A new Digital Plan is being developed to provide clarity on the projects to be delivered this year under the partnership arrangements, focussing on the integrated teams. These teams are using a range of different systems with potential to streamline workflows and improve integrated processes.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The following items were discussed at Digital Board and are highlighted for the attention of FSC. There are no specific actions required but these items are escalated to ensure FSC members are kept informed of key issues.

- Anti-virus protection is currently operating at a reduced level on the PACS system, due to a technical compatibility problem. A new anti-virus product (Windows Defender) is now being implemented to ensure full AV protection is in place. A new project will then be initiated to plan trust-wide migration from the existing AV solution (McAfee) to Windows Defender, which is provided on a more cost-effective basis as part of our Enterprise licence for Microsoft products.
- Dedalus have notified all Lorenzo customers that the solution will be replaced by ORBIS U over the coming years and future development work on Lorenzo will be limited as a consequence. The trust do not expect to migrate to ORBIS U under the new tactical contract, but Lorenzo will increasingly be treated as an "end of life" product.
- The outcome of the EPCMS procurement exercise has not yet been confirmed and a meeting has taken place with ICB Executive Leaders and regional NHSE/I representatives to discuss the impact of emerging policy direction on "EPR Convergence".

- The Badgernet EPR system is on track to go live in Maternity Services on 3rd May, but the % of Midwives trained is currently a challenge due to operational capacity and staffing levels etc. A comprehensive readiness assessment will be conducted to inform the final "Go / No Go" decision for the planned go live.

4. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report, including assurance levels.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/73**			
SUBJECT:	**Digital Board Report**			
DATE OF MEETING:	25 May 2022			
AUTHOR(S):	Tom Poulter, Chief Information Officer			
	Paul Fitzsimmons, Executive Medical Director			
EXECUTIVE DIRECTOR SPONSOR:	Choose an item.			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	√		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Digital Board met on the 11th April 2022. The following assurance status for key delivery areas was noted: • **Digital Programme -** Substantial Assurance • **Vendor Management -** Moderate Assurance (Dedalus) • **Information and Business Intelligence =** Substantial Assurance • **IT Services -** Substantial Assurance • **Digital Compliance and Risk -** Substantial Assurance • **Electronic Patient Record -** Substantial Assurance • **Clinical Safety and Risk Review -** Substantial Assurance • **Digital Diagnostics -** Moderate Assurance • **Digital Maternity -** Substantial Assurance • **eRostering -** Moderate Assurance			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee		
	Agenda Ref.	FSC/22/04/65		
	Date of meeting	20 April 2022		
	Summary of Outcome	Noted for assurance		
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Digital Board Report	AGENDA REF:	BM/22/05/73

1. BACKGROUND/CONTEXT

This report provides an update on the programmes of work in Digital Services and Digital Analytics, with the latest assurance assessment on each work area in scope. The minutes of the April meeting of Digital Board are attached as an Appendix to this report for reference.

2. KEY ELEMENTS

a. **Digital Programme - Substantial Assurance**

One project completed since last report to FSC - Virtual Clinic Consultation Software Procurement .

'Attend Anywhere' were the successful bidders following full procurement with Cheshire and Merseyside – 15 Trusts will share costs across a 2- year contract. 4 projects are green status, and 9 projects are on amber status.

The DOG group last met on the 5th of April. The focus of the meeting was Fraxinus Projects (Elective Recovery) – Assurance for Digital Board that new functionality has been imbedded at other Trusts and change management, configuration and implementation are the requirements and focus for WHH.

Programme Planning – Assurance for Digital Board that Programme Planning for this financial year is underway with current focus on;Resource Planning – within the ePR team and digital colleagues PID development for each project Benefits capture and monitoring for projects and optimisation

b. **Vendor Management - Moderate Assurance (Dedalus)**

Dedalus are planning the removal of support by Microsoft of its Silverlight application framework, this is a significant piece of work. One Ed is progressing well, user acceptance test environment on track to be delivered by 3rd May. Still awaiting update on the CCN a meeting with the Trust's is planned for the 13th of April 2022. Go live is scheduled for the 6th of June. Dedalus colleagues have been on site this week working with ePR team and have tested various performance functions, feedback is the Silverlight issue is causing the performance issues and performance should improve once the Silverlight browser has been modernised.

c. **Information and Business Intelligence- Substantial Assurance**

Statutory reporting remains a challenge due to frequent new and changing requirements from NHS Digital, CIPHA and other external agencies.

One of the Senior Information Analysts is acting up for 6 months, without backfill for their role, in effect the temporary loss of one post. A Principal Information Analyst from the BI team will be leaving the team at the beginning of May 2022, recruitment is under way.
The latest Corporate Information and BI deployments/developments include:

- Specialty Demand and Discharge Pending Consultant report
- Capacity and Demand datasets
- Theatre datasets

- UEC SITREP – 111 First activity
- Outpatient Dashboard - PIFU updates
- Red to Green daily compliance report
- Ward round daily compliance report

d. **IT Services Update - Substantial Assurance**

Five projects completed since last Digital board**.** IT received a total of **2936** Service Desk calls. First time fix via telephone handled activity 61%. To ensure we have full Infrastructure compliancy and protection against Cyber attacks we are required to patch all network Infrastructure. All of March's change requests have been completed, except for 1 pending CAB approval currently on hold and 2 CAB pending following approval. 1048 Service desk calls come via email, 37% of the overall activity which is currently not reported on. IT are looking at options to automate email activity assign it to the correct team and category. SLA's now provided in Digital board reporting these include IT service desk, 2nd line desktop support, 3rd line network support and 3rd line datacentre support.

e. Digital Compliance and Risk - Substantial Assurance

The National Cyber Security Centre (NCSC) has urged organisations in the UK to bolster their cyber security resilience in response to malicious cyber incidents as a result of the ongoing situation in the Ukraine.

The Trust vulnerability score has risen by 8 points but has settled down by 2 points to a score of 36, due to newly found vulnerabilities in Microsoft Edge, Google Chrome Adobe Flash Player and Reader CareCERTs - There was no new High CareCERT reported last month by NHS Digital.

f. Electronic Patient Care Management System - Moderate Assurance

Dedalus Orbis U announcement; EPCMS Project Board recommendation that Dedalus is contacted to stand them down form the procurement before w/c 18th April; the procurement is in its concluding stages; a meeting is being arranged with the ICS Executives requesting confirmation on their endorsement of OBC V3. There is a reduction in the costs compared to the market research, that was done as part of OBC V2; the ask now for the capital costs is less than 50% of the internally generated capital depreciation level- this is looking much more likely that this can be accommodated and potentially not needing CDEL cover.

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1 PAN which was a low risk for the Trust.

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No representation in meeting due to sickness, no update reported from CAMRIN network perspective.

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Additional meetings scheduled to oversee progress and provide rapid escalation and decision making.

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4. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/74**
SUBJECT:	**Learning from Deaths Report Q4 2021-22**
DATE OF MEETING:	25 May 2022
AUTHOR(S):	Eshita Hasan, Associate Medical Director, Patient Safety & Trust Wide Lead for Mortality
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1275** Failure to prevent Nosocomial Infection caused by high transmitability of variant strains, waning effect of vaccines, asymptomatic carriage (staff or patients), false negative test results, high local community prevalence. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance

	#1079 Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff. **#1372** FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY - A failure to develop an affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits - A failure to garner ICS and NHSE support to progress the EPR business case - A failure to deliver Managed Convergence in line with emergent national policy and the ICS Convergence strategy (in development) RESULTING IN (sequentially) – a continuation of the Trust's challenges with the incumbent EPR, Lorenzo (as identified in the Strategic Outline Case), potential for a costly extension to the existing Lorenzo contract or the highly retrograde step of returning to paper systems as Lorenzo will be at end of life at or before the end of the tactical contract extension **#1579** Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#145** Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome

	for our patient population and organisation, potential impact on patient care, reputation and financial position. **#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper summarises 'Learning from Deaths' for Q4 2021/2022, for noting and scrutiny, in compliance with National Guidance requirements on Learning from Deaths. **Key points to note are:** • During Q4 2021/22, 276 deaths occurred within the Trust. • Of these, 99 met the criteria to be subject to a Structured Judgement Review (SJR). • 52 SJRs have been completed in Q4. • 5 deaths have had a Serious Incident investigation. • HSMR (Hospital Standardised Mortality Ratio) based on 12 months data up to November 2021 is 85.24. This result is a low value outlier. • HES SHMI (Summary Hospital-level Mortality Indicator based on Hospital Episode Statistics) for the 12-month period up to October 2021 is 100.41. This result is not an outlier. Attached as appendices are the MRG themes of the month **(Appendix 1,2)** and the UTI focussed review report **(Appendix 3)**

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

RECOMMENDATION:	The Trust Board is asked to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/22/05/130
	Date of meeting	3 May 2022
	Summary of Outcome	To be submitted to Trust Board
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

TRUST BOARD

SUBJECT	Learning from Deaths report Q4 2021-22	AGENDA REF:	BM/22/05/74

1. BACKGROUND/CONTEXT

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

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

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

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

2. KEY ELEMENTS

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

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

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

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

3. MEASUREMENTS AND EVALUATIONS

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

- All deaths of patients subject to care interventions with elective procedures.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.

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

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

3.1 Mortality Review Data Q4 2021/22

- During Quarter 4, 99 deaths met the criteria to be subject to a Structured Judgement Review (SJR).
- 52 SJRs have been completed in Q4.
- Of the 52 SJRs completed, 36 were allocated in Q4 and 16 were allocated in previous quarters.
- An additional 24 SJRs were allocated in Q4 compared to Q3, and the completed percentage has fallen by 16.8% compared to Q3.
- 99 deaths met the SJR criteria; of those, 67 were assigned to a reviewer in Quarter 4. Some deaths occur at the end of the quarter reporting period and are therefore assigned in the next quarter. Each SJR reviewer is assigned 5 SJR per month and as such the number of deaths requiring review exceeds the current capacity of reviewers to facilitate completion of SJR within a month of death. To address this the number of SJR reviewers would need to be increased or the capacity of the current reviewers increased.

Fig. 1 – Key Mortality Data

Fig 2. – Shows the overall and phase of care ratings of the SJRs completed in Quarter 4.

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

Total deaths in quarter	Total LD Deaths	Total deaths that were an SI	Those meeting SJR criteria	Number of SJR reviews completed in Q4	Number of SJR Reviews that were allocated in Q4 and completed compared to Q3	
276	3	5	99	52	Q3 – SJRs were completed on 44 out of 92 assigned. 47.8%	Q4 – SJRs were completed on 36 out of 116 assigned. 31%

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

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

Phase of care *	N/A	Very poor	Poor	Adequate	Good	Excellent
First 24hours/ admission	0	0	0	5	45	2
Ongoing care	7	0	0	12	31	2
Care during procedure	48	0	0	2	2	0
End of life Care	21	0	0	4	16	1
Patient records/ documentation	0	0	0	12	39	1
Overall care	**0**	**0**	**0**	**11**	**40**	**1**

- In SJRs completed within Quarter 4, there have been no instances of very poor or poor care at any stage of admission.
- The highest number of 'good' care ratings happened during the first 24 hours of admission.
- All phases of care had more 'good' ratings of care than 'adequate'.

Fig 3 - Shows the breakdown of care ratings in each SJR category in Quarter 4.

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

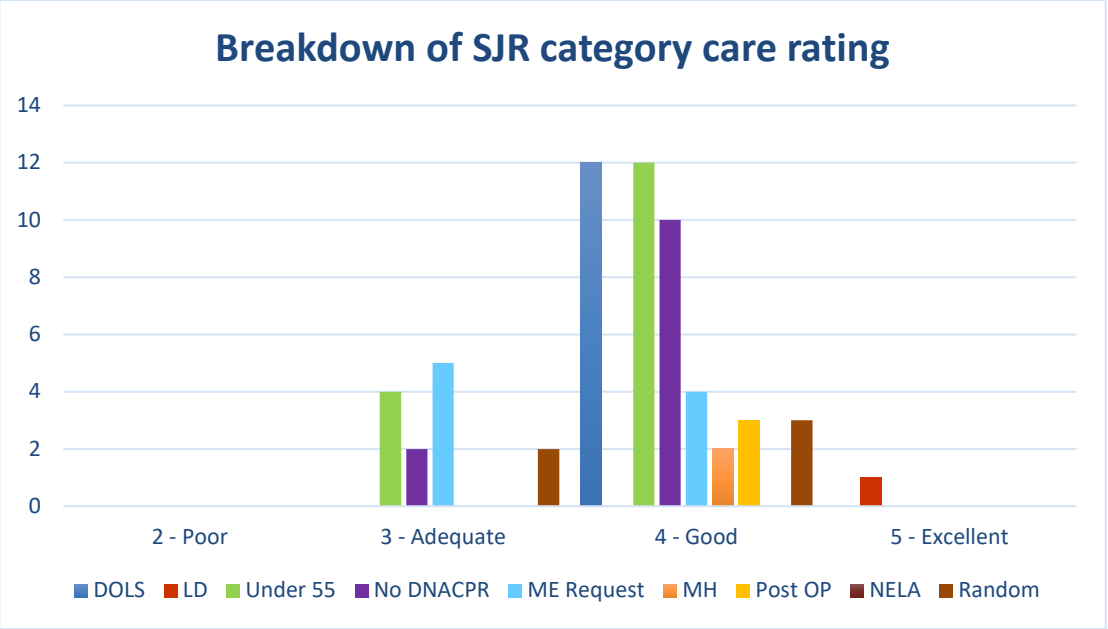
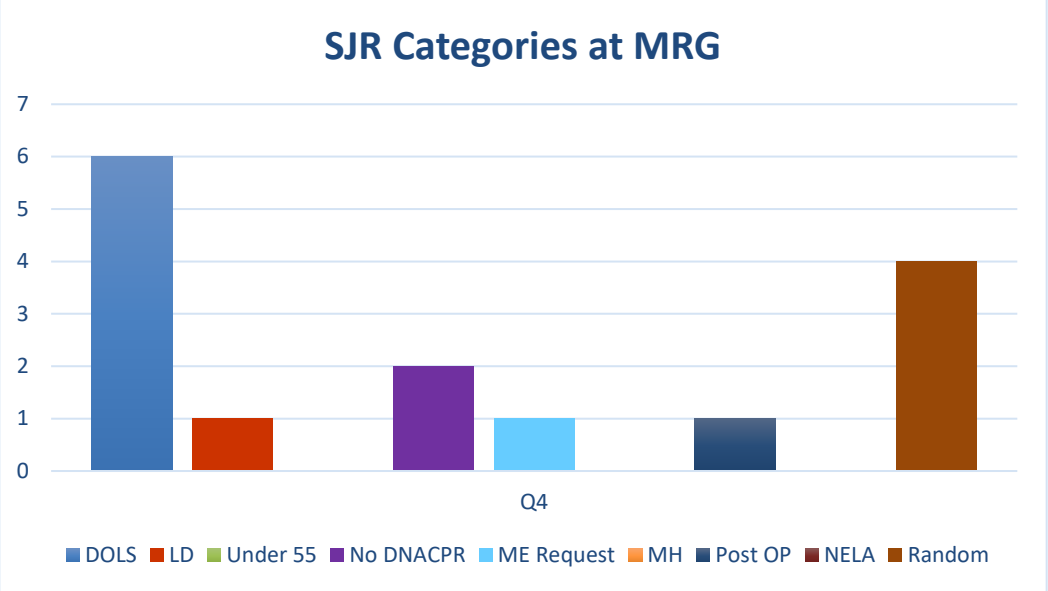


Fig 4 - Shows the frequency of each SJR category presented at MRG in Quarter 4.



- The category with the highest number of SJR's requiring further discussion at MRG is patients with DOLs. There is input and representation at MRG from the Safeguarding Team which facilitates learning and development of improvement plans.
- For Quarter 4, one ME requested review was brought to MRG for discussion. This allows triangulation of the ME review with the findings of the SJR and wider governance processes.
- Four patient deaths that were randomly selected for SJR were discussed at MRG.

3.2 Learning from deaths:

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

Learning	**Action**
ID:8497 – CPR was undertaken despite DNACPR in place as staff were unaware of DNACPR decision – this appears to have been missed on ward move SBAR. No treatment escalation plans in place	MRG theme of the month newsletter to focus on learning identified from this SJR.
ID:8168 – Delay in surgery for fracture neck of femur due to theatre capacity issues – patient was repeatedly kept nil by mouth potentially causing dehydration and AKI; inadequate documentation by clinical team of reasons for delay in surgery	Learning taken back to T&O team and anaesthetic team to improve documentation of peri-operative care.
ID:7314– Earlier consideration of treatment escalation plans and DNACPR.	Learning sent to palliative care lead to triangulate with End of Life Care training programme
ID:7813 – Earlier consideration of treatment escalation plans and DNACPR	Learning sent to palliative care lead to triangulate with End of Life Care training programme
ID:8169 – Good communication with family and friends respecting patient's wishes. Consideration given to IMCA as patient had expressed a wish for family not to be involved when he had capacity to express this.	Learning to be taken back to junior doctors' forum as an example of good communication with family/friend respecting patient's wishes.

Themes

Appendices 1,2 identify the themes and learning that have arisen in the MRG meetings for Q4. These newsletters are then included on CBU and Specialty Governance agendas each month. The key themes focussed on in Q4 : safe handover of care and learning from UTI mortality focussed review.

UTI focussed review

A focussed review into 27 patients who died with an admitting diagnosis of Urinary Tract Infection took place after a CQC Insight red flag report showed that mortality for this group was worse than national average for the period April '20-March '21. (Appendix 3).

The main learning points identified were:

- Need to document all comorbidities during the admission spell.
- Requirement to review antibiotics with urine culture results at 24-72 hours and documenting this as appropriate.
- Documenting diagnosis of CA-UTI (Catheter-Associated UTI) specifically if meets the criterion of CA-UTI.

3.3 Learning from Serious Incident investigations:

Incident	Outcome
162828 Following an extended wait for triage and no bloods taken patient sadly died unexpectedly with a nurse present.	• Investigation is in progress with a due date of 16/06/2022.
162058 This patient was not transferred to LHCH within target time and deteriorated, had a cardiac arrest, and sadly died.	• Investigation is in progress with a due date of 14/06/2022. • There were issues found in the rapid incident review regarding escalation for those waiting to be transferred for care at another Trust.
159694 Patient diagnosed with community acquired pneumonia and received appropriate treatment for this following senior review within 2 hours of presentation to ED. It was initially thought this patient was a missed sepsis diagnosis.	• The investigation has identified learning with regards to correct use and application of the sepsis screening tool and this has been reflected in the action plan.
155411 This patient had a delay of escalation and management of sepsis. There was a failure to follow policy in relation to physiological observations and escalation.	• An action plan created for sepsis escalation within ED.
161613 The patient had a fall, a CT scan was ordered. The patient deteriorated before the scan was completed and sadly died.	• Investigation is in progress with a due date of 24/05/2022.

4. Mortality Indicators

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

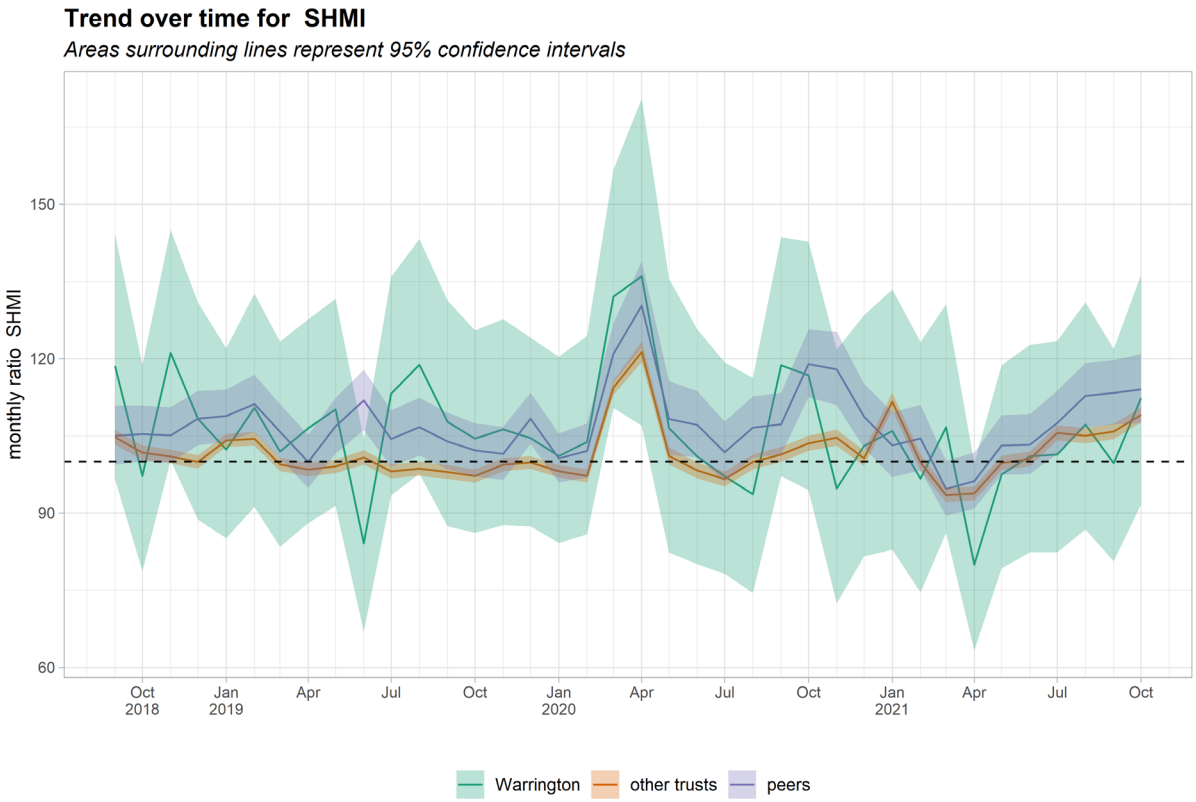
To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

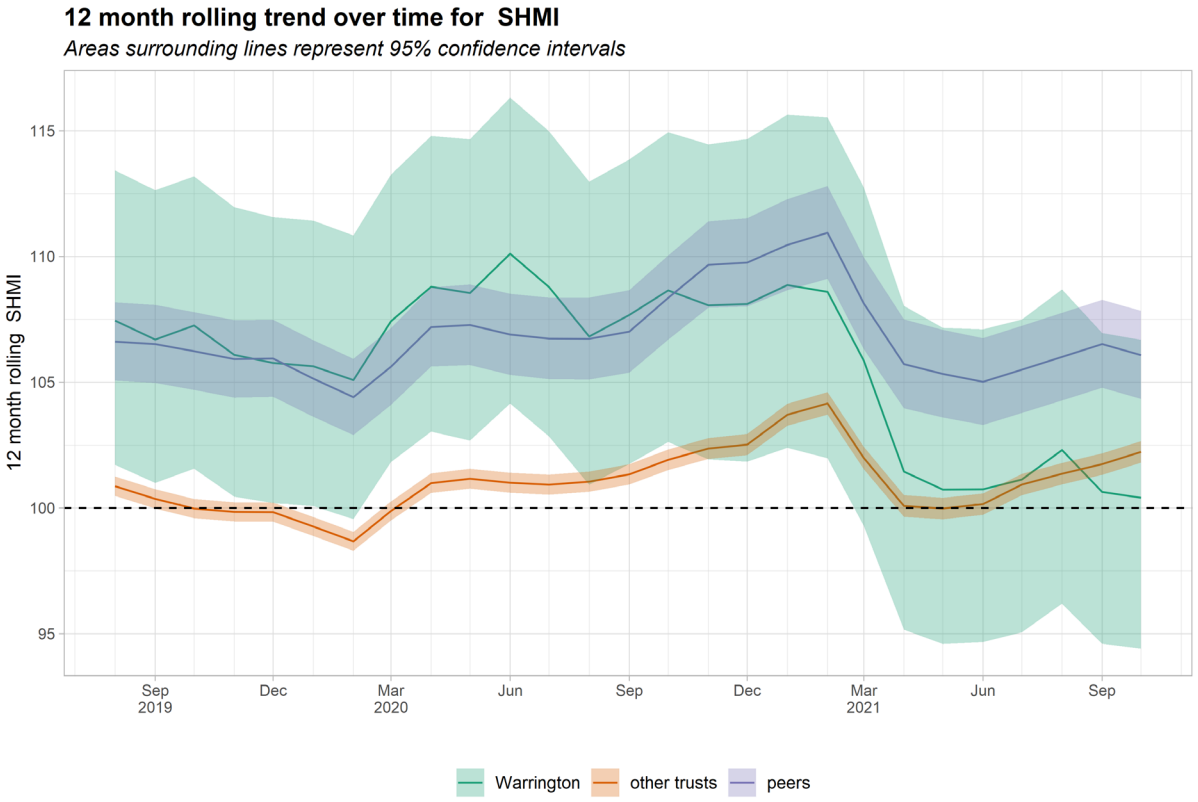
The SHMI data is the ratio between the actual number of patients who die within 30 days following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of patients treated there.

The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents and complaints data.

4.1 HSMR and SHMI indicators

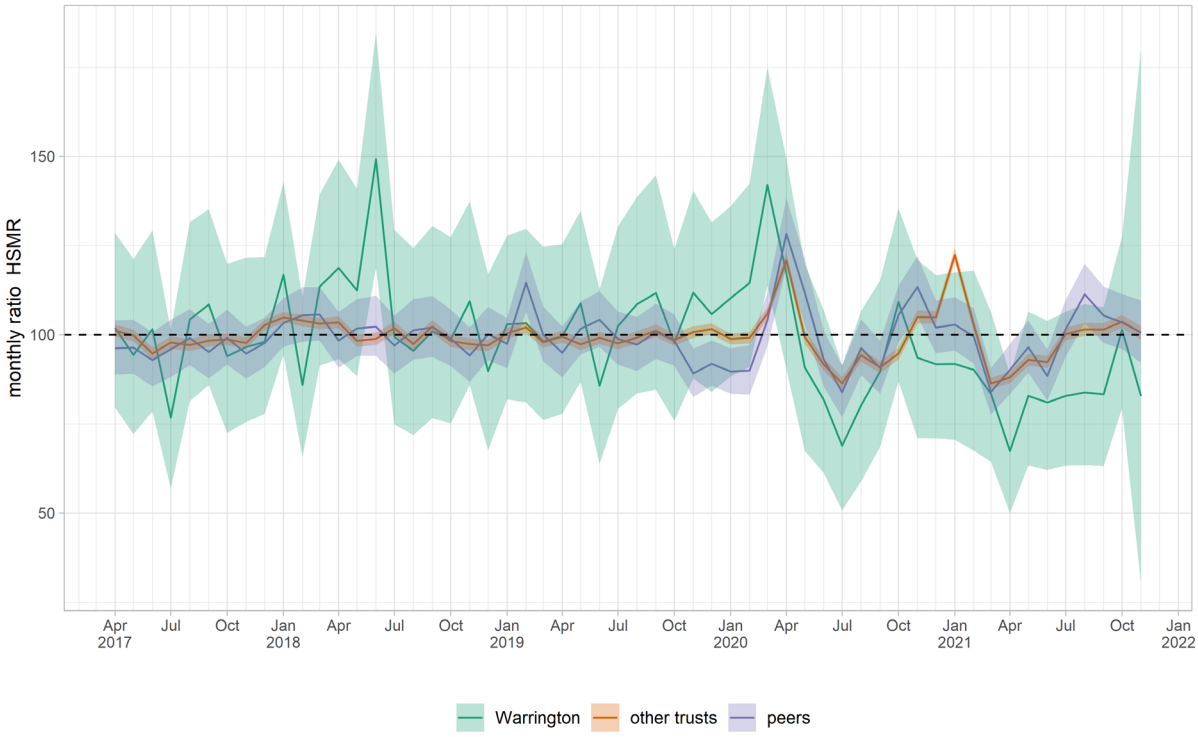




SHMI is **100.41** and the 12 month rolling trend shows a positive lower position compared to peers and other acute trusts.
HSMR is 85.24 This is considered a low value outlier compared to peers as noted below and has seen a steady decrease.

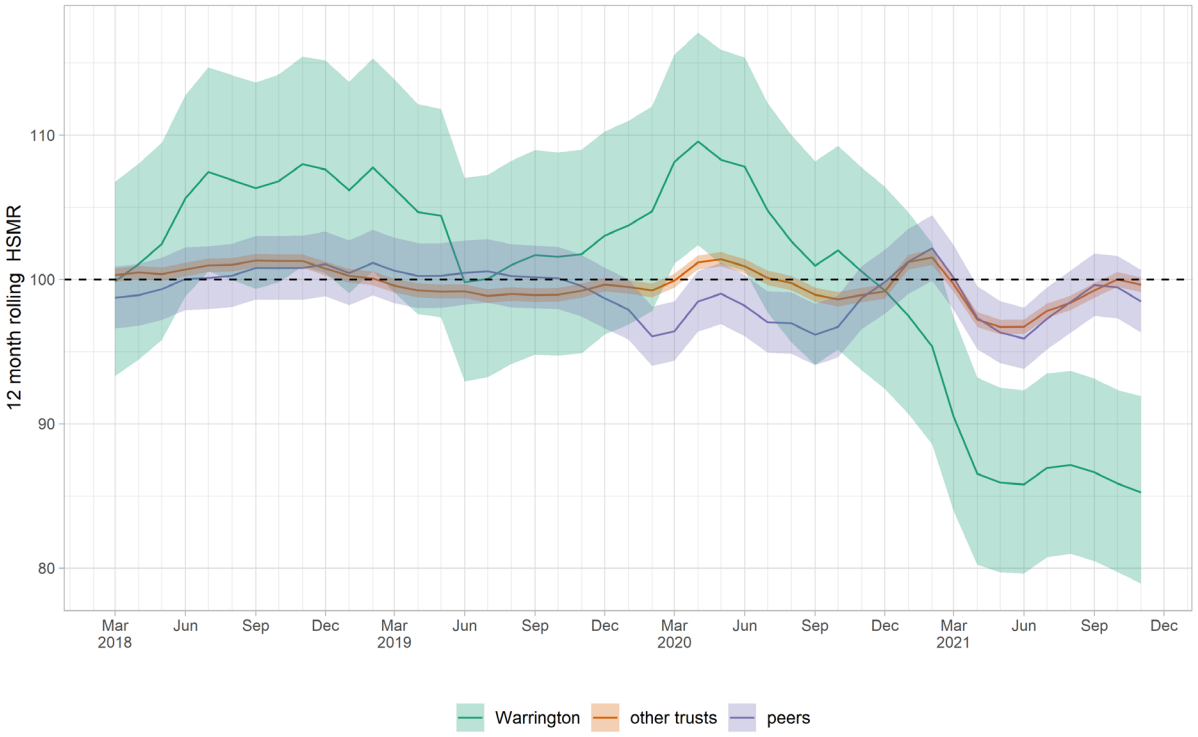
Trend over time for HSMR

Areas surrounding lines represent 95% confidence intervals



12 month rolling trend over time for HSMR

Areas surrounding lines represent 95% confidence intervals



4.2 Outliers

The below diagnosis groups are noted as potential outliers within HSMR and SHMI; however, it is worthwhile noting that these trends are compared with other key indicators within Governance such

as complaints, incidents, SJRS and are not showing an emerging trend of concern. In order to review the areas that are flagging, the Trust wide Lead for Mortality supported by MRG completes case studies including a review of coding into deaths in diagnostic groups that continue to show an outlier trend on the monthly HED report.

Key Diagnosis groups showing as outliers for SHMI using a Poisson funnel plot are:

- Disorders of lipid metabolism, Nutritional deficiencies, Other nutritional; endocrine; and metabolic disorder
- Anal and recal conditions, Diverticulosis and diverticulitis
- Other gastrointestinal disorders
- Superficial injury; contusion

Key Diagnosis groups showing as outliers for HSMR;

- Coronary atherosclerosis and other heart disease
- Non-infectious gastroenteritis

5. MONITORING/REPORTING ROUTES

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

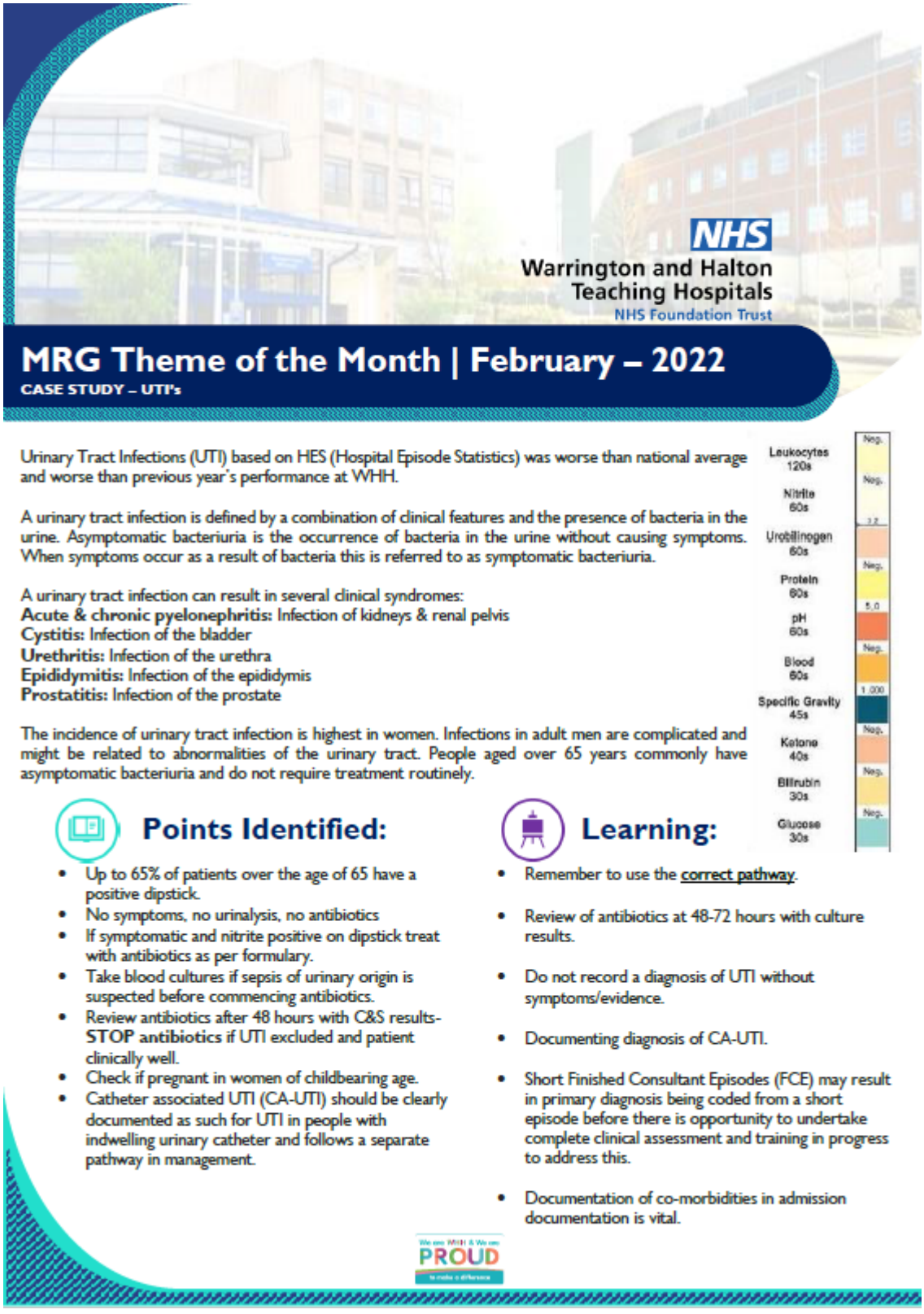
6. TIMELINES

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

7. RECOMMENDATIONS

The Trust Board is asked to note this report.

Appendix 1



Warrington and Halton Teaching Hospitals NHS Foundation Trust

MRG Theme of the Month | February – 2022

CASE STUDY – UTI's

Urinary Tract Infections (UTI) based on HES (Hospital Episode Statistics) was worse than national average and worse than previous year's performance at WHH.

A urinary tract infection is defined by a combination of clinical features and the presence of bacteria in the urine. Asymptomatic bacteriuria is the occurrence of bacteria in the urine without causing symptoms. When symptoms occur as a result of bacteria this is referred to as symptomatic bacteriuria.

A urinary tract infection can result in several clinical syndromes:
Acute & chronic pyelonephritis: Infection of kidneys & renal pelvis
Cystitis: Infection of the bladder
Urethritis: Infection of the urethra
Epididymitis: Infection of the epididymis
Prostatitis: Infection of the prostate

The incidence of urinary tract infection is highest in women. Infections in adult men are complicated and might be related to abnormalities of the urinary tract. People aged over 65 years commonly have asymptomatic bacteriuria and do not require treatment routinely.

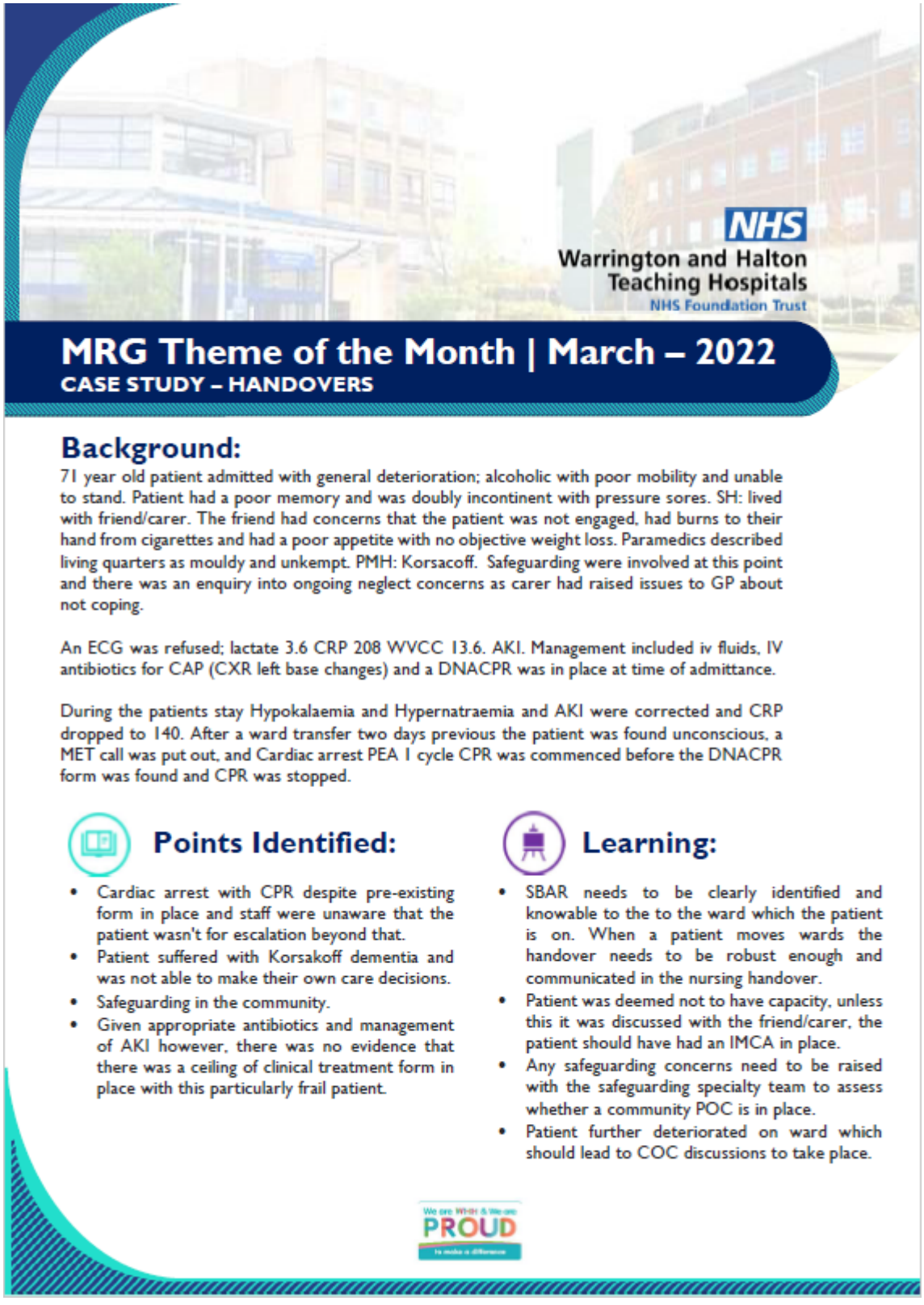
Points Identified:

- Up to 65% of patients over the age of 65 have a positive dipstick.
- No symptoms, no urinalysis, no antibiotics
- If symptomatic and nitrite positive on dipstick treat with antibiotics as per formulary.
- Take blood cultures if sepsis of urinary origin is suspected before commencing antibiotics.
- Review antibiotics after 48 hours with C&S results- **STOP antibiotics** if UTI excluded and patient clinically well.
- Check if pregnant in women of childbearing age.
- Catheter associated UTI (CA-UTI) should be clearly documented as such for UTI in people with indwelling urinary catheter and follows a separate pathway in management.

Learning:

- Remember to use the correct pathway.
- Review of antibiotics at 48-72 hours with culture results.
- Do not record a diagnosis of UTI without symptoms/evidence.
- Documenting diagnosis of CA-UTI.
- Short Finished Consultant Episodes (FCE) may result in primary diagnosis being coded from a short episode before there is opportunity to undertake complete clinical assessment and training in progress to address this.
- Documentation of co-morbidities in admission documentation is vital.

Appendix 2



NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

MRG Theme of the Month | March – 2022

CASE STUDY – HANDOVERS

Background:

71 year old patient admitted with general deterioration; alcoholic with poor mobility and unable to stand. Patient had a poor memory and was doubly incontinent with pressure sores. SH: lived with friend/carer. The friend had concerns that the patient was not engaged, had burns to their hand from cigarettes and had a poor appetite with no objective weight loss. Paramedics described living quarters as mouldy and unkempt. PMH: Korsacoff. Safeguarding were involved at this point and there was an enquiry into ongoing neglect concerns as carer had raised issues to GP about not coping.

An ECG was refused; lactate 3.6 CRP 208 WVCC 13.6. AKI. Management included iv fluids, IV antibiotics for CAP (CXR left base changes) and a DNACPR was in place at time of admittance.

During the patients stay Hypokalaemia and Hypernatraemia and AKI were corrected and CRP dropped to 140. After a ward transfer two days previous the patient was found unconscious, a MET call was put out, and Cardiac arrest PEA 1 cycle CPR was commenced before the DNACPR form was found and CPR was stopped.

Points Identified:

- Cardiac arrest with CPR despite pre-existing form in place and staff were unaware that the patient wasn't for escalation beyond that.
- Patient suffered with Korsakoff dementia and was not able to make their own care decisions.
- Safeguarding in the community.
- Given appropriate antibiotics and management of AKI however, there was no evidence that there was a ceiling of clinical treatment form in place with this particularly frail patient.

Learning:

- SBAR needs to be clearly identified and knowable to the to the ward which the patient is on. When a patient moves wards the handover needs to be robust enough and communicated in the nursing handover.
- Patient was deemed not to have capacity, unless this it was discussed with the friend/carer, the patient should have had an IMCA in place.
- Any safeguarding concerns need to be raised with the safeguarding specialty team to assess whether a community POC is in place.
- Patient further deteriorated on ward which should lead to COC discussions to take place.

Appendix 3

Focussed Review of UTI Mortality

Author: Eshita Hasan, Trust Wide Lead for Mortality

Paper for Mortality Review Group, 15 Feb 2022

8. BACKGROUND/CONTEXT

CQC Insight March '21 reported WHH in-hospital mortality: Urinary Tract Infections (UTI) based on HES (Hospital Episode Statistics) for April '20 - March '21 was worse (193.8) than national average (100) and worse than previous year's performance (138.1).
SHMI (Summary Hospital-Level Mortality Indicator) for this diagnosis group was above the 95% distribution limit for the same time-period.

A focussed review of deaths within this SHMI diagnosis group for the period 1 April '20-March '21 was undertaken to identify any learning points for action.

A coding review was initially undertaken by Senior Clinical Coding Officer.
A case record review was undertaken by an external reviewer.

The following terms of reference were agreed for the case record review of each case:

1. Was diagnosis of UTI made based on Trust UTI pathway?
2. Was treatment as per Antibiotic Formulary?
3. Was antibiotic treatment reviewed at 24-72 hrs with culture results?
4. Was this a CA-UTI (catheter associated UTI) as per definition of CA-UTI? Was diagnosis of CA-UTI documented by clinician? (this is a different diagnosis group to UTI)
5. Structured Judgement Review

9. KEY ELEMENTS

27 deaths were identified for this time period in the UTI SHMI diagnosis group.

Clinical Coding Review
A coding review was undertaken to check accuracy of primary diagnosis coding.

- 96% of the cases were correctly coded to UTI, as 1 of the 27 cases was incorrectly coded to UTI as the primary diagnosis. Although UTI was diagnosed and treated, on review, the main condition treated and investigated in this episode was thrombocytopenia. Feedback will be given to the individual coder.
- All 27 patients died in hospital,1 was transferred to RLUH and died on same day.

- Diagnoses in this CCS group included:
  - "UTI"
  - Pyonephrosis - peri-nephritic abscess with hydronephrosis
  - Pyonephrosis – acute pyelonephritis with hydronephrosis
  - Pyonephrosis – acute pyelonephritis with obstructive calculi & hydronephrosis

- 6 of the cases had short episode 1 for the same ward - this should have been an edit and not a transfer on the ward at the time; 3 of the 6 did not have "UTI" coded as the primary diagnosis in episode 2.
- 2 of the cases had a symptom code as the primary diagnosis in episode 1 which moved the trigger episode diagnosis to episode 2.

- 7 of the cases had one of the "UTI" CCS diagnoses on the death certificate.

- 9 of the cases had a Charlson co-morbidity score of 15 or over
- 19 of the cases had a Charlson co-morbidity score of under 15 –of these:
  - 10 had a score under 10
  - 8 had a score between 10 and 15

An arbitrary Charlson co-morbidity score of 15 has been chosen to stratify the comorbidity score data as high co-morbidity score comes with a higher risk of mortality.

- 5 of the cases had a primary diagnosis of Covid-19 in the final episode.
- 5 of the cases had Charlson co-morbidity coded on a previous admission which was not documented on this admission. 3 of these would have scored over 15 had this been documented in this admission.

Case Record Review

Findings:

4 cases were catheter associated UTIs but were not documented as a catheter associated UTI in the medical records documentation. CA-UTI is a different diagnostic group to UTI.

UTI was diagnosed as per UTI pathway in 24 of the 26 cases with an admitting diagnosis of UTI. MSU was not sent for culture in 2 patients.

Antibiotics were commenced as per the antibiotic formulary in all 26 cases.

There was evidence of review of antibiotic treatment at 24-72 hrs with culture results in 18 out of the 26 cases.

All 27 cases had a Structured Judgement Review (SJR) undertaken.

3 of these 27 cases had had an SJR previously undertaken. 2 of the 3 were patients with a DOLS in place which is a trigger for SJR. 1 of the 3 cases had an SJR at the request of Medical Examiner - overall care was judged poor – this case has had a Concise Investigation following WHH governance procedures.

The remaining 24 of the 27 cases had SJRs by the external reviewer.
2 of these had a secondary review at the request of the external reviewer. This was undertaken by a SJR reviewer. Both were deemed to have had good care.

Overall, 1 of the 27 cases had "poor" care. 4 cases were classed as 'excellent', 19 cases had 'good' care, and 3 were 'adequate'.

10.DISCUSSION

The focussed review provides assurance that the UTI pathway is being adhered to and there are no serious concerns with following the UTI pathway.

Improvement is required with regards to

- Review of antibiotics at 24-72 hours with culture results and documenting this.
- Documenting diagnosis of CA-UTI if meets criteria for CA-UTI. 4 patients in the sample were actually CA-UTI which is a different diagnosis group.
- Short Finished Consultant Episodes (FCE) resulting in primary diagnosis being coded from a short episode before there is opportunity to undertake complete clinical assessment. 3 patients can be excluded from this sample as they had very short FCE and were coded with a different diagnosis in the 2nd episode.

The issue of short FCEs has already been addressed as part of an improvement project looking at R codes; ward clerks were provided with training in June 2021 to reduce the incidence of FCE.
This audit sample relates to a time period prior to this training.

- Documentation of co-morbidities in admission documentation.
  9 patients had a high Charlson comorbidity score. There were 3 patients where co-morbidities documented during a previous admission were not documented in this admission and therefore, these comorbidities could not be coded – these 3 patients would also have had a Charlson co-morbidity score higher than 15. Comorbidity score is an indicator that is taken into account in calculating the expected number of deaths that affects the SHMI value.

In total, 8 patients can be excluded from this sample of 27 patients with a primary diagnosis of UTI on admission:

- 1 patient – incorrect diagnosis coded
- 3 patients – short FCE, diagnosis was different in 2nd episode
- 4 patients – CA-UTI

This reduces the sample size to 19 patients which is the expected number of deaths – 19.5 – for this diagnosis group as compared to the high observed rate of 27.

11.RECOMMENDATION

Disseminate learning to medical staff regarding

- documentation of all comorbidities during the admission spell.
- review of antibiotics with urine culture results at 24-72 hours and documenting this as appropriate
- documenting diagnosis of CA-UTI specifically if meets the criterion of CA-UTI.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/75**	
SUBJECT:	**Working with People and Communities Strategy** (*formerly Patient and Public, Participation and Involvement - PPP&I strategy*)	
DATE OF MEETING:	25th May 2022	
AUTHOR(S):	Alison Aspinall, Senior Communications and Involvement Manager	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***		
EXECUTIVE SUMMARY *(KEY ISSUES):*	A refreshed and refined version of the Trust's PPP&I strategy of 2018-21 has been developed, linked closely to our strategic aims and objectives. **Development and Evolution** The draft strategy for 2022-25 has been developed in partnership with a wide and diverse audience and has received a large amount of high quality feedback which has been insightful, positive and very well received. Engagement and involvement has been both informal and formal through the following fora: 1. The FT Governors – public, staff and partners (Governors' Engagement workshop on 4th May 2022) 2. The members of Warrington's *Staying Connected* partnership (review at meeting on 9th May 2022) 3. The members of the Trust's patient experience cttee (review at meeting on 10th May 2022) 4. The Council of Governors (approve at meeting on 12th May) 5. The members of the Trust's patient equality, diversity and inclusion ctte (review at meeting on 17th May 2022) 6. Healthwatch Halton and Healthwatch Warrington 7. Trust staff including Patient Experience and Inclusion colleagues and Strategy colleagues 8. Following this engagement a further request to present the key elements of the strategy has been received from Healthwatch Warrington's People's Panel (to be held 26th May 2022)	

	Late Guidance Issued Since the production of the final draft, new **draft** guidance has been issued by NHS England **Working with People and Communities** (12th May 2022) and on 17th May Cheshire and Merseyside HCP shared their draft framework for engagement and involvement of people and communities in health and care services in our region. A comparison with the NHS England and Cheshire and Merseyside drafts shows that our WHH strategy closely mirrors the national guidance focus on inclusion, accessibility of information, early involvement of patients and communities and the principle of working in partnership to address health inequalities. Therefore, to reflect NHS England draft guidance we have also renamed our strategy '*Working with People and Communities'*. Following publication of the **final** national guidance and Cheshire and Merseyside framework we will carry out a detailed cross-referencing exercise to bring in any additional elements and reflect these in our annual refresh through our Governance/resporting groups including: Patient Experience Sub-Committee, Patient Equality, Diversity and Inclusion Sub Committee, Moving to Outstanding Steering Group as well as the 'owner' group – the Council of Governors. Subject to Board approval, the next steps are to: 1. Cross reference against the final national guidance 2. Finalise the annual deployment plan to support delivery of the actions in each of the pillars 3. Assign recommended SMART evaluation measures from the national guidance. 4. Report quarterly progress of deployment and outcomes through the identified governance channels described as above.			
PURPOSE: ***(please select as appropriate)***	Information	Approval **x**	To note	Decision
RECOMMENDATION:	With the identified actions, the Board is asked to approve the 'Working with People and Communities' Strategy for 2022-25			
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors		
	Agenda Ref.	COG/22/05/34		
	Date of meeting	12th May 2022		
	Summary of Outcome	Endorsement of strategy with an action plan to measure and evaluate		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Working with People and Communities Strategy 2022-25

Foreword

The Trust published its first strategy for Patient and Public Participation and Involvement in 2019 with a three year deployment plan. Sadly, the COVID-19 pandemic precluded much of the proposed activity and engagement during the life of the document, although some early and late successes were realised.

This second strategy is both a refresh and a refinement of ambition linked closely to our strategic aims and objectives, addressing some of the key principles set out in NHS England's Phase 3 Recovery Plan and the latest draft NHS guidance on working in partnership with people and communities (May 2022) – with particular focus on inclusion, addressing health inequalities and our contribution to being an anchor institution.

In developing this strategy we are grateful to many stakeholders and individuals who gave their time, experiences and professional/personal contributions to making sure that it reflects the views of a wide and diverse audience and is truly representative of the communities we serve.

It is thanks to their contributions and support that we will **#Start With People** each time, every time.

With particular thanks to:

1. The Foundation Trust Governors – public, staff and partners who have become the guardians of our work to engage and involve people and communities and our 'critical friends'.
2. The members of the Trust's patient experience cttee
3. The members of Warrington's Staying Connected partnership (assembly of third sector and statutory partners representing those with seen and unseen disabilities and those with other protected characteristics)
4. The members of the Trust's patient equality, diversity and inclusion ctte
5. Healthwatch Halton and Healthwatch Warrington
6. Our Trust staff and volunteers.

Kimberley Salmon-Jamieson
Chief Nurse
Deputy Chief Executive

Norman Holding
Lead Foundation Trust Governor

Our Objectives

This strategy is an enabling strategy – that means it is designed to support the achievement of the Trust's strategic objectives: Quality, People and Sustainability.

- **#Start with People each time, every time** by standardising our processes to actively and meaningfully involve patients, carers, members of the public and advocates/support groups in our plans for service change and proposed major developments
- **Identify, engage and involve a diverse range** of patients, service users, their carers and loved ones, our statutory and third sector partners, advocate and support groups and our wider communities in our service developments and future plans.
- **Address and remove barriers** by providing alternative and accessible ways for patients and public to engage and work with us
- **Seek, capture, evaluate and incorporate** wide ranges of views, suggestions and concerns in our decision-making processes and when we design or change our services ensuring the patient voice is heard and prioritised.
- **Embed engagement and involvement processes in** the way we work by supporting staff to approach service change and developments in a consistent, quality and meaningful way – starting with equality impact assessments.
- **Build social value** by providing opportunities to maximise our estate and resources in partnership with WHH Charity, by 'giving back' and creating platforms to reduce social isolation and support positive physical and mental health and wellbeing.

Achievements

The strategy for 2019-22 featured a deployment plan, however its full implementation was disrupted by the Covid-19 pandemic in March 2020. Despite most of our activities being curtailed, together we have achieved some successes since April 2019.

- **Achieved our Quality Priority** (Patient Experience) for 2019-20: *Development of the Trust Patient and Public Participation and Involvement Strategy with a number of agreed measures for delivery*
- **Significant service user involvement** in the design of the new birth centre *The Nest*
- **ECG provision at GP practices** – successful deployment following patient engagement at cardio-respiratory clinics
- **Deployed a number of *Your Health Matters* events** in our communities and at our hospitals including Emergency Dept review, Sepsis, Smart Heart, Diabetes and Choose Well
- **Established the Accessible Information Standard** task and finish group – progressing at pace
- **Involved patients, advocates and third sector partners** in a large scale review of patient letters – re-established now under the AIS deployment
- **Hospital food review** – organised a pilot Dining Experience event testing options for children and the elderly
- **Created the Experts by Experience (EbyE) programme** – to capture the lived experiences of patients and ensure we #Start with People.
- **Supported major community and local events** including Diabetes Day and the annual Disability Awareness Day (DAD)
- **Established a Community and Patient Support Hub**
- **Delivered two large public consultations** (Reconfiguration of Breast Services and Relocation of some OPD services to Runcorn Shopping City)
- **Promoted opportunities and recruitment for local people** to participate in clinical trails and health research at the Halton Clinical Research Centre.
- Invested in key roles to support engagement and involvement – Engagement and Involvement Officer in 2021 and Senior Communications and Involvement Manager from Jan 2022.


'What Matters to You'
We are actively seeking the voice of our patients, service users and local communities to support us to continually improve our services whilst ensuring they are accessible and inclusive for all
Quality
How do we do this
Community Engagement through Events, Advocacy Services and Partners
Friends and Family Test (FFT) and Patient Feedback
National Surveys
Engagement with our patients and service users at our hospitals
You can contact the Patient Experience and Inclusion Team
whh.patient.experience@nhs.n
The NHS Breast Screening Programme saves 1,400 lives every year and is coming to this area soon
Get checked!
Detection Saves Lives


ASDA
Confectionary
Toilets
ProActiv


WELCOME TO THE
Captain Sir Tom Moore Building


Community and Volunteer Hub


312 of 390

Engagement and Involvement

The Ladder of Engagement is a recognised framework to manage involvement, commitment and ultimately influence, required from stakeholders for different stages of projects or different situations.

Meaningful co-production and co-design requires the patient voice to be central and evident in our service change and development #Start with People. heart of everything we do, and informs our plans and the decisions we make about the delivery of services.

Involving our patients, carers, their advocates and support groups, Foundation Trust Governors and membership, volunteers, our wider communities and our staff in co-producing services or infrastructure projects ensures the best possible experiences for patients – as they have been designed in partnership with 'Experts by Experience'. This is core to the Trust's mission to be outstanding for its patients, its staff and its communities.

***The guiding principles are that as the programme moves up the ladder (from 6 to 1) the number of people/partners involved decreases but the level of commitment and influences increases.**

****Co-production is not suitable or even required in all situations and the Ladder of Engagement provides different approaches which can be applied in different situations.**

Co-production/co-design

involves people who use health and care services, carers and communities. It engages groups of people at the earliest stages of service design, development and evaluation. Co-production acknowledges that people with 'lived experience' of a particular condition or service are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to maintain a person-centred perspective.
Examples: Experts by Experience sharing a perspective from their 'lived experience'.

Participation

gives stakeholders authority to work as collaborators with leaders and staff to co-design services, improvements, or care pathways. Mechanisms could include working in partnership with partners or the voluntary and community sector or advocates or support groups on each aspect of the decision, including the development of alternatives and the identification of the preferred solution.
Examples: Stakeholder representation on Board or committee meetings, Policy meetings, Partnership Boards.

Involvement

is a process that not only listens to stakeholder views, concerns and aspirations and but seeks to understand and consider them.

Examples include user reference groups, workshops, users, WHH Carers Café, WHH What Matters to Me, Conversation Café.

Effective stakeholder engagement

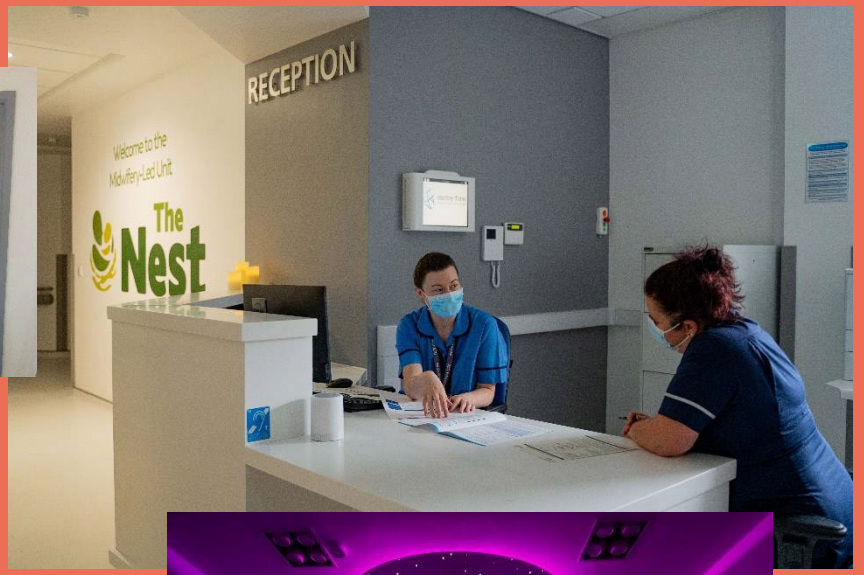
maps relevant stakeholders and their interests and engages them for a clear purpose. It aims not only to communicate with stakeholders on strategic progress, performance and decisions but seeks to involve stakeholders proactively and fully in the organisation's strategic journey.
Examples include partnership meeting updates, surveying advocacy groups on proposals and developments.

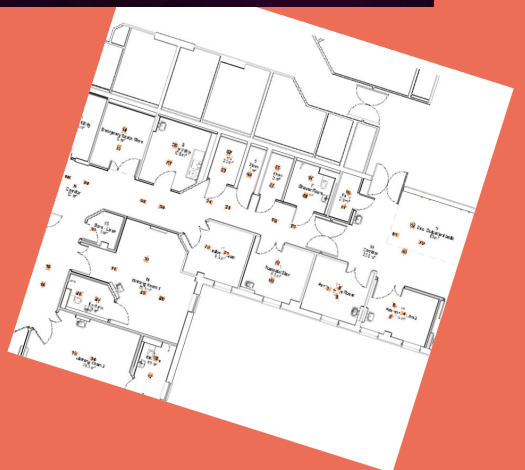
Consultation

is a targeted process to test a proposal with audiences to understand the different views, perspectives and the potential impact of the change proposal before making any decision on the proposals.
Consultation is a statutory requirement placed on NHS bodies when considering a proposal for substantial development or variation in the provision of a service.
Outcomes of consultation are formally reported to Trust Board and Overview and Scrutiny Committees.

Communication

is the process and mechanisms through which people and groups are kept informed and updated of developments.
Communication is a one way mechanism and should always meet accessibility standards to ensure it is inclusive.
Examples include print, digital, verbal and signed information via channels such as news releases, social media, websites, video, posters, newsletters,


RECEPTION
Welcome to the
Midwifery-Led Unit
The
Nest



Key pillars

Co-production/co-design in Service Change and Development	Recruit, train, deploy, maintain, recognise and reward patients and public who are 'Experts by Experience' to specific estate and service change programmes
Accessible Information Standard	Launch WHH AIS policy to support those with sensory impairments, learning disabilities and non-English speakers to access our services and participate equally in their care
Reducing Health Inequalities	Using WHH 'Your Health Matters' brand working in partnership to address health inequalities in Warrington North, Warrington South, Widnes and Runcorn
Anchor Institution/ Building Social Value	Using Trust estate and resources in partnership with others for the benefit of the wider community

Our approach

Our focus for Engagement and Involvement activity will be informed by our capital, quality and service development plans but will also be responsive to insights from our Patient Experience surveys as well as themes identified by PALS, complaints, service reviews and other sources, including public and governor engagement.

The process demonstrates how we want engagement and involvement to become embedded in the WHH way of working to ensure that involvement and co-production are part of our day to day business and we are all accountable for it. This approach will ensure the patient is at the centre of everything we do #It Starts with People

Insight	Involve	Prioritise	Improve	Evaluate
Continuous listening	Focused participation	Acting on feedback	Delivering improvements	Measuring impact
Patient experience surveys and established patient feedback routes are supplemented by insight from other engagement mechanisms including via our Public Governors, Carers Cafes and feedback at engagement events to deliver quantitative and qualitative insight to further inform involvement activity.	We involve a wide range of stakeholders in our planning, including adult and child patients, carers and advocacy groups. Increased numbers of Experts by Experience (EbyEs) support our greater involvement and co-production activity. We pay particular attention to those who are typically seldom heard to ensure diverse representation and views.	Feedback is taken into account to understand what matters most to patients and local people. An inclusive decision-making process allows us to prioritise our work within the resources available. Transparent communication enables us to share how feedback is used and the reasons it may not be.	Within WHH and across One Halton and Warrington Together changes to services and improvements in the way services are delivered are informed by stakeholder views. We report on the benefits for patients, staff and our communities to demonstrate accountability.	We regularly evaluate the impact of our activity to understand what has changed because we have engaged people. We learn how to extend and enhance this activity for the benefit of our patients, staff and communities. We use this evaluation to recognise the contribution of people in our communities.

We underpin our work with clear and relevant communications. Messages are tailored to the needs of different stakeholders and a wide range of channels are used to share information with different audiences using accessible information formats where required.

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Our Stakeholders

Our service users and supporters

- **People who use our services** (adults, young people and children)
- **Individuals who advocate for patients** including carers, family, friends
- **Advocacy and Support groups** including those who represent patients with protected characteristics
- **Foundation Trust members**

Our colleagues

- Staff
- Trust Board
- Staff Side
- WHH Staff Networks
- WHH Charity
- Governors
- Volunteers/Leagues of Friends

Our Statutory Partners

- **One Halton Partners –** NHS, Local Authority, Healthwatch, other public services including police, fire, ambulance, housing, education
- **Warrington Together Partners** NHS, Local Authority, Healthwatch, other public services including police, fire, ambulance, housing, education
- **Clinical and Research Alliance Partners**

Our Places and Communities

- Voluntary and Community Sector Partners
- Youth Fora/Parliaments
- People's Panels Warrington and Halton
- MPs and Councillors
- Organisations representing those with protected characteristics
- Community groups and organisations

Pillar 1: Co-production/design in Service Change/ Development

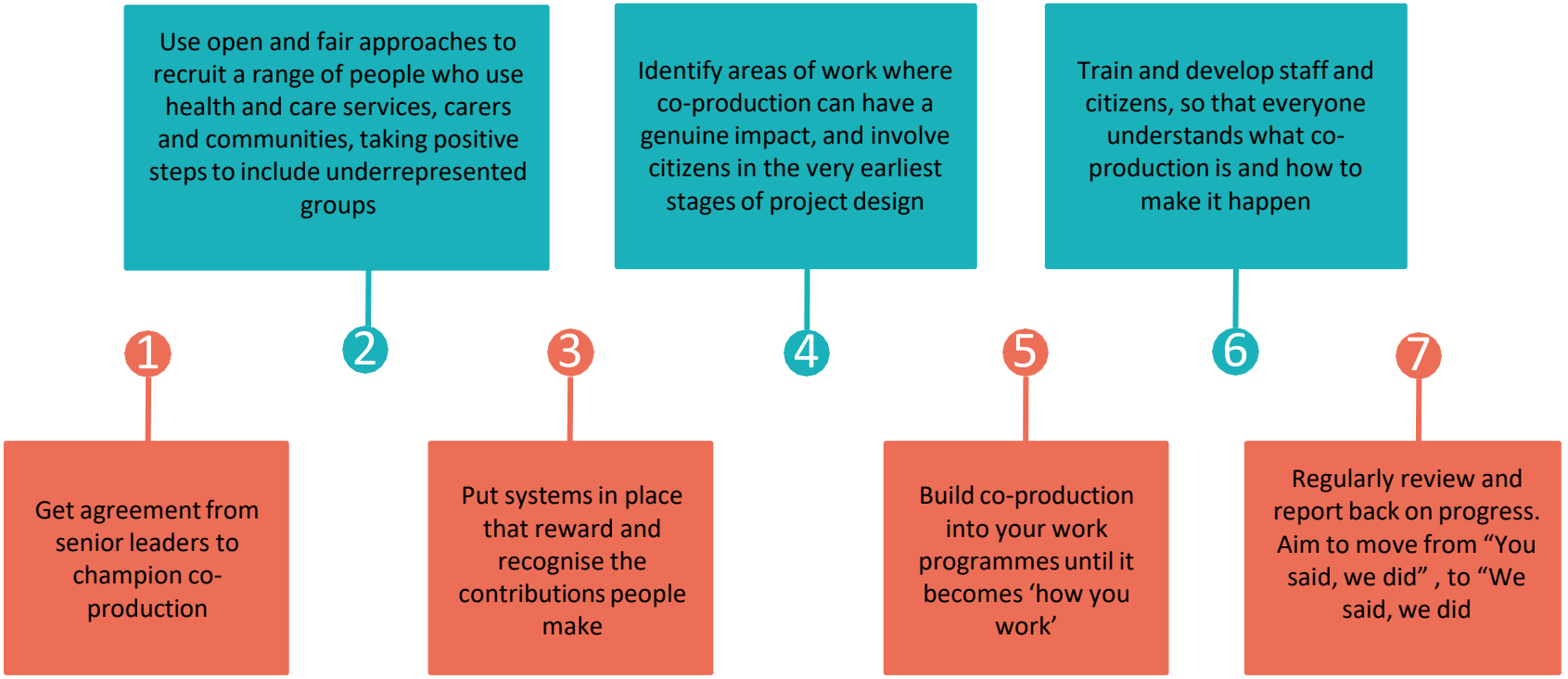
Recruit, train, deploy, maintain, recognise and reward patients and public who are 'Experts by Experience' to specific estate and service change programmes

1. Grow Experts by Experience (EbyE) capacity to embed Co-production in service design within WHH	• Updated internal EbyE campaign, staff toolkit and SOP delivers increased staff awareness of responsibilities/processes to engage within CBUs/corporate services • Evidence of greater involvement of seldom heard groups and those with protected characteristics
2. Support EbyE recruitment and retention	• Brand developed • Recruitment toolkit for patients and advocacy groups • Effective onboarding and processes including check-ins to support EbyEs
3. Enhance our programme for EbyE involvement	• Annual involvement timetable for 'What Matters to You' • Substantial Strategic, Capital or Service Developments have assigned patient (EbyE) or advocacy representation • Regular monitoring, evaluation and reporting processes to evidence activity and impact eg through case studies and national PE survey scores
4. Undertake consultation and engagement training to enable effective support for services	• Attendance at training and coaching events for consultation and involvement • Facilitation and engagement techniques for co-production • CQC rate us to be outstanding for Well-Led KLOE 7
5. Ensure representation to support Place-Based integrated care delivery	• Work collaboratively through the Warrington and Halton People's Voice forums • Use our resources to support wider Place-Based initiatives and to access insight from our communities and advocacy/equality groups
6. Enhance our Member communications	• Re-fresh member communications to provide opportunities for members to be involved and engaged in the work of the Trust

Co-production – 7 steps

To achieve co-production/co-design there must be a clear commitment to sharing power and decisions with patients or citizens for the purpose of a particular project or development. It requires an open and honest culture in which people and their views are valued and respected and clear communication which is accessible to all. For it to work successfully all partners in the process must have a full understanding of and provide full support for Co-production.

In honouring the commitments in the NHS Constitution we will commit to put patients at the heart of everything we do by embedding genuine co-production within our engagement and involvement activity where appropriate. Below are seven steps required to make co-production happen in reality.



Source: NHS England and Coalition for Collaborative Care

Pillar 2: Accessible Information Standard

Launch WHH AIS policy to support those with sensory impairments, learning disabilities and non-English speakers to access our services and participate equally in their care

1. Re-convene AIS Task and Finish Group	• Revise Terms or reference for bi-monthly meeting to agree and oversee implementation including deployment plan and staff training and audit process. • Ensure involvement of Experts on visual and hearing impairment and learning disability • Accessible Information standard delivered by end of 3rd quarter of FY 2022/23
2. **Patient Letters**	• Refresh patient letter templates based on previous patient/carer feedback and to ensure AIS compliance via 'Letters Be the Best' workstream group • Test outputs with patient Experts by Experience and specific advocacy partners for visual, hearing and learning disability
3. **Ensure website technical compliance with WCAG standards**	• Frank Design implement website accessibility upgrade
4. **Accessible content creation**	• Ensure all WHH generated content including web, extranet, social, video, design and print is AIS compliant
5. **Patient Information**	• Ensure Patient Information Leaflets are AIS compliant including making key patient information readily available in alternative formats and promoting Patient Passport
6. **Chat Bot pilot**	• Introduce a trial of a Chat Bot Artificial Intelligent (AI) assistant to help patients, carers and visitors ask questions to support them in accessing their care at the Trust.
7. **Signage/Wayfinding**	• Delivered via First Impressions programme – ensure consistency of approach with reference to AIS implementation

Pillar 3: Reducing Health Inequalities

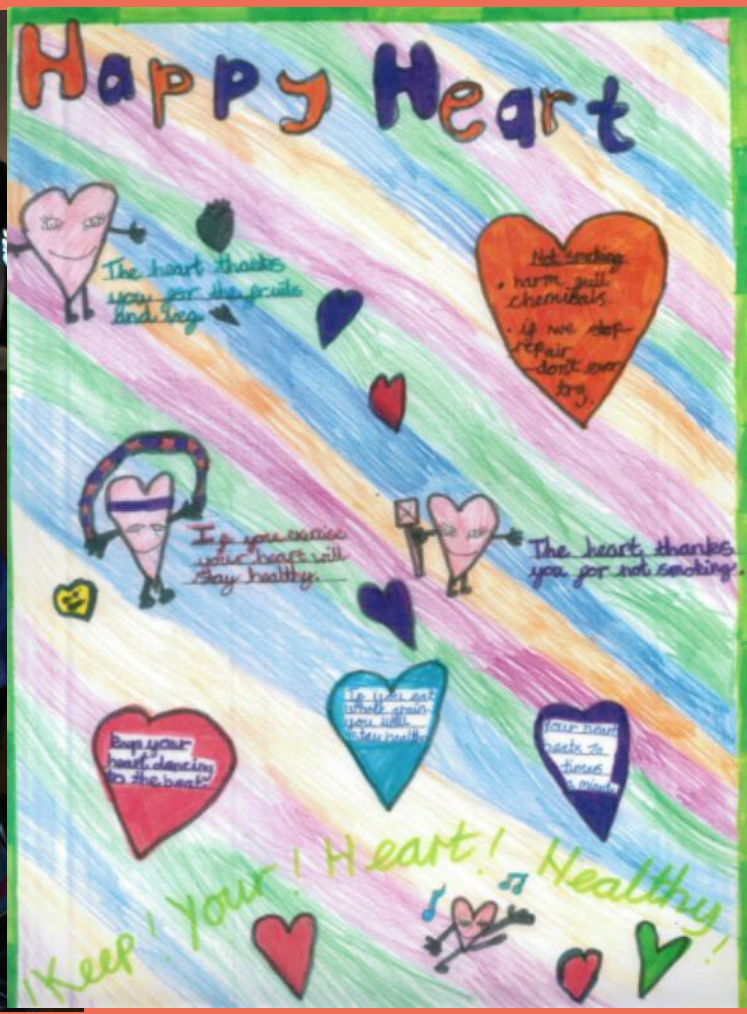
Using WHH 'Your Health Matters' brand and mapping health inequalities to geographical areas of Warr North, Warr South, Widnes and Runcorn

1. Strengthen WHH 'Your Health Matters' engagement programme	• Deliver specific health education and awareness programmes with WHH clinical leads and in partnership with others to raise awareness of prevention of disease and early detection in the following areas: Respiratory, Cardiac, Diabetes, Cancer (breast, bowel, cervical, prostate/urology) obesity/physical activity, alcohol harm, NHS health checks and maternity with particular focus on hard to reach/engage groups.
2. Engage governors in Your Health Matters	• Identify opportunities for Governors in each area to attend Your Health Matters and other events to support initiatives and seek the views of their members and patient constituents. • Provide Governors with toolkit to support engagement activity • Governors represented at least 4 events/activities in each constituency in FY 2022/23. • Regular governor feedback routes to Council of Governors
3. Support Place Based activity and other key local events	• Engage teams and governors in activity and events, including Disability Awareness Day, Annual Members' Meeting and national events including Platinum Jubilee and health profession days • Ensure representation at events includes those communities and groups who are typically underserved by health services
5. Increase participation in research	• Support wider participation in clinical trials and health research among members of our local communities via our Halton Clinical Research Unit.

Pillar 4: Anchor Institution/Building Social Value

Use Trust estate and resources in partnership with others for the benefit of the wider community

1. Establish WHH's position as an anchor institution in our communities	• Promote the availability of WHH venues for social activities. • Use WHH channels of communication to increase engagement with the voluntary and third sector and raise awareness of key health improvement and economic wellbeing initiatives
2. Promote opportunities for work, training or volunteering	• Promote WHH as a great place to work, train or volunteer in order to enhance the aspirations and life chances of local people • Level of engagement with social media and websites • Number registering/attending recruitment events in local venues and number of conditional offers made#
3. To utilise local suppliers and venues	• Use local suppliers and venues to support engagement and involvement programmes, where possible
4. Support the work of the WHH Charity	• Work in conjunction with charity team to ensure charity presence at public engagement and involvement events to promote charity campaigns, fundraising and volunteering opportunities which support patients and communities
5. Give back to our communities	• Sharing health and wellbeing information with our key partners and supporters of the charity including corporate partners


Happy Heart
The heart thanks you for the smile and hug
Not smoking, harm full chemicals. If we stop repair don't even try.
If you exercise your heart will stay healthy.
The heart thanks you for not smoking.
Keep your heart dancing to the beat!
Keep your Heart Healthy!

Accountability and Risk

This strategy is supported by an annual deployment plan which will be risk assessed, evaluated and accountable.

Oversight and assurance will be provided by:

1. Monthly reports included in High Level Briefing Paper to Patient Experience Sub-Committee (PESC)
2. Monthly reports included in High Level Briefing Paper to Patient Equality, Diversity and Inclusion Sub-Committee (PEDISC)
3. Quarterly (Annual) Engagement and Involvement Dashboard to Governor Engagement Group/Council of Governors/Trust Board
4. Annual Report on Communications, Engagement and Involvement to Trust Board

The Accessible Information Standard Task and Finish Group

reporting will report to the following forums for the duration of the Task and Finish Group:

5. Bi-monthly reporting via High Level Briefing Paper to PESC
6. Bi-monthly reporting via High Level Briefing Paper to PEDISC
7. Progress report on AIS deployment to Trust's Moving to Outstanding Group as part of Communications and Engagement High Level Briefing Report

Risk	Risk score	Mitigation	Target
Failure to provide or engage with of or training in the statutory duties of engagement and consultation for NHS Trusts			
Failure to recruit and retain sufficient Experts by Experience (EbyEs)			
Failure to provide training to Experts by Experience (EbyEs) on areas of constructive challenge			
Failure to engage clinical services in co-production involvement activity for service developments due to service demands			
Failure to engage clinical leads in Your Health Matters/ reducing health inequalities engagement activity			
Failure to provide adequate Engagement and Involvement expertise and support to clinical and corporate teams			

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact the Communications Team on 01925 662710.

Polish:	Niniejsza publikacja jest dostępna w alternatywnych językach lub formatach na życzenie
Punjabi:	ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਬੇਨਤੀ 'ਤੇ ਵਿਕਲਪਿਕ ਭਾਸ਼ਾਵਾਂ ਜਾਂ ਫਾਰਮੈਟ ਵਿੱਚ ਉਪਲਬਧ ਹੈ
Urdu:	یہ اشاعت درخواست پر متبادل زبانوں یا فارمیٹس میں دستیاب ہے
Bengali:	এই প্রকাশনাটি অনুরোধের ভিত্তিতে বিকল্প ভাষা বা বিন্যাসে
Gujurati:	ઉપલબ્ધ આ પ્રકાશન વિનંતી પર વૈકલ્પિક ભાષાઓ અથવા
Arabic:	فورمات بديلة عند الطلب هذا المنشور متاح
French:	Cette publication est disponible dans d’autres langues ou formats sur demande
Cantonese:	本出版物可應要求以其他語言或格式提供
Portugese:	Esta publicação está disponível em idiomas ou formatos alternativos a pedido
Spanish:	Esta publicación está disponible en idiomas o formatos alternativos bajo petición

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Engagement and Involvement Team
Warrington and Halton Teaching Hospitals
www.nhs.uk email: whh. engagement@nhs.net

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/76**
SUBJECT:	**Annual Review of the Patient Experience Strategy (2020-2023)**
DATE OF MEETING:	25 May 2022
AUTHOR(S):	Layla Alani, Director of Governance & Quality
	Jen McCartner, Head of Patient Experience & Inclusion Adam Harrison, Patient Experience & Inclusion Manager
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive Officer
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#145** Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.
EXECUTIVE SUMMARY *(KEY ISSUES):*	At Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH), our key quality priority which helps us achieve our mission of delivering outstanding patient experience, every time is: “To be outstanding for our patients, our communities and each other”. This paper provides an update on the progress to date of the WHH Patient Experience Strategy 2020 – 2023.

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

RECOMMENDATION:	The Trust Board is asked to note and receive assurance provided in this paper in relation to the progress made in the delivery of the Patient Experience Strategy (2020-2023)

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/22/04/91
	Date of meeting	5 April 2022
	Summary of Outcome	To submit to Trust Board
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication	

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/22/04/91**			
SUBJECT:	Annual Review of the Patient Experience Strategy (2020-2023)			
DATE OF MEETING:	5th April 2022			
AUTHOR(S):	Layla Alani, Director of Governance and Quality Jen McCartney, Head of Patient Experience and Inclusion Adam Harrison, Patient Experience and Inclusion Manager			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse &+ Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first through high quality, safe care and an excellent patient experience.			
EXECUTIVE SUMMARY	At Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH), our key quality priority which helps us achieve our mission of delivering outstanding patient experience, every time is: "To be outstanding for our patients, our communities and each other". This paper provides an update on the progress to date of the WHH Patient Experience Strategy 2020 – 2023.			
PURPOSE: (please select as appropriate)	Information x	Approval	To note X	Decision
RECOMMENDATIONS:	The Quality Assurance Committee are asked to note and receive the assurance provided in this paper in relation to the progress made in the delivery of the Patient Experience Strategy (2020-2023).			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 - Information intended for future publication			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Annual Review of the Patient Experience Strategy (2020-2023)	AGENDA REF:	BM/22/05/79

1. BACKGROUND/CONTEXT

At Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH), our key quality priority which helps us achieve our mission of delivering outstanding patient experience, every time is: "To be outstanding for our patients, our communities and each other".

We pledge to actively seek, listen and act on feedback received from our patients, staff and other key stakeholder groups such as our Foundation Trust Governors, Healthwatch, Volunteers and Carer organisations plus the extensive number of advocacy groups that support the Trust.

The Patient Experience Strategy was developed in collaboration with our patients, carers, visitors and community partners with an underpinning ask, 'What Matters to You?'. Utilising this collaborative approach and feedback received, five pledges were developed to ensure an outstanding patient experience at WHH:

Pledge 1 – We will listen, learn and lead change.
Pledge 2 – We will communicate in line with our values.
Pledge 3 – Personal, needs-based care based on Always Events® / Co-creation.
Pledge 4 – Healing Environments.
Pledge 5 – Making Care, Treatment and Experience Accessible.

2. KEY ELEMENTS

This paper provides an update in relation to the delivery of Patient Experience Strategy (2020-2023) to ensure that the workstreams outlined in the strategy are progressed.

Updates have been split by each pledge to provide assurance to the Quality Assurance Committee of progress made in the delivery of the strategy.

Pledge 1: We will listen, learn and lead change.

At WHH numerous communication methods are utilised to support every patient, service user, their carer or family member to give feedback about their care and experience. We do this to drive change through engagement and active listening with our 'people' and our community partners. Workstreams undertaken have included the following:

Friends and Family Test (FFT)
In line with national guidance the Friends and Family Test process was reintroduced at WHH in February 2021 for all areas in the Trust following a national suspension of collating this data due to the COVID-19 pandemic. Response rates are monitored monthly per clinical business unit (CBU) via the Patient Experience Sub-Committee with interventions and best practice shared as appropriate.

The Patient Experience and Inclusion team have reviewed existing feedback methods in relation to Friends and Family testing to enhance the accessibility of the survey. All areas of the Trust setup for Friends and Family Test (FFT) surveys are now able to support patients to utilise the digital 'Patient Experience Surveys' link to complete their FFT in addition to paper surveys already in place. The benefit of utilising the digital

solution includes the use of 'browse aloud' which is an accessibility tool to support people living with a visual or hearing impairment and allows for the survey to be transcribed into other languages or simplified utilising images as well as text. The digital survey can be accessed via the QR code on FFT posters across the Trust or by utilising the link on the paper copies. Focused work will continue by the Patient Experience and Inclusion Team in conjunction with the Community Engagement and Involvement Officer to raise awareness of feedback methods to ensure engagement with the local community.

National Surveys
The Trust actively partakes in national surveys supported by an impartial company, Quality Health, to receive detailed feedback of the care and experience our patients receive at WHH. The Trust partakes in 4 patient surveys as detailed below:

Adult National Inpatient Survey 2020 – sample was drawn in December 2020 with fieldwork taking place between January 2021 to May 2021. Results of the survey were received by the Trust in September 2021 with results published in October 2021.

The Adult Inpatient 2020 survey was significantly different to previous years' surveys with regards to methodology, sampling month and questionnaire content the 2020 results are therefore not comparable with previous years' data and trend data is not available.

The Trusts response rate was 42%, an increase of 2% from the previous year. The national average response rate was 46%.

The scores for WHH signify a broadly secure picture with 41 questions scoring 'about the same' as other Trusts, 3 'better than expected' and 1 worse than expected.

A full action plan is in place in response to recommendations set out in the survey report.

The Urgent and Emergency Care Survey 2020 – sample was drawn in October 2020 with fieldwork taking place between October 2020 to March 2021. Results of the survey have been received by the Trust in August 2021 with results published in September 2021.

The Urgent and Emergency Care Survey is split into two survey types:

- Type 1 involves Trusts with an accident and emergency (A&E) department.
- Type 3 involves Trusts with an urgent treatment centre or minor injury units.

Type 1 - The Trust response rate was 24.97%, with 230 patient responses. The national average response rate was 30.5%.
The Trust's results were better than most trusts for 1 question.
The Trust's results were worse than most trusts for 2 questions.
The Trust's results were about the same as other trusts for 35 questions.

Type 3 - The Trust response rate was 24.88%, with 104 patient responses. The national average response rate was 30.8%.
The Trust's results were better than most trusts for 4 questions.
The Trust's results were worse than most trusts for 1 question.
The Trust's results were about the same as other trusts for 25 questions.

Results have been shared at Trust wide committees with a full action plan in development to respond to areas for improvement, which include arrival to A&E and wait times.

The Children and Young People's Patient Experience Survey 2020– sample was drawn in January 2021 with fieldwork taking place between February 2021 to June 2021. Results of the survey have been received by the Trust and were published in December 2021.

The survey sample was drawn from patients discharged from the Trust during November and December 2020. Three different questionnaires were issued to patients depending on their age group: the 0-7 years questionnaire completed by the parent or carer; the 8-11 years questionnaire completed by both the child and parent or carer; the 12-15 years questionnaire completed by both the young person and parent or carer.

Results of the survey detail 5 questions which scored significantly higher in comparison to the 2018 survey. In 46 questions, WHH scored about the same as other trusts.
Overall, the report congratulates the standards and improvements made to children and young person's 8yrs-15yrs.
Focused improvements on food, play for 0-7yrs olds and overnight facilities for parents and carers. This will be monitored through a formulated action plan to follow.

The Maternity Survey 2021 – sample was drawn in March 2021 and fieldwork was undertaken between April 2021 to August 2021. Embargoed results have been received by the Trust with results expected to be published in February 2022 by the CQC. Warrington and Halton Teaching Hospitals are in the top 9 Trusts for response rate for the Maternity Survey 2021. A full report has been presented at Quality Assurance Committee in February 2022 and to the Patient Experience Inclusion Committee in March 2022.

The report detailed the majority of Warrington and Halton Teaching Hospitals NHS Foundation Trust's scores are in the intermediate 60% of all Trusts surveyed by Quality Health. Of the 50 questions benchmarked, WHH had 8 questions RAG rated as 'Red', 36 questions rated as 'Amber' and 6 questions rated as 'Green' when benchmarked against other Trust. Eight scores can be found in the bottom 20% range (rated Red). The report noted close attention should be paid to scores around midwives or doctors' awareness of patients' medical history during antenatal check-ups; and providing the help needed during pregnancy when patients contact a midwifery team.

Digital Patient Stories
Sharing the experience of our patients in story format is utilised to support the sharing of best practice, lessons learned and to support staff training. The Head of Patient Experience and Inclusion has undertaken a national training programme to introduce digital storytelling to the organisation. Digital stories allow for the patient to be at the centre of the story through dialogue and imagery.

Digital stories are made up of three basic principles:

- It is a first-person story.
- It is always short – <3 minutes.
- The storyteller/ patient remains the director of the story.

Digital stories have formed part of meetings such as Patient Experience Sub-Committee, Patient Equality, Diversity and Inclusion Sub-Committee, Quality Assurance Committee and Trust Board. The stories are shared with teams within the Trust to support lessons learned from complaints and have also been integrated into customer care training to ensure that the Trust listens to 'experts by experience' and for learning at ward/ department level.

Pledge 2: We will communicate in line with our values.

Ensuring the patient voice is at the centre of all care delivered is an essential basis of the Patient Experience Strategy, to ensure that the patient, their carers or family members are at the centre of all we do. Workstreams undertaken have included the following:

Carers Strategy and Carers Passports

The Trust has representation at the Warrington's Carer Partnership Board. The main focus of the board is the delivery of the Warrington Carers Strategy. The production of the strategy was completed in quarter 2 of 2021/22, and the Patient Experience Sub-Committee and Equality, Diversity and Inclusion Sub-Committee provided comments and insight to ensure that the strategy met the needs of the local WHH community.

In November 2021 as part of Carers Rights Day the Trust launched a collaborative Carers Passport in conjunction with Trusts in Cheshire and Merseyside. At WHH we value the work done by carers and are committed to working together with them as expert partners in care, this is delivered through extensive engagement with WIRED Carers Centre and the Patient Experience and Inclusion Team. Furthermore, promoting a culture that recognises carers and their needs within our hospitals, moving to address the inequalities faced in care by carers in the future. The passport aims to:

- Aide identification and support of carers,
- Raise awareness of caring,
- Provide information to key health professionals on a carer's role,
- Help in local discussions and support but allow for consistency across the region at other NHS hospitals.

Customer Care Training

In collaboration with the Trust Learning and Organisational Development Team, the Patient Experience and Inclusion Team have worked to enhance the delivery of the customer care training package. This is through the utilisation of patient stories to ensure training sessions are meaningful and support the lessons learned process from complaints.

Following thematic reviews of complaints data, a focused approach has taken place to ensure department level customer care training is delivered with the most recent bespoke customer care training taking place for staff within the Emergency Department. To develop effective bespoke training packages outcomes of observational visits, friends and family data and survey results have been considered.

Pledge 3: Personal, needs-based care based on Always Events® / Co-creation.

At WHH we believe that our patients, their carers or family members ('people') should always receive care that is based on their specific needs. To achieve this, it is important to utilise a partnership-based approach to ensure people are given every opportunity to be involved in the co-creation of their care and experience. Workstreams undertaken have included the following:

Community Partners

The Patient Experience and Inclusion Team work closely with community partners as advocates for the diverse community in which we serve. This has included regular engagement with advocacy groups as detailed below:

- Warrington Disability Partnership
- Deafness Resource Centre
- Healthwatch (Warrington and Halton)
- Carers Centres (WIRED and Halton Carers Centre)

Engagement continues to take place in formal settings such as Patient Experience Sub-Committee and the Patient Equality, Diversity and Inclusion Sub-Committee as well as informal meetings whereby a more targeted focus is in place to review trends and themes to celebrate success and drive change where necessary.

The Trust is actively engaged with community forums such as 'Staying Connected', which brings together third sector and advocacy services to discuss healthcare and living in Warrington. The Trust engages from this group with service managers to ensure that the Trust is continually improving the experience for people who access our hospitals.

Experts by Experience

The term 'Experts by Experience' is an assembly of patient panels, services users, interested individuals. Any changes, developments, improvements or introductions to our patient-facing services have a requirement for patients/service users to be informed, engaged and invited to participate in the service change. More importantly, the input of our patients provides healthcare and support professionals with real insight into what patients and the public think of their work and can save a great deal of time and effort by pointing out something that may not have been considered by those involved.

The Engagement and Involvement Team are supporting the introduction of Experts by Experience to ensure the voice of the patient is represented in all major service developments, changes and new initiatives and will shortly be undertaking a full launch internally within the Trust to support further recruitment of Experts from across our services. The team are currently processing a number of requests to allocate experts including First Impressions, Breast Screening and a Zero Carbon Patient Pilot.

Maternity Voices Partnership (MVP)

The MVP launched in November 2021 following the appointment of a new Chair. A event was held pre-launch with the Chief Nurse and Deputy Chief Executive, Director of Midwifery, Continuity of Carer (CoC) Lead Matron and Deputy Head of Midwifery to further develop the MVP action plan for the year. This included:

- Ongoing recruitment of MVP members via local nurseries, National Childbirth Trust (parents in mind) and social media
- Building relationships with broader MVP groups
- Meeting key stakeholders within WHH (Maternity, Communications, Health and Safety, Community Engagement, Patient Experience and Inclusion)
- Meeting key stakeholders outside WHH such as Dads Matters; Homestart, Healthwatch

- Developing an MVP calendar which aligns to the wider Public Health agenda

To enable open discussions the MVP meets on a three-monthly basis to encourage people to discuss their experiences. Due to the COVID-19 pandemic, some meetings have been held virtually, however on the 28th January 2022 a formal launch event was held at the Peace Centre in Warrington with attendance from service users, advocacy groups, Patient Experience and Inclusion Team and Trust colleagues.

The MVP principles underpin the Patient Experience Strategy (2020-2023) pledge enabling a partnership-based approach by ensuring members are valued as equal partners and given every opportunity to be involved in the co-design and co-production of service development.

Pledge 4: Healing Environments.

At WHH we believe every patient should experience care and treatment in the right environment with a focus on making continuous improvements on what patients, carers and their families see, do, hear and feel during their time in the hospital. Workstreams undertaken in year one of the strategy included the following:

First Impressions
First impressions are the lasting impressions, which inspire confidence in the safe care and experience that our patients are about to receive. First impressions are formed within 15 steps of entering the hospital and can influence the way patients, service users, their families and carers perceive their whole experience.

Utilising the 15 Steps Challenge tool, the domains of 'See + Hear = Feel' have been developed to enhance patient and service user experience as part of a continuous improvement principle 'The First Impression'. The delivery of this programme is a joined-up approach led by the Patient Experience and Inclusion Team, Estates and Facilities and the Communications Team. This programme explores environmental factors, patient information, patient and staff noticeboards, wall space and corridors.

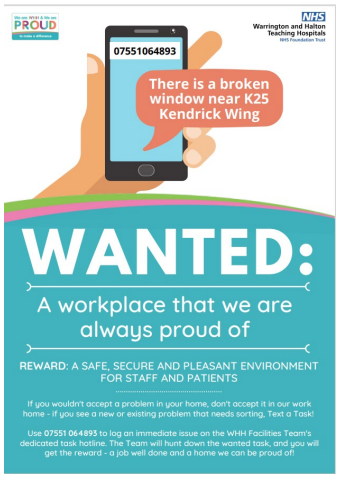
The programme is split into two workstreams as illustrated in the infographic below and is be underpinned by Patient Experience Strategy, Equality, Diversity and Inclusion Strategy and the Accessible Information Standards.

Patient Experience Strategy
Equality, Diversity and Inclusion Strategy
Accessible Information Standards

Work currently in development within the First Impressions programme includes:

- Task and finish groups initiated with clear terms of reference and reporting structures in place.
- Overarching promotional materials have been developed with plans in place to share Trust wide to support the instilling of pride into the Trust in April 2022.
- Launch of 'Text a Task' campaign planned to take place in May 2022. This campaign will enable staff to log an immediate estates issue via a dedicated task hotline supported by the WHH Facilities Team.
- Development of literature guidance is underway detailing how to present information to both staff and patients in poster and leaflet form to ensure clear, concise, and relevant information is displayed in a format that is accessible for all.

- Introduction of First Impressions observational rounds in April 2022.



Patient Experience Community Hub

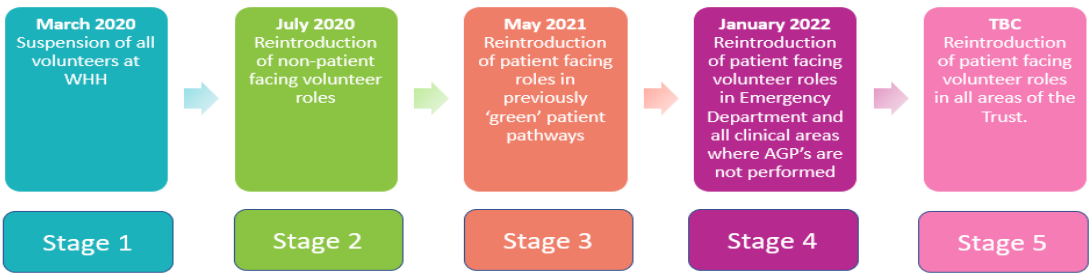
In January 2022, the Community Hub was transferred from the WHH Charity to the Patient Experience and Inclusion Team. The hub will be utilised to enable a variety of activities to take place such as Digital Cafés, to support social value in the community, focused on enabling digital inclusion in line with the increase in digital and virtualisation of healthcare services.

The hub has continued to provide additional support to patients, including the use of patient clothing and toiletries. The hub will operate in line with the plan for staffing the Welcome Desk at Warrington Hospital and will be open five-days per week, Monday to Friday.

Volunteers

Volunteers at WHH provide a valuable supplementary service, enhancing the experience of patients, visitors and supporting staff.

Over the past two years the COVID-19 pandemic has had a detrimental impact on volunteering services and significant impact on the NHS overall. In response to the COVID-19 pandemic and in line with receipt of the "NHS Volunteer Guidance Version 1.0" from NHS England (NHSEI), all patient facing volunteer roles at Warrington and Halton Teaching Hospitals (WHH) were suspended in March 2020 until July 2020 when a recovery plan was initiated. The recovery plan is monitored on a bi-monthly basis via the Patient Experience Sub-Committee. This is evidenced below:



Since July 2020 several roles have been adopted by the WHH Volunteer service in a staged approach to support the overall priorities of patient safety, improving quality reducing demand on staff and improving patient flow and wellbeing. These roles have included:

- Support provided to the Trust Personal Protective Equipment (PPE) Safety Team ensuring mask stations where 'manned' ensuring all visitors to the Trust supported to follow Trust Infection Prevention and Control Guidelines

- Patient Information Reader Panel – ensuring a proof-reading service for all patient facing material.
- Support to the Vaccination Hub / Outpatient service supporting wayfinding and the wellbeing of patients whilst in the waiting rooms
- Wingman Lounge support
- Forget Me Not Ward Gardening –to ensure the garden is tidy and accessible for patients in the Forget Me Not Ward and surrounding wards
- Discharge Lounge – wellbeing support for patients during their time in the Discharge Lounge.
- Wayfinding support – to ensure visitors to the Trust can navigate their way to the relevant ward or department.

This has resulted in:

- 137 existing Volunteers returning to support the Trust
- 5413 hours of support provided to the Trust by Volunteers
- 265 new Volunteers recruited to support the Trust

In addition to the above the WHH Volunteer team have provided support to external voluntary organisations and internal teams/ departments to restart roles in line with guidance from Infection Prevention and Control team including Halton Hospital Radio, Friends of Halton Hospital, Warrington General Hospital Radio; Warrington League of Friends and Delamere CANtreat Volunteers.

Welcome Team

As part of the refurbishment plan led by the Director of Communications and Engagement for the main entrance of Warrington Hospital, a welcome desk was built to ensure an enhanced experience for all visitors at the hospital 'front door'.

To ensure a consistent, safe, welcoming, and professional image at our front entrance, the Trust was successful in a fully funded Department for Work and Pensions bid to support 16- to 24-year-olds to gain employment via a government initiative, 'Kickstart' as an interim measure. The 'Welcome Team' Kickstart programme commenced on 13th September 2021 for a period of six months. As part of this programme, six staff members were recruited on a part-time contract to maintain a consistent service Monday to Friday.

The 'Welcome Team' function has included supporting patients who require additional reasonable adjustments, for example, interpretation, accessibility, and wayfinding. This has provided key support for clinical staff who would normally be required to assist patients from the front entrance to wards or outpatient areas. The team have supported the Trust in respect of restricted visiting, by acting as an information source, directing queries to relevant teams. They also support clinical areas with queries relating to interpretation and translation utilising digital technology to connect to interpreters. By having a support function at the front of the hospital this has enabled people to communicate with the Trust, reducing potential calls to wards and responding to queries via Switchboard which may have been directed elsewhere in the Trust previously.

On 17th March 2022 a business case was approved by the Executive Team for the provision of a substantive Welcome Team and an insourced Volunteer Service. This will be implemented from April 2022 to ensure to continuation of the service provided by the 'Kickstart' initiative, to ensure quality patient experience and improved patient access and experience.

Pledge 5: Making Care, Treatment and Experience Accessible.

At WHH, we believe that our processes should be designed with our patients at the centre. We will develop our processes, so everything is clear, simple and accessible for all 'people'. Workstreams undertaken in year one of the strategy included the following:

Interpretation and Translation
Warrington and Halton Teaching Hospitals (WHH) has both a moral and legal duty to demonstrate fairness and equality to our patients, service users, their carers, families, and to our employees. WHH is required to meet its statutory obligation requirements under the Equality Act 2010.

Foreign Language Interpretation:
The Big Word has been the primary provider at WHH since May 2018, providing translation and interpretation services for foreign languages both by telephone and face to face. The Deafness Resource Centre (DRC) provides British Sign Language (BSL) services, this has been in place with consistently satisfactory service experience for some years.

Data provided by the Big Word for utilisation in 2019-2020 found that:

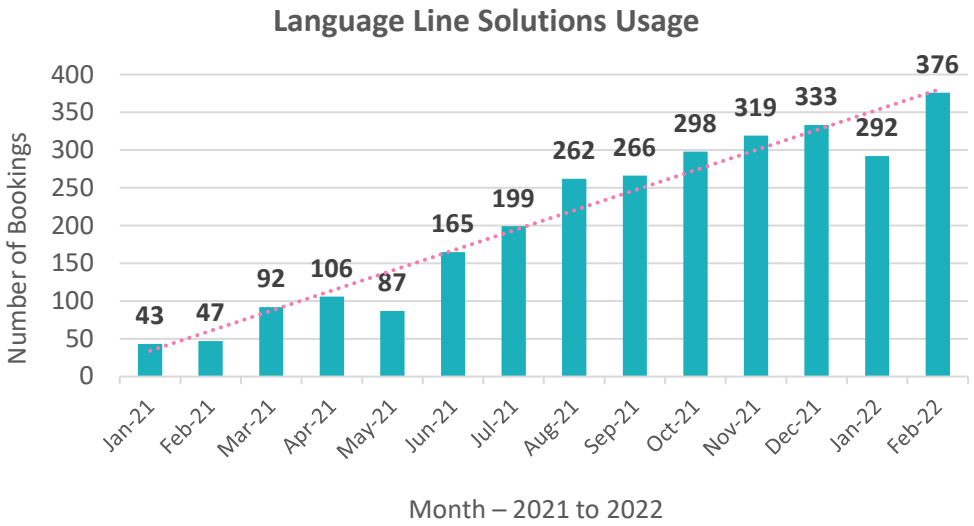
- Face to Face (F2F) bookings (<24 hours' notice) had a 43.75% fulfilment rate set against a KPI of 80%
- Face to Face (F2F) bookings (>24 hours' notice) had an 89.95% fulfilment rate set against a KPI of 95%

Due to the lack of consistency provided by The Big Word during the contract term a trial with Language Line Solutions® (LLS) was completed as part of the initial review in March 2020 across four areas of the Trust: Breast Screening, Ophthalmology, Outpatients and Emergency Department. This was received with positive reviews from staff with regards to the easy application, the speed to access an interpreter and the standards of interpretation and translation.

In 2021 the Trust introduced Language Line Solutions as an additional supplier for foreign language interpretation and translation services, this was supported by a robust procurement process.

The COVID-19 pandemic brought many challenges in the way that interpreting services were provided, this was continued into 2021/22 with additional waves of the pandemic and subsequent national lockdowns. As a result, the addition of Language Line Solutions allowed for a virtual interpreter to be present via video or audio connection through tablets and other electronic devices available on wards, in outpatient departments and the emergency department.

The below chart provides an update on usage for Language Line Solutions following the introduction of the supplier across all clinical business units in 2021:



The above data demonstrates a 254% increase in Language Line usage from April 2021 to February 2022 where a full calendar months data can be analysed. The average usage of interpreter services remains consistently between 265 and 330 bookings per month. The increase in usage for interpretation and

translation has resulted in a reduced request for the Warrington and Halton Teaching Hospitals workforce to act in the position of an interpreter. This ensures that the Trust meets its quality standards and that patients are supported by bilingually competent, neutral, independent and professionally trained interpreters.

British Sign Language (BSL) Interpretation:

Throughout the pandemic British Sign Language interpreters have continued to visit site in a safe and controlled manner to support patients who require a BSL interpreter. If a BSL interpreter is unable to visit the hospital site, a virtual BSL interpreter could be connected through Language Line Solutions.

The below table provides an update on usage for the Deafness Resource Centre in 2021/22 (up to the end of January 2022):

Dates	Number of bookings
April 2021 – June 2021	**43 active bookings**
July 2021 – September 2021	**28 active bookings**
October 2021 – December 2021	**31 active bookings**
January 2022	**16 active bookings**
Total	**118 active bookings**

Data demonstrates a consistent delivery of BSL interpretations across the Trust with data reviewed on a regular basis at the Trust Patient Equality, Diversity and Inclusion Sub-Committee to ensure there are no known barriers to accessing the hospital by a BSL patient or service user.

To promote awareness of BSL in the Trust, the Patient Experience and Inclusion Team with support from the Deafness Resource Centre celebrated 'Deaf Awareness Week' in May 2021 enabling on-going improvement and awareness for staff on how to support patients, service users and their families. In addition, the Trust commissioned a 6-week non-accredited BSL training programme for 12 clinical and non-clinical staff across the Trust. The aim of this programme was to:

- understand and use a limited range of simple health related words and sentences in BSL.
- take part in simple, everyday conversations in BSL.
- give and follow simple directions or instructions in BSL.
- give and follow simple familiar healthcare statements or descriptions in BSL.

Tools to enable Interpretation and Translation:

In response to patient feedback the Patient Experience and Inclusion Team delivered an Interpretation and Translation 'Hot Topic' in August 2021 focused on:

- Improving awareness of how to access an interpreter.
- Recording alerts on patients' records if an interpreter is required.
- The different types of interpretation and translation.
- Seeking additional support in the event an interpreter has not been booked.

Following the success and feedback collated during the hot topic the Trust launched an 'Interpretation, Translation and Accessible Information' Staff Guide to simplify the interpretation and translation process and enable appropriate continuous learning. The guide has information on:

- Foreign language interpretation
- British Sign Language
- Accessible Information Standards
- Safeguarding and consent
- Easy read documentation
- Makaton
- Language identifiers

To support the rollout of the staff guide, drop in training was provided to wards and departments as required to promote usage of the guide.

Equality Impact Assessments (EIA)
Warrington and Halton Teaching Hospitals (WHH) is required to have due regard when carrying out its functions to meet the Public Sector Equality Duty.

The principles of 'due regard' state it is good practice for public functions to keep an accurate record showing that they have considered the general equality duty and pondered relevant questions.
An Equality Impact Assessment is a tool that is used to ensure due regard is recorded in respect of decision making, policies, procedures, and strategic and operational decisions so they are inclusive and don't disadvantage individuals or groups protected under the Equality Act 2010. Equality Impact Assessments are an evidence-based tool to enable a demonstrated compliance with the public sector equality duty, it helps to support good decision-making through methodical assessment of likely or actual impact and analysis for people relating to the 9 protected characteristics.

In 2021/22 the Trust progressed a development programme to have a more effective equality analysis process to inform and improve health outcomes for all. This is being achieved through a three-step process:

1. Implementation of a quality review process which is completed by the Patient Experience and Inclusion Manager and Workforce Equality, Diversity and Inclusion Manager. This enables potential and/or actual impacts which have not been identified, recorded, analysed or judgement made to be addressed with steps taken to address this.
2. Bi-monthly quality assurance process which reviews EIAs completed in the previous period for approval. Following assurance this is presented to both Patient and Workforce Equality, Diversity and Inclusion Sub-Committee for comments and learning.
3. Training commissioned by Jagtar Singh Associates to deliver a suite of EIA knowledge and skills improvement modules to clinical and non-clinical stakeholders in the organisation.

3. MONITORING/REPORTING ROUTES

Progress against the work plan and associated plans are monitored through the Trust Patient Experience Sub-Committee.

4. RECOMMENDATIONS

The Quality Assurance Committee are asked to note and receive the assurance provided in this paper in relation to the progress made in the delivery of the Patient Experience Strategy (2020-2023).

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/77**	
SUBJECT:	**Annual Quality Strategy**	
DATE OF MEETING:	25 May 2022	
AUTHOR(S):	Layla Alani, Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	

	#1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	Following approval at the Quality Assurance Committee, the paper will provide a summary of the following: • Progress made in relation to the Trust Quality Strategy 2021-2024 and the Quality Priorities detailed within the strategy. • Proposals for reviewing the final draft of the 2022-23 Quality Priorities for approval which are also aligned to the priorities detailed in the Quality Strategy.

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

RECOMMENDATION:	The Board of Directors is asked to: Note the update on the 2021-22 Quality Priorities; and note the approved Quality Priorities 2022-23 as detailed within the paper.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/22/03/67
	Date of meeting	1st March 2022
	Summary of Outcome	Approved by Quality Assurance Committee for Submission to Trust Board
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

1. BACKGROUND/CONTEXT

The Trust recognises that staff are its most valuable and import resource and therefore organisation is committed to providing a learning culture where staff are nurtured and encouraged to learn

The Trust aims to be a learning organisation that consistently enables staff to transform practice by continuous learning and improvement in order to provide the best possible health care.

The Trust has to develop a Quality Accounts report which is published on the NHS website annually by NHS providers and describes the quality of services provided. A requirement of the Quality Account is that Trusts should identify areas for continual improvement in the quality of services provided. To assist with this, the Trust has developed a Quality strategy 2021 – 2024 which was devised to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be. With the above care model in mind, we use the following three priority quality domains: Patient Safety, Clinical Effectiveness and Patient Experience.

Our 3 strategic objectives under the three priority quality domains are:

- **Priority 1 - Patient Safety:** The Trust is committed to developing and enhancing its patient safety and learning culture where quality and safety is everyone's top priority.

- **Priority 2 - Clinical Effectiveness:** Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.

- **Priority 3 - Patient Experience:** By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

For each priority quality domain, we have selected a series of Quality Priorities for improvement for 2021/2022 detailed below; the progress of each priority is reported on a quarterly basis to the Trust's Patient Safety and Clinical Effectiveness Sub Committee and Quality Assurance Committee. Where possible we include performance indicators to measure and benchmark progress and they are reported on a monthly basis, via the Quality Dashboard to the Board of Directors. The Quality Priorities for 2021/2022 are:

Patient Safety

- DNACPR- Improve communication with family/patients with effective communication, documented discussion and inclusive decision making.
- COVID Recovery- robust waiting list management, with clear clinical oversight to avoid and recognise potential patient harm.
- A reduction in Gram Negative Bloodstream Infections (GNBSI) – ensuring that there is a 5% reduction per quarter in bloodstreams infection.

Clinical Effectiveness

- Medical Examiner- embed the service across the acute setting and act as the pilot site for community roll out.
- Evidence-based Interventions- Ensure effective decisions about health care are based on the best available, current, valid and reliable evidence.
- CBU Governance- to be strengthened ensuring consistency across the organisation.

Patient Experience

- End of Life – Serious Illness Programme; Better Communication and Better Care for those sadly reaching the end of life.
- Learning Disabilities and Mental Health Strategies - Implementation of the Trust Learning Disability Strategy.
- Improve patient experience by enhancing the standard and timely delivery of nutrition.

2. KEY ELEMENTS

The Quality Strategy uses the following measures of success:

- ✓ We will ensure every patient has the opportunity to feedback about their experience and we promise to use this to improve care and services
- ✓ We will always put our patients first in everything we do, and we promise to communicate based on what matters most to you and in line with our values
- ✓ We will ensure that we minimise harm for patients
- ✓ Our patients should always experience care that is based on their specific needs, and we promise to work in partnership with you and your carers to achieve best possible outcomes
- ✓ Every patient should experience care and treatment in the right environment, and we promise to continuously improve what you can see, do, hear and feel during your stay.
- ✓ Our processes should be designed to support our patients and we promise to develop these so that everything is simple, done in a timely manner and easy to understand.
- ✓ We will be the best place to work and have safe systems of work in place
- ✓ We will ensure partnership working and needs based care.

With the above measures of success in mind, the following infographics details some of our key achievements from the Quality Priorities for 2021-22.

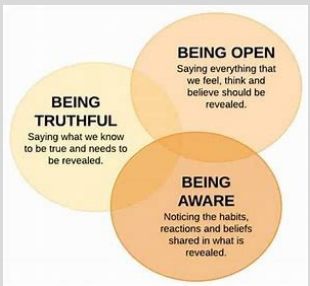
Key Quality Achievements To Date

Complaints – Response Times Achieved

The Trust has successfully achieved 100% response rate within the allocated timeframe In December 2022, due to the commitment of staff, the Complaints Department had the lowest number of complaints open, 33 in total.

Consistent Incident Reporting

The data shows an overall improved performance in incident reporting in the fact that Incident reporting continues to increase, and these are monitored through a robust governance framework. This also shows a positive reporting culture as the data shows that incidents reported as low, or no harm are high and moderate or major harm are low. This demonstrates a safe and transparent culture.



Achieved Statutory Duty of Candour Requirements

The Trust has achieved 100% compliance with notifying a patient of a verbal and written Duty of Candour within 10 working days after becoming aware that a notifiable safety incident has occurred.

1. Progress on Quality Priorities and Assurance

The Quality Strategy contains Quality Priorities for 2021-22 and the information below contains an update on progress on each of the quality priorities under the three domains: Patient Safety, Clinical Effectiveness and Patient Experience. Where possible we include performance indicators to measure and benchmark progress.

Patient Safety Strategic Quality Objective:
The Trust is committed to developing and enhancing its patient safety and learning culture where quality and safety is everyone's top priority.

Quality Priority: A reduction in Gram Negative Bloodstream Infections (GNBSI) – ensuring that there is a 5% reduction in Bloodstreams infection per quarter.

Lead: Lesley McKay, Associate Director of Infection Control

Why we chose this priority

There is a national ambition to reduce healthcare associated Gram-negative bloodstream infections (Healthcare Associated GNBSIs). The target is set at a 25% reduction by March 2022 and 50% by 2024.

This priority links in with our Quality Strategy and we are committed to developing and enhancing our patients' safety.

What success will look like

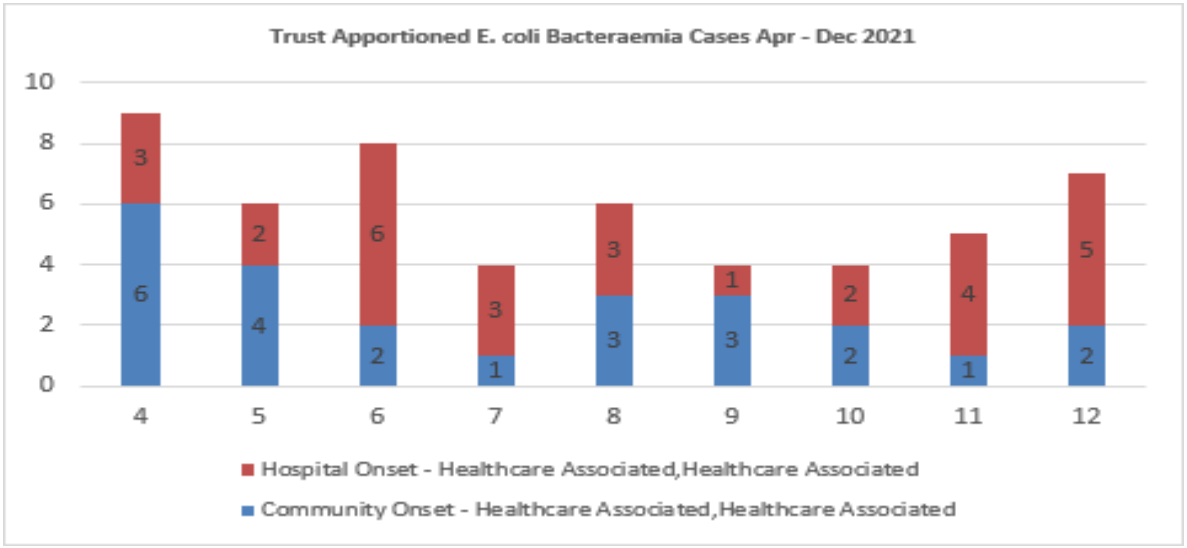
A reduction in Gram Negative Bloodstream Infections (GNBSI) in line with NHS Improvement and Public Health England (NHSI/PHE) national target.

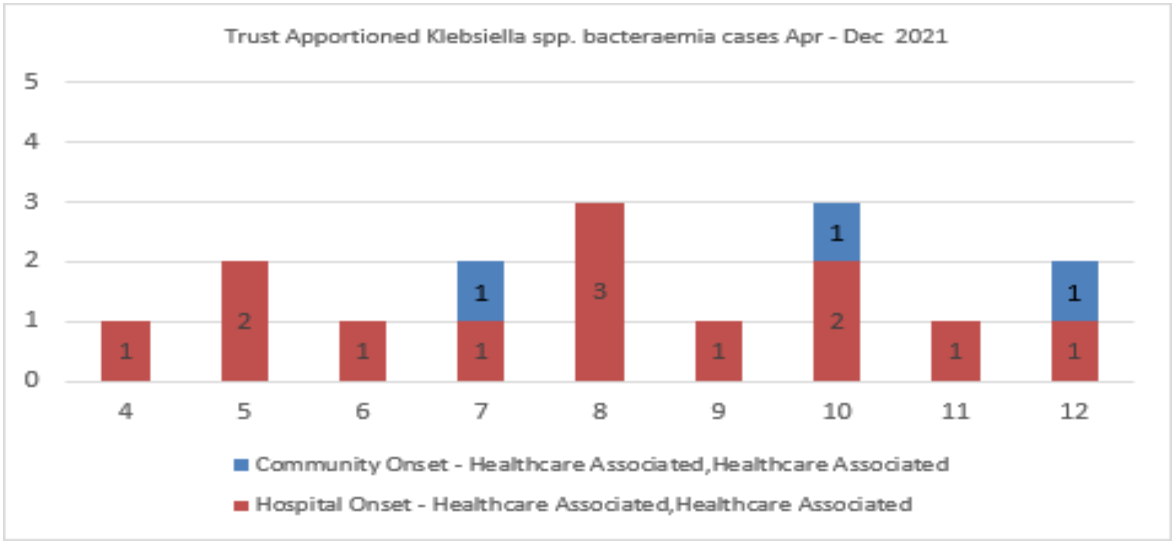
Q3 progress

The Trust has had a targeted focus on reducing the number of GNBSI s and is on trajectory to meet the thresholds as demonstrated in the performance data shown in table 1 and graphs 1, 2 and 3 below.

Table 1: Gram Negative Bloodstream Infections (GNBSI)

HCAI	Reduction	WHH Threshold 2021/22	Apr-Dec 2021 case totals	End of Q3 position
E. coli	Minus 5%	≤81	**53**	**Below trajectory**
Klebsiella spp.	Minus 5%	≤23	**16**	**Below trajectory**
P. aeruginosa	Minus 5%	≤4	**3**	**On trajectory**


Trust Apportioned E. coli Bacteraemia Cases Apr - Dec 2021
10
8
6
4
2
0
4
5
6
7
8
9
10
11
12
Hospital Onset - Healthcare Associated,Healthcare Associated
Community Onset - Healthcare Associated,Healthcare Associated


Trust Apportioned Klebsiella spp. bacteraemia cases Apr - Dec 2021
5
4
3
2
1
0
4
5
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8
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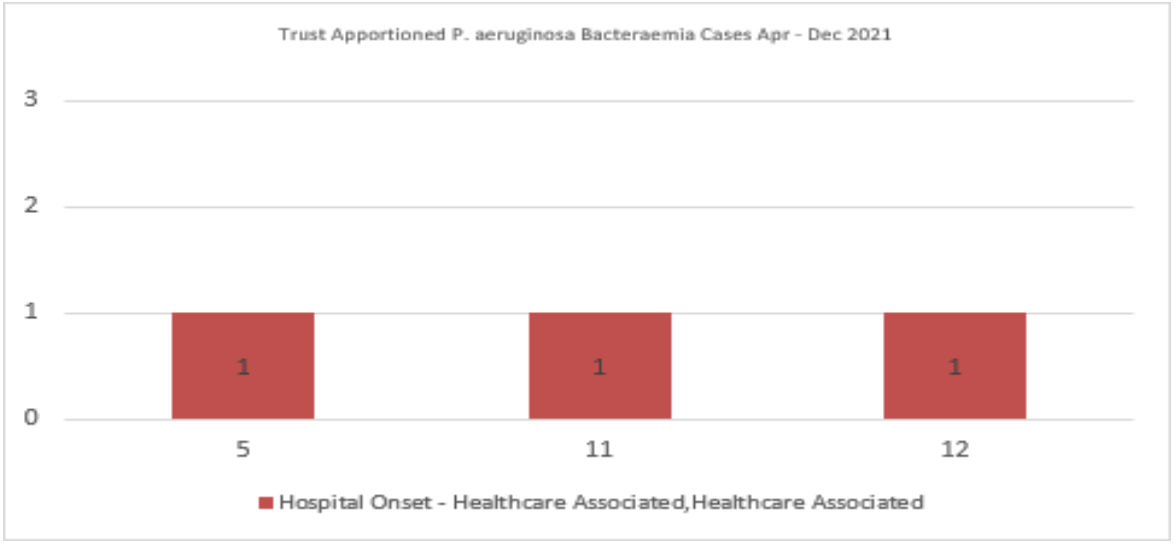
11
12
Community Onset - Healthcare Associated,Healthcare Associated
Hospital Onset - Healthcare Associated,Healthcare Associated


Trust Apportioned P. aeruginosa Bacteraemia Cases Apr - Dec 2021
3
2
1
0
5
11
12
Hospital Onset - Healthcare Associated,Healthcare Associated

The Trust has a planned schedule of ward visits that have been carried out with the support of the Quality Academy to review tests of change.

The Infection, Prevention and Control (IPC) Team and the Quality Academy will review the revised Toolkit (NHS, 2020) and re-assess additional actions required.

GNBSI has been added to the Draft revision of the IPC strategy.

Two wards have higher incidence of UTI associated GNBSI and will be supported with further UTI prevention strategies. The UTI pathway has been revised and is awaiting ratification.

Q4 Implementation Plan

The GNBSI Collaborative will continue with regular education sessions for all wards and department using the Quality Improvement (QI) methodology to test changes in practice and to develop a package of evidence-based changes to be embedded across the rest of the organisation. This will be supported by the QI and IPC teams who will conduct regular ward walkarounds.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Lead: James Wallace, Deputy Clinical Director for Emergency Care

Why we chose this priority

Communication is fundamental in the decision-making process regarding the completion of a DNACPR form, for patients and how options and recommendations for DNACPR are discussed with patients, carers and their families.

What success will look like

Improvement in the communication processes when completing a DNACPR form for patients by demonstrating a reduction in the number of complaints and incidents citing DNACPR communication as a concern from patients, carers, and their families.

Improvement in the number of wards that are compliant in relation to documented discussions with patients, carers, and their families. on the completion of the DNACPR in the patients' medical records.

Q3 progress

Progress related to the work plans and action plans have been delayed due to operational pressures but significant improvement has been made since the introduction of this priority. The latest DNA CPR audit presented at Patient Safety and Clinical Effectiveness Sub Committee confirmed over 90% compliance with measures indicated.

Q4 Implementation Plan

A further DNACPR Quality Audit to be undertaken to review the use of and completion of DNACPR forms.

Ensure DNACPR education and training package is delivered to optimise the number of staff trained to ensure accurate completion of DNACPR forms.

COVID-19 Recovery – Ensure a robust process for the proactive management of waiting lists and early recognition of potential clinical harm
Lead: Zoe Harris, Director of Operations and Performance.
Why we chose this priority
The COVID-19 pandemic has challenged the NHS in many different ways, including operational delivery, capacity and capability. The Trust will continue to ensure that a robust and proactive process for the management of waiting lists is in place to avoid unnecessary delays to clinical review and treatment potentially resulting in clinical harm.
What success will look like
A clear process of clinical triage of waiting lists for each speciality is in place. Three weekly meetings or more frequent if necessary to review any potential clinical harm from patients on a waiting list and follow existing governance process for investigation. Referral to Treatment Time (RTT) wait times minimised.
Q3 progress
The Trust are on trajectory to achieve compliance with 104-week patients who are awaiting appointments. A revised stretch target has been submitted in relation to our admitted and non-admitted targets following additional central funding. In December 2021 the Trust will achieve the trajectory for non-admitted but are forecasting to be just short of achieving the admitted target as this was impacted by the rise in COVID-19 levels. The Trust will continue to prioritise the longest waiting patients and those of greater acuity and urgency (Urgent, P2 and long waiters) in line with local and national recommendations.
Q4 Implementation Plan
Submission regarding performance on our waiting times to NHS England/Improvement has been completed for Q4. Compliance and performance is monitored via the weekly Performance Review Group and Clinical Services Oversight Group. Specific targets included as part of the submission are: • Completion of patient waits over 104 weeks by March 2022 except where patients whose choose to wait longer.

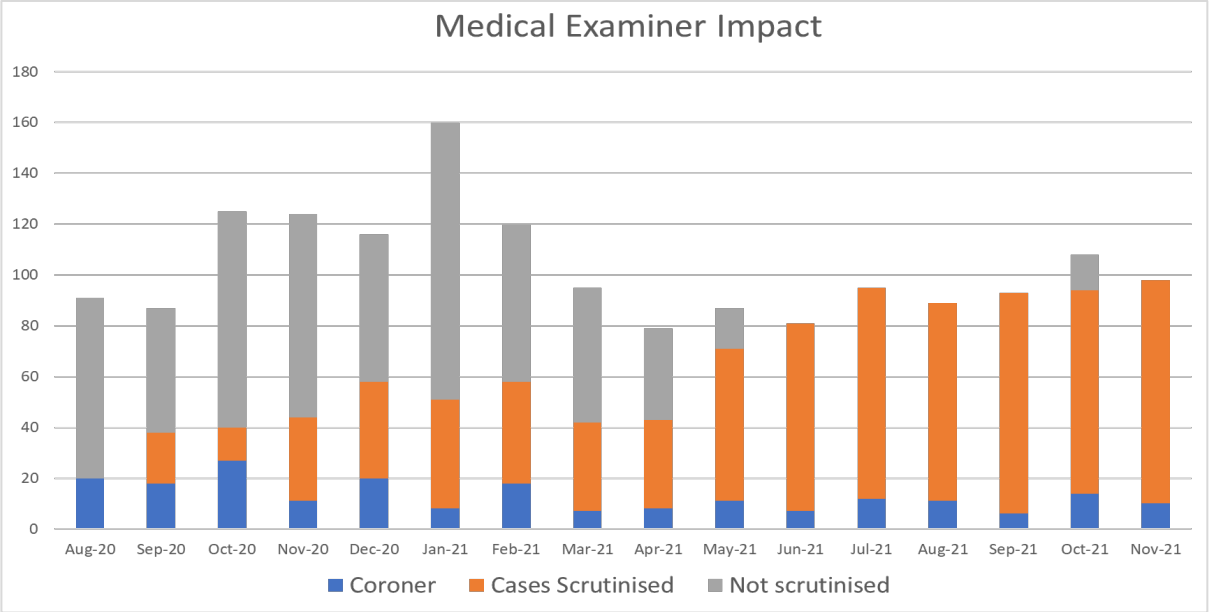
- Hold or where possible reduce the number of patients waiting over 52 weeks – in accordance with our H1 trajectory.

The Trust to continue to stabilise waiting lists with continued oversight at the weekly Clinical Services Oversight Group.

Clinical Effectiveness Strategic Quality Objective: Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.
Medical Examiner
Executive Lead: Medical Director **Lead:** James Williamson, Chief Medical Examiner / Alison Talbot, Associate Director of Governance
Why we chose this priority
The Medical Examiner (ME) role was introduced in April 2019 following the Harold Shipman inquiry. The Medical Examiners function is designed to provide a voice to those who have sadly lost a loved one and ensure that families are able to ask questions to answer that they may need. Through further embedding this role across the Trust, the ME can enhance the governance and regulatory systems by scrutinising all non-Coronial Deaths of patients (not under review or inquest by the coroner) and recommend actions and areas for improvement. Acting as the pilot site for the implementation of the ME service into community services.
What success will look like
Embed the Medical Examiner system across the Trust. 100% of deaths will be reviewed by the Medical Examiner Early identification of patient safety issues, highlighted to the Governance and the Mortality Review Group, with appropriate actions taken for improvement. A reduction in the number of Coroners Inquests when the service is fully embedded. Enhanced family experience and explanations on how their loved one died, improving the experience for families. Enhance the support already provided by the bereavement service.
Q3 progress
The Trust has positively continued the successful implementation of the Medical Examiner Service at Warrington and Halton Hospital.

The Chief Medical Examiner advises that the Trust have achieved 100% scrutiny of all non-Coronial Deaths with a slight decrease in October 2021 due to annual leave.

The graph below details the reviews undertaken and the Medical Examiner impact since it began in August 2020.



An additional Medical Examiner has successfully been appointed to in Q3.

A funding envelope has been received which outlines the provisional funding for the community role out of the ME service. This has been factored into the recruitment of additional resource.

Q4 Implementation Plan

Expansion of the medical Examiner services into the community during 2022.

Continue to provide notifications to our governance team, but also reach out to the equivalent teams in the community.

Recruit to an additional Medical Examiner Officer to support with the community Medical Examiner service role out.

Evidence-Based Interventions

Executive Lead: Kimberley Salmon Jamieson, Chief Nurse

Lead: Alison Talbot, Associate Director of Governance/Medina Yassin, Clinical Effectiveness Manager

Why we chose this priority

We aim to do the right thing for patients by ensuring decisions about health care are based on the best available, current, valid, and reliable evidence. The National Institute for Health and Care Excellence (NICE) guidelines are evidence-based recommendations for health and care. They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings.

This priority seeks to reduce the number of inappropriate interventions patients receive by utilising NICE, NICE-accredited or specialist society guidance and audits.

Compliance will reduce avoidable harm to patients, deliver safer patient care, address unwarranted variation and to ensure that clinicians are supported to provide the best care for patients, and free up limited resources.

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. GIRFT's model of analysing data to uncover best practice supports the identification of ideal service pathways and provides case studies for Trusts to adapt to their own needs. GIRFT has continued to help specialties refocus within the constraints of COVID-19, adopting changes that did not seem possible before the COVID-19 pandemic.

What success will look like

Complete an annual programme of local and national clinical audits.

Participate in all relevant national clinical audits that we are eligible to partake.

Review all published national audit reports and produce a management summary and action plan, where relevant.

Ensure NICE guidance is reviewed and, where relevant, implemented and embedded into everyday clinical practice.

Over 90% compliance to be achieved for NICE guidance which are relevant to the Trust.

Implement recommendations arising from National Confidential Enquiries (NCE's), where relevant to the Trust.

Implement recommendations and action plans from the Getting it Right First Time Programme (GIRFT).

Q3 progress

Audit

An annual programme of local and national clinical audits has been developed. Compliance with audits undertaken are monitored at the Patient Safety and Clinical Effectiveness Sub Committee

NICE

The NICE compliance has reached and maintained above WHH target of 90% since April 2021. NICE compliance is currently at 92%.

GIRFT

During Q3 the Trust had a deep dive for Urology and a virtual review of Trauma and Orthopaedics. Feedback is currently awaited following both these reviews.

Action plans for specialities were updated in Q3. Due to operational pressures, agreement, and rollout of the new GIRFT process, was paused until Q4. The overarching Trust action plan will be revised to ensure further improvements are made in line with the new GIRFT Trust process.

Q4 Implementation Plan

Audit

To implement the annual programme of local and national clinical audits within allocated timescales.

NICE

The newly appointed Clinical Effectiveness Manager will be working with each Clinical Business Unit to target individual compliance as well as monitoring the Trusts overall compliance to maintain above 90%

GIRFT

The Medical Director is reviewing process to consider how best to implement GIRFT process effectively across the organisation.

Clinical Business Units (CBU) Governance

Lead: Alison Talbot, Associate Director of Governance

Why we chose this priority

Good governance is a key component in supporting the delivery of quality healthcare. As such, regular developmental reviews of governance structures are good practice.

Robust governance arrangements are in place to operate effectively at Care Group, CBU and Specialty level. This priority focuses on ensuring that the governance processes are further strengthened, and lessons are widely shared for learning.

This is a continuation of a 2020/21 Quality Priority.

What success will look like

A reduction in high and moderate or major harm identified and monitored via incident reporting.

Increase in incident reporting to show an open and transparent reporting culture.

Promoting just culture amongst staff.

Clear and robust governance arrangements, with appropriate levels of accountability established.

Clearly documented discussions at local CBU governance meetings and clearly defined actions.

No duplication or gaps in assurance.

A key focus on key quality issues.

Open and transparent challenge at Care Groups, CBU and Specialty level.

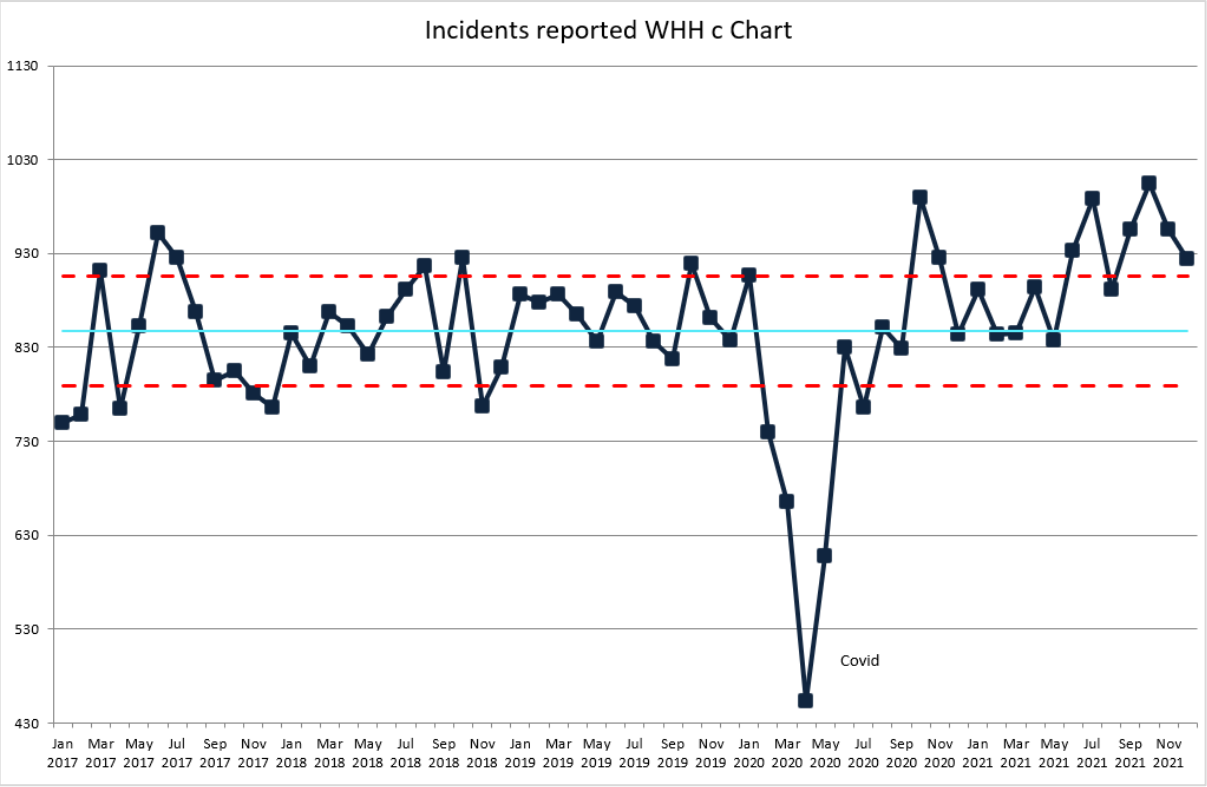
Robust risk registers in place and action plans for high scoring risks in place and implemented timely

SMART action plans for incidents and complaints and implemented within allocated timescales

Q3 progress

Incidents

The data shows an overall improved performance in incident reporting in the fact that Incident reporting continues to increase as shown in the graph below. These are monitored weekly through a robust governance framework. This also shows a positive reporting culture as the data shows that incidents reported as low, or no harm are high and moderate or major harm are low. This demonstrates a safe and transparent culture.



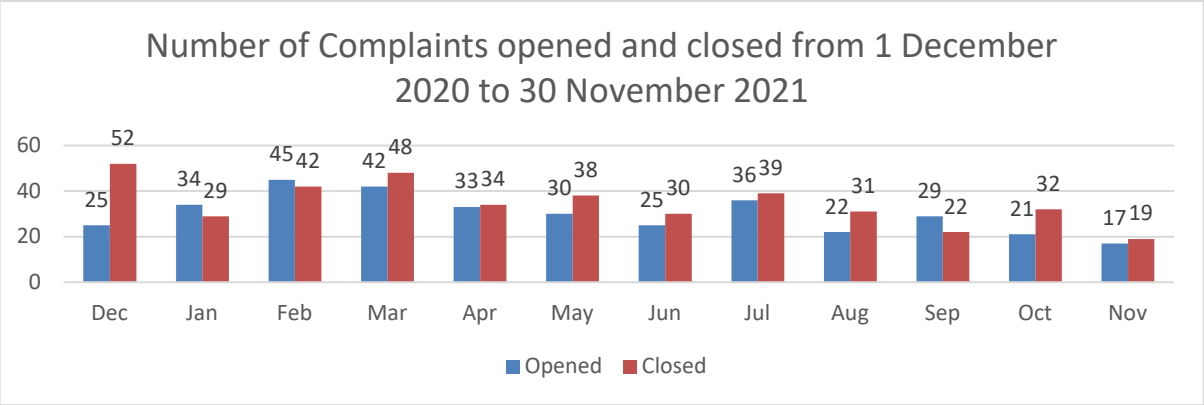
A staff leaflet supporting managers and staff members involved in incidents was developed by the Associate Director of Governance and Patient Safety Manager in quarter 3, which supports staff who have been involved in an incident.

Duty of Candour

The Trust has achieved 100% compliance with notifying a patient of a verbal and written Duty of Candour (DoC) within 10 working days after becoming aware that a notifiable safety incident has occurred. This is a key focus for each CBU, and it is important that early conversations with the families are had.

Complaints

A key focus in quarter 3 has been on reducing the number of formal complaints to the Trust with a drive to increase the number of PALS queries, which can be resolved quickly. In December 2021 the Complaints Department had the lowest number of complaints open (33). The table below notes the number of complaints opened and closed. This increase in performance is largely attributed to engagement from each of the CBUs to support with timely resolution.



Risk Management and Governance

A key focus in quarter 3 was to review risk management within the Trust to ensure the following:

- The risk processes and risk registers are continually monitored by the CBU Governance meetings and the Trust monthly Risk Review Group.
- Risk registers are updated regularly and kept in date.
- There is a positive and open risk management culture throughout the Trust.
- Staff are aware of the process for the management of risk at a local and Clinical Business Unit (CBU) level.
- Identification of any training needs i.e., Risk Assessment Training. A programme of training will be rolled out in quarter 4.

Q4 Implementation Plan

Develop a toolkit for completing an investigation as an aid to support staff undertaking reviews.

Continue to encourage the completion of the complaints response within the allocated timescales.

Continue to work with the CBU's around all aspects of Governance.

A review of the Trust's Risk Management Strategy will take place in quarter 4 with clear objectives to further strengthen the risk management process.

Patient Experience Strategic Quality Objective:
By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

End of Life – Serious Illness Programme - Better Communication, Better

Leads: Alison Coackley, Consultant.

Why we chose this priority

The Serious Illness Care Programme - Better Communication, Better Care - is a system-level intervention designed to improve the lives of people with a serious illness by optimising the timing, frequency, and quality of serious illness conversations.

Comprising clinical tools, training, support, and systems innovations, the programme empowers patients to actively participate in planning for the future with their illness. It enables clinicians and other professionals in the wider healthcare system to personalise care according to the goals and priorities of individual patients.

Effective communication is key to ensuring that a patient feels empowered to input into their healthcare needs and to ensure that they understand the discussion that has taken place.

What success will look like

The Trust will have an established an organisational process in place for regular screening of patients at risk of death within 12-24 months.

Increased number of patients screened for risk of death within 12-24 months.

Pilot areas will have scheduled and preparation processes in place.

Patient, family and clinical tools will be in place and being utilised.

100% of serious illness conversations are documented in the agreed template.

75% of patients are satisfied with the serious illness conversation.

Q3 progress

Due to staffing pressures relating to the COVID-19 pandemic, this priority has not progressed. This has been escalated to the Deputy Medical Director.

Q4 Implementation plan

Consideration is being given to the reallocation of this programme or next steps. This is being reviewed by the Medical Director.

Learning Disabilities Strategy and Mental Health Strategy
Leads: Learning Disabilities and Adult Mental Health Lead: Wendy Turner, Lead Nurse for Adult Safeguarding Children's Mental Health Lead: Katie Clarke, Lead Nurse for Children's Safeguarding
Why we chose this priority
The NHS Long Term Plan has detailed that NHS staff will receive information and training on supporting people with a learning disability and/ or autism. Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) will be expected to make sure all local healthcare providers are making reasonable adjustments to support people with a learning disability or autism. Over the next five years, national learning disability improvement standards will be implemented and will apply to all services funded by the NHS. These standards will promote greater consistency, addressing themes such as rights, the workforce, training competencies, specialist care and working more effectively with people and their families. By 2023/24, a 'digital flag' in the patient record will ensure staff are able to access GP records to review if a patient has a learning disability or autism. There is an internal flagging system in place at Warrington and Halton Teaching Hospitals NHSFT that allows staff to know when patients with an LD diagnosis has been admitted or is due into an outpatient clinic. The implementation of the Trust Learning Disability Strategy and Mental Health Strategy will improve the care delivered to these patient groups.
What success will look like
Implementation of the Trust Learning Disability Strategy will ensure that the needs of people with learning disabilities and autism are met to the highest standard, optimising clinical outcomes and patient experience. Implementation of the Trust Mental health strategy will evidence that dedicated mental health and psychology provision as part of an integrated service can substantially reduce poor health outcomes and increase the quality of Mental Health Act provision.
Q3 progress
Due to operational pressures and staff absence related to the COVID-19 pandemic, planned progress for quarter 3 has been impacted. It is anticipated that this will progress in quarter 4. Although the Trust Learning Disability Strategy and Mental Health Strategy have been agreed, circulated and discussed with work plans underway and under scrutiny it has been recognised that there has been no wider

formal launch of these. Therefore, a formal launch and further promotion of the strategies is to be delivered.

Progress related to the work plans and action plans will continue to be monitored with concerns escalated via the Safeguarding Committee and a review of the progress of these will be provided in the next update.

The Learning Disability (LD) and Mental Health (MH) Steering Groups have not taken place due to operational pressures, therefore the updates from CBU's regarding progress of the strategy workplan actions has not been received, however the following updates can be offered from the Safeguarding Teams during quarter 3:

- The LD and MH workplans associated to the strategies are monitored via the respective Steering Groups with HLBP to Safeguarding Committee.
- LD and Autism Training: Daily training sessions continue to be delivered at levels 1 and 2 with twice monthly level 3 sessions. An audit has been completed regarding the effectiveness of training with positive results demonstrated. Staff have reported increased knowledge of this area of their practice and training is ahead of trajectory.
- WHH has 20 champions across the Trusts wards and departments.
- Makaton Monday weekly sessions provided via Trust Wide Safety Brief are well received
- Alerts of patients on the Trusts EPR system is now in place for Autism as well as LD.
- The Lead Nurse Adult Safeguarding attends the Warrington LD board, the Cheshire and Merseyside LD improvement group and regional LD network and transition meetings
- The Lead Nurse for Safeguarding Children attends the Child Health Improvement Committee.
- ICE notifications have been amended so that staff can inform the Adult Safeguarding Team when patients are placed under a section of the Mental Health Act, or if they arrive at WHH under section.
- Posters have been placed on all wards asking staff to speak to patients about their mental health on a daily basis.
- The Trust website has been updated to ensure it contains information about where patients can access mental health support.
- The Lead Nurse for Safeguarding Adults attends the Halton Mental Health Board.

Q4 Implementation plan

Work will continue to proceed to plan the formal launch of the Learning Disability and Mental Health Strategies during quarter 4. Both Safeguarding Committee and the LD and MH Steering Groups will recommence with subsequent reporting channels from CBUs, and Care Groups reviewed. The following documents will be progressed in quarter 4:

- The Trust Reasonable Adjustments SOP and Care Planning Tool is scheduled for ratification at the February 2022 Safeguarding Committee.
- The Trust will launch an Easy Read communication aid which is due for ratification at March 2022 Safeguarding Committee following the Trust Readers Panel.
- An Easy Read version of the Learning Disability Strategy is currently underway.
- Patient information regarding coming into hospital and staying in hospital is underway in an Easy Read format.
- Progress to submit The National Improvement Standards which underpins the Learning Disabilities Strategy will be submitted.

- In line with an objective within the LD Strategy, 20 LD champions are now in place throughout WHH wards and Depts. Quarterly meetings and enhanced training ensure that the role of champions support the implementation of the LD strategy

Children's Mental Health

- The recruitment of a Children and Young Person's Mental Health Liaison Practitioner, funded by the CCG and Warrington Local Authority.

Adults Mental Health

- Work will progress on the design and delivery of the Trust Mental Health training following feedback from staff on their mental health knowledge. The Adult Safeguarding Team will continue to work with Merseycare Mental Health Liaison Team to build a training programme and e-Learning package for all staff to have access to Mental Health Act training.
- Work has happened to improve how ICE notifications let the safeguarding and MH liaison teams know about patients receiving MH care. Staff are now able to use ICE to inform the Adult Safeguarding team and the MH liaison team when patients are placed under a section of the MHA, or if they arrive at WHH under section.

Improve patient experience by enhancing the standard of nutrition and hydration.
Leads: Jennifer McCartney, Head of Patient Experience and Adam Harrison, Patient Experience and Inclusion Manager
Why we chose this priority
Varied, food and hydration are an integral part of a patient's treatment, giving the nutrients and fluids needed to support recovery from illness or surgery. Meeting the nutritional and hydration needs for all patients is also a CQC regulatory requirement (Regulation 14). In doing so we will enhance the patient experience and ensure that patients' needs are met.
What success will look like
Successful implementation of the Nutritional Steering Group. Implementation of the recommendations and actions in the Trust Nutritional Care Strategy 2019-2022. New menus designed with an extended choice of meals. Board members to undertake 2 food tasting sessions for assurance of food standards. Reduction in the number of complaints/concerns raised in relation to quality and accessibility of food. Improved patient experience, patient experience survey in relation to quality and accessibility of food.
Q3 progress
During quarter 3 work has continued to ensure the delivery of the recommendations outlined in the "Independent Review of NHS Hospital Food" report, although COVID-19 and operational pressures have impacted on delivery timescales. This is monitored via an action plan at the WHH Expert Food Panel,

ensuring that hydration and nutrition continue to remain an integral element of the patient experience quality priorities for 2021-22.

The Expert Food Panel following a review of its Terms of Reference convenes in a multi-disciplinary approach to ensure that through discussion an inclusive style is adopted. This triangulates into an action plan that focuses on improvements in patient care, wellbeing and experience.

During quarter 3, the expert food panel adopted a three-phase approach to drive improvements in nutrition and hydrations, they include:

- **Phase 1 –** A communication piece to ensure all wards and departments are aware of 'the offer' to patients' meals, this includes the process to follow for supplementary menus and special diets, e.g., cultural requirements. This is currently ongoing into quarter 4 with a standard operating procedure (SOP) being designed for the service of food at ward level.
- **Phase 2 –** Review of the current catering questionnaire to gain qualitative feedback from patients. This includes the implementation of questionnaires in accessible formats (e.g., Easy Read) to ensure feedback is received from all patient groups.
- **Phase 3 –** Begin to utilise feedback received through phase 2 to enhance the Expert Food Panel action plan to meet improvements, with the patient voice driving change.

The National Adult Inpatient Survey 2020 results highlighted focused improvement is still required on nutrition and hydration. The quantitative findings and subsequent comments report will be incorporated into the action plan for the Expert Food Panel and further details related to dietetics will be shared through the Trust Nutritional Steering Group by the Patient Experience and Inclusion Team.

Additional progress to date against the action plan in place includes:

- Patient nutritional and hydration needs is now a standing item on key meetings within the Trust including the Patient Experience Sub Committee.
- Review of a Standard Operating Procedure to ensure standard practice for patient mealtimes.
- Review of the Catering Policy outlining our standards.
- A 1.8million capital bid has been secured in order to upgrade the kitchen on the Warrington site.
- The introduction of snack boxes for adults and "pizza take out" for children's ward to support patient choice.
- Food tasting with key stakeholders – Board members, Governors, Patient Experience and Inclusion Team to support ongoing improvements.

Q4 Implementation plan

A communications plan will be rolled out to all wards and departments in quarter 4 to ensure patients receive a consistent offer, which meets their nutrition, hydration and specific dietary and cultural requirements. This will be monitored monthly by the Expert Food Panel in conjunction with feedback received from the patient feedback questionnaire. The trial of questionnaires in other formats will be shared across the Trust.

Nutrition and hydration will continue to be monitored in a multi-disciplinary approach to ensure that the needs of all patients are considered.

2. Progress on Maternity Quality Priorities and Assurance

This Quality Strategy is an important link to the WHH Maternity Services Strategy as it sets out additional measures to drive improvement further and faster. The following information provides an overview of progress and assurance regarding the maternity quality indicators for 2021/22.

Maternity and **Quality Indicators**
Leads: Catherine Owens, Director of Midwifery
Why we chose this priority
We aim to put the family at the centre of decisions so that all women, babies and their families get the highest quality of care which meets their needs, and improves their overall physical, mental and emotional wellbeing.
What success will look like
• Maternity Performance Indicators dataset show good performance indicators monitored at the CBU, Maternity Governance meetings and reviewed at ward meeting. • Compliance with the Ockenden report 7 immediate and 26 local safety actions supported and benchmarked with our peers. • Compliance with the NHS Litigation Authority (NHSLA) 10 safety standards for maternity services. • Implemented the learning from the Healthcare Safety Investigation Branch (HSIB) safety recommendations • Increase in incident reporting to show an open and transparent reporting culture. • Promoting just culture amongst staff. • Pregnancy remains safe, MBRACE actions identified and implemented to prevent women from dying in the future • Improved outcomes of the maternity services following implementation of the actions following the gap analysis using the perinatal safety surveillance tool and recommendations from the report - Maternity Review Better Births: Improving outcomes of maternity services in England. • Utilise the maternity self-assessment tool to help maternity services achieve sustained improvement across the five CQC domains – i.e., are services safe, effective, caring, responsive to people's needs, and well-led. • Improved patient experience and maternity services through ongoing feedback and collaborative working.
Q3 progress
Completed the Maternity Transitional Monitoring Approach (TMA) self-assessment tool to help maternity services achieve sustained improvement across the five CQC domains – i.e., are services safe, effective, caring, responsive to people's needs, and well-led. The progress of the Maternity indicators is comprehensively detailed in the Maternity TMA report Progress is monitored on a monthly basis at the M2O Steering Group, Patient Safety and Effectiveness Committee and the Quality Assurance Committee.

Progress regarding the implementation of the Ockenden Provider report an action plan has been developed and all Safety Actions are on track and is reported monthly to the Quality Assurance Committee. The Regional Local Maternity System Team has announced each provider will be invited to provide an update of their Ockenden action plan as part of a face to face assurance visit. The date has yet to be confirmed.

Good progress is being made on the implementation and embedding of the actions within the maternity combined action plan on Moving to Outstanding which is monitored at the monthly Moving to Outstanding Steering Group (M2O)

The incident reporting data shows an overall improved performance in incident reporting in the fact that Incident reporting continues to increase. This demonstrates a safe and transparent culture. These are monitored weekly through a robust governance framework. This also shows a positive reporting culture as the data shows that incidents reported as low, or no harm are high and moderate or major harm are low.

Q4 Implementation plan

Progress related to the Ockenden action plan will continue to be monitored with concerns escalated to the Quality Assurance Committee until full compliance is achieved and all actions are embedded.

Continue to monitor progress regarding the implementation of the Ockenden Provider report action plan until all Safety Actions have been implemented and embedded; Reported monthly to the Quality Assurance Committee.

To await confirmation of a date to be invited to present to the Regional Local Maternity System Team to provide an update of the Ockenden action plan as part of a face to face assurance visit.

Progress related to the maternity combined action plan on Moving to Outstanding will continue to be monitored with concerns escalated via the monthly Moving To Outstanding Steering Group (M2O) and a review of the progress of these will be provided in the next update.

Maternity Voices Partnerships (MVPs) to provide ongoing feedback to continuously improve maternity services.

3. Progress on the National Quality and Safety Indicators and Assurance

The metrics within the Accountability and Oversight Framework demonstrates the important link with the local quality indicators within the Quality Strategy. The following information provides an overview of progress and assurance regarding the National Quality and Safety Indicators. for 2021/22.

National Quality and Safety Indicators

Executive Lead: Chief Nurse / Deputy Chief Executive
Leads: Director of Integrated Governance & Quality

Why we chose this priority

As well as recognising well-led services, the Accountability Oversight Framework (Department of Health 2017) enables early identification and support if performance falls below the expected level. Safety measures are weighted and override all other measures, ensuring that safety is central to every Hospital, including WHH's Strategy and that leadership teams are held to account for the quality and safety of their services.

The metrics within the Accountability and Oversight Framework demonstrates the important link with the local quality indicators within the Quality Strategy.

What success will look like

- Performance Indicators within the Accountability Framework will demonstrate good performance and improved outcomes for our patients which are reported and monitored at the Quality Assurance Committee and the Board of Directors.

Q3 progress

An integrated performance dashboard and quality dashboard is reported and monitored monthly to the Quality Assurance Committee and to the Board of Directors. Where possible we include performance indicators to measure and benchmark our progress against each quality improvement priority and local quality indicators. The report focuses on progress and any areas of change since the last update was received.

Q4 Implementation plan

Progress related to the local and national indicators will continue to be monitored with concerns escalated to the Quality Assurance Committee and the Board of Directors.

A review of the progress of these will be provided in the next update.

4. Progress on Research and Innovation

The link between the Quality Strategy and the link between research active organisations and those that deliver the highest quality care is clear and so our commitment to research will be essential if we are to continually improve the quality of the services we deliver. The following information provides an overview of progress and assurance regarding the delivery of research and innovation for 2021/22.

Research and Innovation Indicators

Leads: Director of Integrated Governance and Quality

Why we chose this priority

At both Warrington and Halton Hospital sites we participate in studies to promote medical research and improve care in the future for certain conditions. These studies are large studies that often involve many patients in many different hospitals. On March 2021 WHH opened the Halton Clinical Research Unit and developed a strong partnership with Liverpool University Hospital Trust and the Clinical Research Network. Urgent Public Health Studies have been undertaken at this site and a substantive workforce is in place.

Our Research and Development (R&D) Department works closely with the clinical Business Units within the hospitals to ensure that we can offer patients the opportunity to participate in high quality research that has been approved by an independent ethical body.

The link between research active organisations and those that deliver the highest quality care is clear and so our commitment to research will be essential if we are to continually improve the quality of the services we deliver.

What success will look like

- Maintain or improve the number of research trials available for patients to participate in and
- Improve the number of patients participating in clinical research trials.
- Maintain and improve performance in initiating clinical trials and studies.
- Improved research and Innovation by acting upon regular feedback from patients who have experienced care as part of a research study.

Q3 progress

The Research and Development department is funded by the National Institute for Health Research and takes part in nationally funded studies. In addition, WHH have the Halton Clinical Research Unit (HCRU) and have developed a partnership board with Liverpool University Hospitals NHS Foundation Trust (LUHFT) and the Clinical Research Network. Discussions have also been held with Alder Hey regarding the opportunity to undertake paediatric research.

Our own dedicated research and clinical trials facility at our Halton Hospital site supports our research ambitions and continues to widen participation in research across Warrington, Halton and surrounding areas.

We have supported our staff to develop skills in research and innovation and routinely offer patients in all specialities the opportunity to participate in high quality research studies. In addition, we have strengthened research governance and expanded the research and development support function. Furthermore, we have secured a clinical fellow and substantive staffing.

Q4 Implementation plan

- Build research activity into our measures of performance and clinical quality.
- Work closely with our commercial development team to identify opportunities to generate income, reinvest and drive quality of care through best evidence and innovation.
- To scope academic research opportunity.
- Progress related to the research and innovations programmes of work and the quality metrics will continue to be monitored with concerns escalated via the Quality and Assurance Committee and a review of the progress of these will be provided in the next update.

5. Progress on Equality, Diversity and Inclusion Quality Indicators and Assurance

The link between the Quality Strategy and the link between organisations providing high quality, accessible and responsive services that deliver the highest quality care is clear and so our

commitment to this will be essential if we are to continually improve the quality of the services we deliver. The following information provides an overview of progress and assurance regarding the delivery of Equality, Diversity, and Inclusion Quality Indicators for 2021/22.

Equality, Diversity and Inclusion Quality Indicators
Executive Lead: Chief Nurse / Deputy Chief Executive **Leads**: Deputy Chief Nurse
Why we chose this priority
As a Trust, we remain committed to promoting equality and diversity amongst our workforce, ensuring our services and employment practices are fair, accessible, and inclusive for the diverse communities we serve and the workforce we employ. This is reflected and reinforced in our 'vision and values', celebrating diversity and creating an inclusive culture for our patients and workforce.
What success will look like
• Positive patient experience for all patients regardless of their identity and protected characteristics. • Accessible information and communication with patients. • Recording of equality data so that reasonable adjustments are identified and provided. • Reduced health inequalities and advancing equality of opportunity for all patients
Q3 progress
▪ We are taking steps to ensure that we are a great employer who values and welcomes the different ideas, skills, behaviours and experiences of our staff. ▪ We also foster a culture that promotes wellbeing and mental health and provides support to enable all our colleagues to thrive, particularly during the impact on staff of the difficult times during the COVID-19 pandemic. ▪ We monitor staff experiences via the staff survey and respond appropriately. ▪ We have equality and diversity champions at a local level across the trust. ▪ We foster talent which is fair and inclusive and ensure equitable career progression for all staff groups and for staff of all protected characteristics ensuring a fair recruitment process. ▪ The Trust actively engages with local community partners, patient groups and advocacy services to ensure that we react to our local community population and their needs. ▪ The Trust successfully completed an application for the In-Trust Merseyside and Cheshire Navajo Charter Mark which recognises WHH as an inclusive healthcare provider and employer, specifically for the LGBTQ+ community. This will be assessed in quarter 4. ▪ The Patient Experience and Inclusion Team with Healthwatch Warrington attended a focus group event to listen to experiences of the d/Deaf community in Warrington with a review of British Sign Language provision planned for quarter 4. ▪ CQC surveys have included monitoring of respondent demographics and characteristics as part of the survey completion. ▪ Developed digital stories and shared patient stories to drive improvement across the Trust, including a digital story voiced by the Diabetes Youth Worker, focusing on mental health, transitional services and improving health equality for young people with diabetes.

Q4 Implementation plan
▪ Continue working towards meeting the requirements of the anticipatory duty to make reasonable adjustments on public functions in the Equality Act. Meet the requirements of the public sector equality duty and NHS Contract ensuring completion of the NHS Equality Delivery System for 2021/22. ▪ Implement a more effective process for equality analysis by enhancing the current equality impact assessment process and tools. ▪ Work with Digital Analytics Team to develop equality demographic dashboards to enrich decision making and support analysis. ▪ Commence the internal Accessible Information Standards 12-month deployment plan in conjunction with the Trust Engagement and Involvement Team. ▪ Develop case studies to improve awareness and understanding of different protected characteristics amongst staff and patients. ▪ Continue to enhance the equality, diversity and inclusion workstream to focus on all protected characteristics for patients and workforce through engagement with community partners. A review of the progress of these will be provided in the next update.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

As detailed in Section 2 - Key Elements of this report.

4. IMPACT ON QPS?

The Quality Strategy was developed to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be.

5. MEASUREMENTS/EVALUATIONS

As detailed in Section 2 – Key Elements of this report.

6. TRAJECTORIES/OBJECTIVES AGREED

As detailed in Section 2 – Key Elements of this report.

7. MONITORING/REPORTING ROUTES

The Quality Strategy is monitored by the Director of Integrated Governance and Quality. Progress against some of the Quality Priorities is reported monthly to the Patient Safety and Clinical Effectiveness Sub-Committee and bi-monthly to the Quality Assurance Committee in the form of the Trust Integrated Performance Report.

A quarterly report providing an update on progress against all of the Quality Priorities within the Quality Strategy is provided to the Quality Assurance Committee.

Overall progress against the Quality Strategy is provided in this annual report submitted to the Trust Board of Directors and also annually in both the Quality Account and to the Clinical Commissioning Group via the Clinical Quality Focus Group.

8. TIMELINES

As detailed in Section 2 – Key Elements of this report.

9. ASSURANCE COMMITTEE

Progress in relation to the Quality Strategy is reported to both the Patient Safety and Clinical Effectiveness Sub-Committee and the Quality Assurance Committee.

10. RECOMMENDATION

The Board of Directors is asked to note the report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/05/78**	
SUBJECT:	**Infection Prevention and Control Strategy**	
DATE OF MEETING:	25 May 2022	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse Infection Prevention & Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	√ √ √
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments, and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	To provide the Trust Board with information on the Infection Prevention and Control Strategy 2022 – 20225.	
PURPOSE: *(please select as appropriate)*	Information | Approval | To note ✓ | Decision	
RECOMMENDATION:	The Trust Board is asked to receive the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	**QAC/22/05/118**
	Date of meeting	3 May 2022
	Summary of Outcome	Submit to Board
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Infection Prevention and Control Strategy	AGENDA REF:	BM/22/05/78

1. BACKGROUND/CONTEXT

Prevention of healthcare associated infections is a legal, financial, and morally compelling activity for the Trust. This Infection Prevention Strategy is integrated with several other local enabling strategies to support the Trust's mission to be outstanding for our patients , our communities and each other.

Infection prevention standards are fundamental to Covid-19, including recovery, where planned care is being stepped up safely to meet the needs of our local population. National guidance on Covid-19 is being updated regularly and these updates are considered to guide operational activity plans.

National drivers for infection control and cleanliness include (but are not limited to):

- NHS Standard Contract (2021/22) Minimising Clostridioides difficile and Gram-negative Bloodstream Infections B0720-nhs-standard-contract-21-22-minimising-clostridioides-difficile-and-gnbi-v1.pdf (england.nhs.uk)

- HM Government, (2019) Tackling antimicrobial resistance 2019-2024: The UK's five-year national action plan. UK_AMR_5_year_national_action_plan.pdf (publishing.service.gov.uk)

- NHS England and Improvement (2021) National Standards of Healthcare Cleanliness 2021 B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)

- NHS England and Improvement (2021) Infection prevention and control board assurance framework Briefing template (england.nhs.uk)

2. KEY ELEMENTS

The Strategy is focussed on the 5 key elements of infection prevention and Control and Covid recovery and will be promoted with the acronym SPACE-R:

- Surveillance
- Policy and audit
- Antimicrobial Stewardship
- Clinical Advice
- Education
- Recovery from Covid

There are 3 key objectives:

- Prevention of healthcare associated infections
- Strengthening antimicrobial stewardship
- Delivering high standards of environmental cleanliness

Full details can be found within the strategy document.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Action plan development and monitoring to meet the strategy objectives

4. IMPACT ON QPS?

- **Quality -** Putting patients first - Reducing avoidable harm from preventable healthcare associated infections
- **People** – Being the best place to work – Engaging and empowering all healthcare workers, patients, and their carers by providing education on evidence-based practice for infection prevention
- **Sustainability** – Working in partnership – To implement system wide learning on preventing healthcare associated infections and to work closely with procurement to ensure the Trust meets its corporate and social responsibility to the planet by reducing waste and re-using or recycling items appropriately. Decision making will consider the NHS ambition to be 'net zero' by 2040

5. MEASUREMENTS/EVALUATIONS

Measurement will include:

- Incident reporting and HCAI surveillance
- Antibiotic prescribing audits
- Cleanliness audit reports
- Surveillance of the Covid pandemic and link to Planned Care Group elective recovery programme

Successful implementation of this strategy is recognised as a dynamic process that will take account of changes both external and internal to WHH.

Ongoing feedback and engagement from our stakeholder will be considered in measures of success.

6. TRAJECTORIES/OBJECTIVES AGREED

- Objectives for HCAI prevention as per annual NHS Standard Contract (updated annually)

7. MONITORING/REPORTING ROUTES

This Strategy will be reviewed bi-annually by the Infection Control Sub-Committee and progress updates provided by High Level Briefing Papers to:

- Quality Assurance Committee
- Trust Board

8. TIMELINES

- 2022 – 2025

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10. RECOMMENDATIONS

- The Board is asked to note the Strategy

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Infection Prevention Strategy

2022 - 2025

SPACE-R

Contents

Welcome to our Infection Prevention Strategy

Kimberley Salmon-Jamieson

Chief Nurse & Deputy Chief Executive

Director of Infection Prevention and Control

We are proud to present our revised Infection Prevention and Control Strategy 2022 - 2025 which focuses on our continued commitment to preventing healthcare associated infections (HCAIs), delivering safe high-quality care and service recovery during the Covid-19 pandemic.

Aligned to our WHH Trust mission, vision and objectives outlined in the Quality, People and Sustainability Framework, this strategy places patients first and seeks to engage, educate, and empower staff, patients, and their carers' in preventing HCAIs.

Developed in partnership with staff across the Trust, WHH Governors and external partners, the strategy will be implemented via six key action areas which will be promoted using the acronym **SPACE-R.**

The Covid-19 pandemic brought infection prevention to the forefront in all health and social care settings. Learning has been vast, and staff have shown an ability to adapt to rapidly changing guidance as evidence emerged about this new virus. Infection prevention standards are fundamental to Covid-19, including recovery, where planned care is being stepped up safely to meet the needs of our local population.

Strategy progress will be monitored by our Infection Control Sub-Committee, Quality Assurance Committee and Board of Directors. Success will be measured by achieving the objectives which include demonstrable reductions in HCAIs, strengthening antimicrobial stewardship which aims to slow down the development of antibiotic resistant organisms and implementing new cleanliness standards.

We look forward to partnership working to implement this strategy and express our thanks to all WHH staff for their continued support of infection prevention and patient safety.

Prior Achievements

This infection prevention strategy builds on existing achievements in reducing HCAIs.
In 2020/21, WHH successfully reduced : -

- MRSA bacteraemia cases to 1 (from 24 in 2006/07) and,
- Clostridium difficile to 45 cases (from 393 in 2007/08)

Over time, the way these infections are counted and apportioned to the Trust has changed and these figures currently include patients who develop these infections within 28 days of being discharged from the Trust, making these achievements even greater.

New Challenges

In July 2021, quality requirements for NHS Trusts were extended from reducing Clostridium (Clostridioides) difficile (C. difficile) by one case, to include reducing Gram-negative bloodstream infections (GNBSI) by 5%. These infections include: - Escherichia coli (E. coli), Klebsiella Spp. (Klebsiella) and Pseudomonas aeruginosa (P. aeruginosa).

An ambition is set to build on the thresholds set this year and demonstrate year on year case reductions for these HCAIs. Our objectives will be updated annually to reflect this.

Strategy Success

Pivotal to the success of this strategy is alignment with our WHH mission, vison, values, aims and objectives.

Through a series of stakeholder engagement sessions, we have jointly agreed an infection prevention mission, vision, aims and objectives that reflect WHH's aspiration to be an outstanding Trust for our patients, communities, and each other.

Our Infection Prevention Mission is…

To work together to deliver outstanding healthcare by engaging, educating, and empowering healthcare staff, patients, and their carers to prevent healthcare associated infections.

Our Infection Prevention Vision is…

A world in which healthcare associated infections have been reduced to the lowest possible level.

Our Aims are…

Q - Putting patients first -
Reducing avoidable harm from preventable healthcare associated infections.

P – Being the best place to work –
Engaging and empowering all healthcare workers, patients, and their carers by providing education on evidence-based practice for infection prevention.

S – Working in partnership –
To implement system wide learning on preventing healthcare associated infections and to work closely with procurement to ensure the Trust meets its corporate and social responsibility to the planet by reducing waste and re-using or recycling items appropriately. Decision making will consider the NHS ambition to be 'net zero' by 2040.

Our Objectives are…

Linked to the WHH Quality Strategy and NHS England/Improvement (NHSE/I) requirements. These objectives will be revised annually, and progress considered when monitoring the strategy for success.

Healthcare Associated Infections
Linked to the patient safety domain of the WHH Quality Strategy: -

- 5% reduction in GNBSI
- Reduction in C. difficile cases by one
- Zero avoidable MRSA bacteraemia

Antimicrobial Stewardship

- Strengthening the current approach to antimicrobial stewardship
- Empower staff by education on optimum prescribing choices
- Provide assurance on optimum prescribing choices by robust auditing

Cleanliness
We recognise that all patients deserve to receive care in a clean and safe environment and the vital link this provides to preventing healthcare associated infections. In collaboration with the First Impressions programme WHH will: -

- Sign up to the Commitment to Cleanliness Charter
- Display star ratings for cleanliness in all areas
- Ensure the highest standards of cleanliness through our time to shine campaign
- Monitor cleaning standards and take action to improve where required

Our Values…

We recognise the importance of effective communication in all aspects of everyday life and that nothing is achieved in isolation. **Working together** will be pivotal to the success of this strategy alongside evidence-based education to achieve **excellence** in all we do. The approach will be **inclusive** of all relevant stakeholders, show **kindness**, compassion, and consideration of the feelings of patients with known or suspected infections and **embrace changes** in practice to prevent the spread of infection and improve safe care delivery.

Meet the Infection Prevention Team

Lesley McKay
Associate Chief Nurse for Infection Prevention and Control/Associate DIPC

Louise Meikle
Infection Prevention and Control Matron

Joanne Oldfield
Infection Prevention and Control Nurse

Aalifha Mariadhas
Infection Prevention and Control Nurse

Astasia Chantelle Jackson
Infection Prevention and Control Nurse

Amanda Millington
Infection Prevention and Control Secretary

Consultant Microbiologists

Dr Zaman Qazzafi
Consultant Microbiologist/ Infection Control Doctor/ Deputy DIPC

Dr Toong Chin
Consultant Microbiologist

Dr Janet Purcell
Consultant Microbiologist

Jacqui Ward
Lead Pharmacist in Antimicrobial Stewardship

Surveillance

Surveillance of healthcare associated infections involves collecting and analysing information. A key element to effective surveillance is timely feedback to clinical teams, with a view to generating action aimed at preventing further incidences.

The Trust participates in mandatory surveillance of: -

- E. coli bacteraemia
- Klebsiella spp. bacteraemia
- P. aeruginosa bacteraemia
- C. difficile
- Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia
- Meticillin-sensitive Staphylococcus aureus (MSSA) bacteraemia
- Orthopaedic surgical site infections

The GNBSI Prevention Group, supported by WHH's Quality Academy, has agreed 5 key action areas which are hydration, continence management, urinary catheter management, patient hand hygiene and urinary tract infection detection and management.

This Group uses surveillance data (results) to assess tests of change (activity) implemented to prevent infections (objective). This is an agile approach to performance management and uses a bottom-up approach to standard setting to meet objectives.

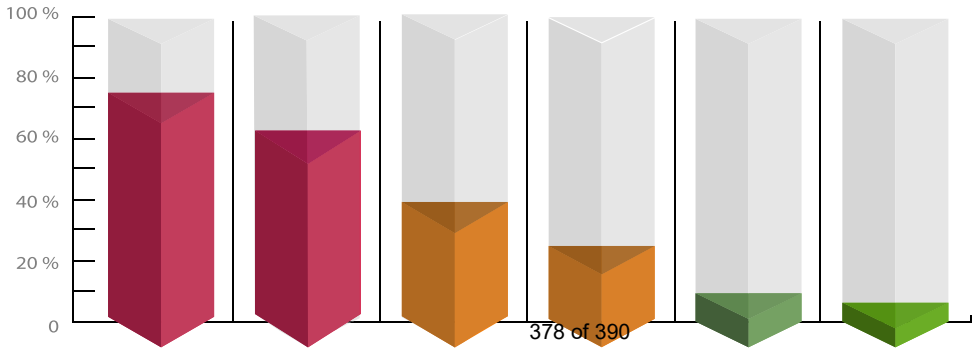
Healthcare associated infection prevention plans are in place for C. difficile and MSSA/MRSA bacteraemia that focus on hand hygiene, environmental cleanliness, appropriate specimen collection, antimicrobial stewardship, and use of asepsis for management of invasive devices.

Surveillance reports are shared monthly at Infection Control Sub-Committee meetings and by the Integrated Performance Report at the Quality Assurance Committee and Trust Board. Information is available on the Trust website for patients and members of the public that shows how we are doing.

Root cause analysis investigation is conducted into all cases of Trust apportioned C. difficile infection and learning is shared across all CBUs.

Surveillance is carried out on patients undergoing planned surgery for hip and knee replacements and the Trust has extremely low rates of infection for this type of surgery.

Data on surgical site infection rates can inform and influence improvements to minimise the risk of infection and help to clearly communicate the risks to patients. As some infections only become apparent after the patient has been discharged from hospital, post discharge surveillance is necessary. Additional types of surgery will be monitored for infection rates in partnership with the planned care group.



Policy and Audit

WHH have key policies in line with the Code of Practice of the Prevention and Control of Infections. These documents are evidence based and provide useful guidance on standards required by staff on caring for all patients including those with suspected or known infections.

To provide assurance on these standards a proactive programme of audit is in place.
The audit programme gives timely feedback on standards highlighting both good practice and areas for care improvement. The Audit plan includes: -

- Standard Infection Control Precautions – including hand hygiene
- High Impact interventions for care of invasive devices

Managers are asked to share audit findings with their teams and complete action plans to address any areas identified for improvement.

Additional audits are undertaken in response to any HCAI incidents/identified clusters of infection. These audits identify factors that may be contributing to the increase in infections so that timely action can be implemented to prevent further cases.

Antimicrobial Stewardship

Antimicrobial resistance (AMR) is considered by the World Health Organisation as one of the top ten global health threats to humanity. Mis/overuse of antimicrobials is a driver for development of antibiotic resistant organisms. Without effective antimicrobials treating common infections will be more difficult or impossible.

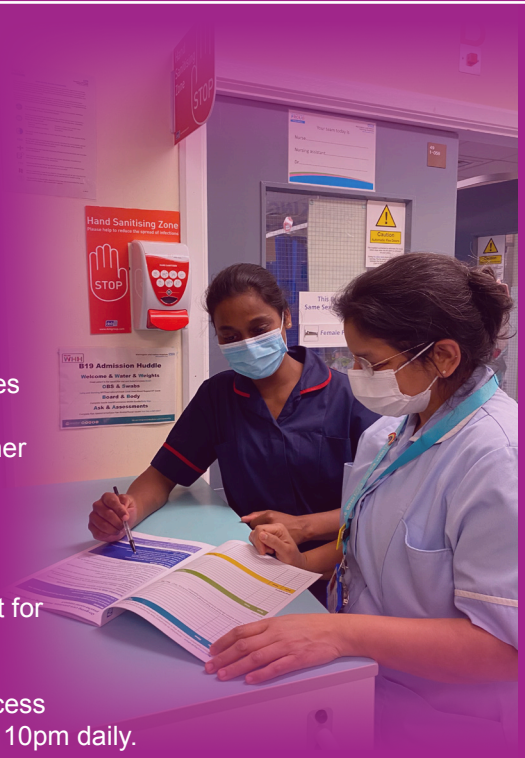
Whilst overall reduction of antibiotic use is necessary, it is essential to ensure when required the most appropriate antibiotic(s) is/are chosen.

WHH is committed to antimicrobial stewardship (AMS) and the following actions:-

- Making the antimicrobial audit programme more robust by investing in staffing
- Revising the approach to Point Prevalence Audits to collect data on 72-hour review
- Providing more meaningful audit data and timely feedback
- Addition of small focussed ‘temperature check’ 5/5 audits
- Refreshing membership of the Antimicrobial Management Steering Group (AMSG)
- Maintaining a multi-disciplinary approach to AMS ward rounds
- Implementing a digital solution that improves access to the Antimicrobial Formulary
- Continuing to work in close partnership with the IV therapy team in the OPAT MDT, to maintain high standards of AMS Strengthening the roles of all healthcare workers in stewardship
- Annual participation in World Antibiotic Awareness Week

We are WHH & We are PROUD to make a difference

Clinical Advice



The Infection Prevention and Control Team members are highly visible across the Trust and can be contacted for advice on a broad range of patient care needs, including but not limited to: -

- Infection control precautions for suspected/known infections - aligned to policies and guidelines
- Antimicrobial management
- Estate and facilities concerns that can impact the safety of staff, patients, or visitors to premises

Infection Prevention and Control Team members attend other committee meetings and groups including water safety, decontamination, and ventilation, to ensure integration of infection prevention and control across the organisation.

Infection Prevention and Control is considered at the outset for new builds and upgrades to existing buildings.

Antimicrobial management advice is available 24/7 and access to infection prevention and control advice is available up to 10pm daily.

Education

Aligned to our WHH Quality Strategy, we are committed to developing and enhancing patient safety through a learning culture. We view our staff, patients, and their carers as partners in care and will support this by proactive planned education sessions and in response to requests for additional information.

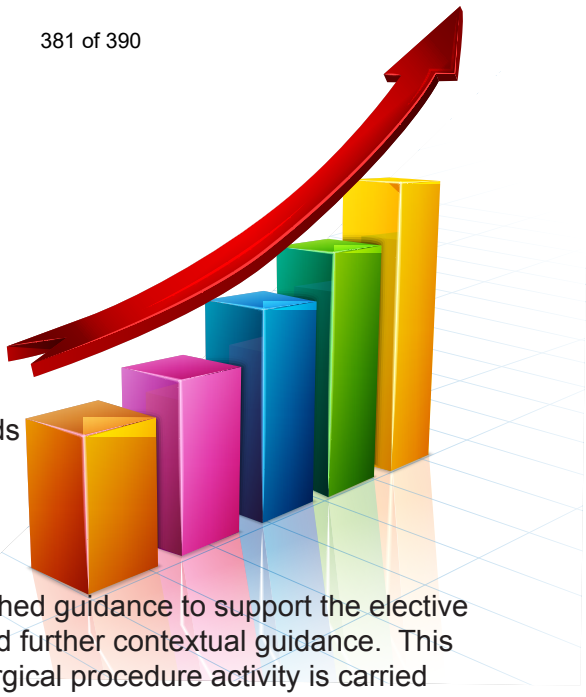
Training includes: -
- Mandatory: via e-learning or taught sessions (including virtual during Covid-19)
- ANTT assessor training
- Blood culture training
- AMS training

Peer feedback is requested from training sessions to drive further improvements and Infection Prevention & Control Nurses (IPCNs) will undertake reflection for revalidation purposes.

Other methods of education include: -
- Single point lessons
- Patient information leaflets

We respect patient autonomy and are promoting engagement by providing information on HCAI risks via the WHH website and information leaflets. This will aid joint care decision making and improve experience by promoting the 'no decision about me without me' philosophy.

Recovery from Covid-19



Infection prevention standards are fundamental to Covid-19, including recovery, where planned care is being stepped up safely to meet the needs of our local population. National guidance on Covid-19 is being updated regularly and WHH decision making will consider these updates.

The UK Health Security Agency (UKHSA) published guidance to support the elective recovery programme and NHSE/I have published further contextual guidance. This guidance is considered to ensure increase in surgical procedure activity is carried out safely.

Review of the Board Assurance Framework for Covid-19 will be undertaken bi-monthly and reported to the Quality Assurance Committee and Trust Board of Directors.

Strategy Mapping to Succeed

Successful implementation of this strategy is recognised as a dynamic process that will take account of changes both external and internal to WHH. Ongoing feedback and engagement from our stakeholder will also be considered in measures of success. WHH is a learning organisation and mechanisms are in place to share learning.

The three objectives (preventing HCAIs; improving AMS and standards of cleanliness) are underpinned by action plans. These action plans will be updated quarterly or in light of newly published evidence-based guidance. The HCAI objectives will be updated annually in line with published NHSE/I objectives.

Close monitoring of HCAI data will direct timely implementation of actions if cases start to increase. Identification of risk will be reported using the WHH incident reporting system alongside actions being taken to address these risks.

Progress against objectives in this strategy will take place at Infection Control Sub-Committee with communication to Clinical Business Unit Governance meetings, Quality Assurance Committee, and Trust Board of Directors.

Summary

This strategy outlines actions WHH is taking to prevent HCAIs and provide safe high-quality patient care.

We encourage active participation from all our WHH colleagues, partners, patients, and carers to ensure infection prevention activity is embedded across the Trust.

Associated Trust Documents

Antibiotic Formulary
Estates and Facilities Strategy
Infection Control Policy
Moving Forward to outstanding with you - Our Nursing and Midwifery Strategy
Quality Strategy

References

Department of Health (2015) Health and Social Care Act 2008 Code of Practice of the Prevention and Control of Infections and Related Guidance
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf

HM Government, (2019) Tackling antimicrobial resistance 2019-2024: The UK's five-year national action plan.
UK_AMR_5_year_national_action_plan.pdf (publishing.service.gov.uk)

NHS England and Improvement (2019) The NHS Patient Safety Strategy Safer culture, safer systems, safer patients
Report template - NHSI website (apo.org.au)

NHS England and Improvement (2021) National Standards of Healthcare Cleanliness 2021
B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)

NHS England and Improvement (2021) Infection prevention and control board assurance framework
Briefing template (england.nhs.uk)

National Institute for Health and Care Excellence NICE (2013) Surgical site infection Quality Standard (QS49) https://www.nice.org.uk/guidance/qs49

National Institute for Health and Care Excellence NICE (2020) COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services NICE guideline [NG179]
Overview | COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services | Guidance | NICE

NHS Standard Contract (2021/22) Minimising Clostridioides difficile and Gram-negative Bloodstream Infections
B0720-nhs-standard-contract-21-22-minimising-clostridioides-difficile-and-gnbi-v1.pdf (england.nhs.uk)

National Institute for Health and Care Excellence NICE (2014) Infection prevention and control Quality Standard (QS 61)
https://www.nice.org.uk/guidance/qs61?unlid=150625743201536104842

National Institute for Health and Care Excellence (2016) Healthcare-associated infections Quality Standard (QS113)
https://www.nice.org.uk/guidance/qs113

For more information on Infection Prevention and Control please contact us

Address	Infection Prevention and Control Department Kendrick Wing Warrington and Halton Teaching Hospitals NHS Foundation Trust Lovely Lane Warrington WA5 1QG
Website	www.whh.nhs.uk
Email	whh.infectioncontrol@nhs.net
Telephone	01925 662117

If you would like to receive this document in another format.
Please do not hesitate to contact us.

Cantonese:
如果你希望以另外一種格式接收該資訊，請和我們聯絡，不必猶豫。

Gujarati:
જો તમને આ માહિતી બીજી રચના કે ફોર્મેટમાં મેળવવાની ઈચ્છા હોય, તો કૃપા કરી અમારો સંપર્ક કરતા અચકાશો નહિ.

Hungarian:
Kérjük, vegye fel velünk a kapcsolatot, ha más formában kéri ezt az információt.

Polish:
Jeżeli chciał(a)by Pan/Pani otrzymać niniejsze informacje w innym formacie, prosimy o kontakt.

Punjabi:
ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿਚ ਇਹ ਜਾਣਕਾਰੀ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰਨ ਤੋਂ ਨਾ ਝਿਜਕੋ।

Urdu:
اگر آپ اس معلومات کو کسی اور صورت میں حاصل کرنا چاہتے ہیں تو برائے مہربانی ہم سے رابطہ کرنے میں ہچکچاہٹ محسوس نہ کریں۔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/05/79**			
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined Report for Q4 2021-22**			
DATE OF MEETING:	25 May 2022			
AUTHOR(S):	Mrs Frances Oldfield, Guardian of Safe Working Hours			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The 2016 Junior Doctor Contract is fully established at WHH for all our Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of Exception Reporting via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 4 (Jan - March) 2021-22, 42 Exception Reports were submitted of which 2 were highlighted as immediate patient safety concerns. The majority (86%) of Exception Reports relate to hours of working. 1 Exception Report relates to missed educational opportunities and 5 Exception Reports submitted related to service support available to the doctor. The total number of Exception Reports is in line with normal variation for the quarter.			
PURPOSE: *(please select as appropriate)*	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		

	Agenda Ref.	SPC/22/05/56
	Date of meeting	18 May 2022
	Summary of Outcome	The report was noted.
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Guardian of Safe Working for Junior Doctors Quarterly Report – Quarter 4 2021-22 (1st January – 31st March 2022)	**AGENDA REF:**	BM/22/05/79

1. BACKGROUND/CONTEXT

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

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

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

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

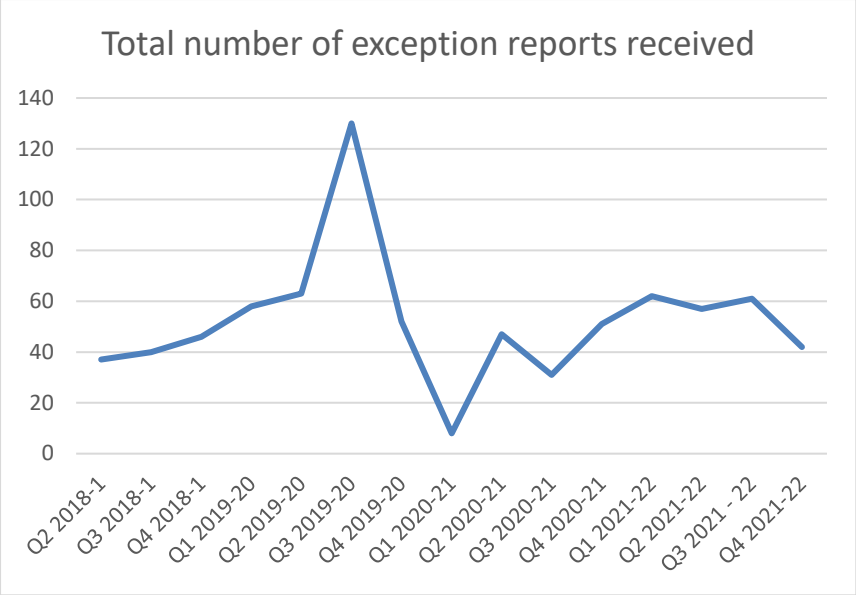
2. KEY ELEMENTS

Exception Reporting (January – March 2022)

During Q4 2021-22, 42 Exception Reports were submitted. This is lower than the last quarter and may represent a plateaux, as exception reporting may be returning to pre-pandemic levels. Reporting levels will continue to be monitored over the next quarter as any further decrease in reporting may indicate that juniors are underreporting.

Recent JDF meetings have been extremely well attended and there continues to be strong engagement between junior doctors' representatives, the chief registrars, the DME and GSW.

Chart 1 below illustrates pre and post pandemic reporting trends:



The majority (86%) of exception reports (ERs) relate to hours of working. Trainees comment that they stay late to complete ward duties or for review and management of sick inpatients, which they feel they cannot handover to the on-call teams. This is entirely understandable and predictable, although routine duties should not often need to be done out of hours.

There remains a 50:50 split of ERs raised due to working hours in the medical and surgical specialties. However, many of the ERs submitted by surgical juniors relate to issues when covering medical outlying patients and this is a recurring theme during Q4. This has also been noted in previous GSW Reports. Juniors report a late ward round by a medical consultant, a lack of middle grade support and the need to stay late to complete tasks generated during the ward round. One ER raised was categorised as having immediate safety concerns (ISC), relating to inadequate senior cover for medical outliers.

It is recognised that there have been problems due to staff sickness at all levels within the hospital and this has significantly impacted the medical outlier cover. Positive changes have occurred within the Surgical Junior Doctors Rota to ensure there is formal rota scheduling for cover of the medical outlier patients, removing the ad hoc unplanned nature of previous cover. This has led to improved Junior Doctor morale and improved continuity of care for patients. There has also been a noticeable improvement in the timing of the consultant ward round, however this is still not consistent.

Despite the above interventions, both ERs and ISCs continue to be submitted and therefore this area will require regular review and evaluation to ensure positive change continues and solutions evolve.

5 ERs submitted related to service support available to the doctor. The only other ER raised during this quarter categorised as having immediate patient safety concerns (ISC), related to gaps in the medical rota and senior support in cardiology. This was again at a particularly challenging time of reduced medical staffing and has not been a recurring problem.

There has been a decrease in ERs for the quarter relating to missed educational opportunities (n=1), a significant improvement since Quarter 3.

The majority of ERs have been submitted by Foundation Trainees (79%) reflecting the busy workload of juniors on the wards. 9 ERs were submitted by trainees with central contracts from the Lead Employer.

Exception Reports (ER) over past quarter	
Reference period of report	01/01/22 - 31/03/22
Total number of exception reports received	42
Number relating to immediate patient safety issues	2
Number relating to hours of working	36
Number relating to pattern of work	0
Number relating to educational opportunities	1
Number relating to service support available to the doctor	5

Summary

- number of exception reports raised = 42
- number of work schedule reviews that have taken place = 1
- ERs flagged as immediate safety concerns = 2
- fines that were levied by the Guardian = nil

Historically, there have been delays in the review meetings between the ES and Junior Doctor once an ER has been submitted.

The GSW and Medical Trainee Workforce Administrator are working on a Standard Operating Procedure for Exception Reporting. It is hoped that by sharing this document with trainees and Educational Supervisors it will result in an improvement in resolving ERs.

At the end of Q4, there were 22 unresolved ERs. This is a significant improvement since Q3 when there were 41 unresolved ERs. The GSW and Medical Trainee Workforce Administrator will continue to monitor outstanding exception reports and encourage continued engagement from both trainees and educational supervisors.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The support structure for Junior Doctors covering Medical Outliers continues to be a recurring theme for ERs and ISCs.

- Further review of the senior support provided to Junior Doctors covering the Medical Outliers.
- The AMD for Unplanned care will be invited to attend the Junior Doctors Forum to enable open discussion of the concerns raised, to ensure mutually appropriate interventions are undertaken to reduce the associated risk.

4. MEASUREMENTS/EVALUATIONS

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	16
Total number of overtime payments	12
Total number of work schedule reviews	1
Total number of reports resulting in no action	0
Total number of organisation changes	0
Compensation	0
Unresolved	22
Total number of resolutions	**29**
Total resolved exceptions	**32**

Note:
** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*

** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*

** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

5. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days.
4. The Trainees need to indicate “acceptance” or “escalate” to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the GSW will issue an email to expedite sign-off.

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

6. MONITORING/REPORTING ROUTES

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

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

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

7. TIMELINES

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

- Q4 – (end of March 2021) – submitted May 2022
- Q1 – (end of June 2021) - submitted July 2022
- Q2 – (end of September 2021) – submitted November 2022
- Q3 – (end of December 2021) – Submitted January 2022

8. RECOMMENDATIONS

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