Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD
Supplementary Agenda

MAIN AGENDA

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

Board Assurance Framework

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	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.	1	25 (5x5)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1215	Daniel Moore	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	1	25 (5x5)	6 (3x2)	TBC	Quality Assurance Committee
1273	Daniel Moore	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1272	Kimberley Salmon-Jamieson	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.	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1275	Kimberley Salmon-Jamieson	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1289	Daniel Moore	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	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	1	20 (5x4)	12 (4x3)	TBC	Quality Assurance Committee
134	Andrea McGee	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b)	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee

Board Assurance Framework

		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	Michelle Cloney	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Alex Crowe	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.	1	20 (5x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1125	Daniel Moore	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	1	20 (5x4)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1079	Kimberley Salmon-Jamieson	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.	1	20(4x5)	2 (1x2)	TBC	Quality Assurance Committee
1207	Michelle Cloney	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	2	16 (4x4)	8 (2x4)	TBC	Strategic People Committee

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		welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.					
1372	Alex Crowe	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 an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1233	Alex Crowe	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.	1	16 (4x4)	6 (2x3)	TBC	Quality Assurance Committee
125	Daniel Moore	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	1	16 (4x4)	4 (4x1)	TBC	Executive Management Team
1108	Kimberley Salmon-Jamieson	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	1	16 (4x4)	4 (4x1)	TBC	Quality Assurance Committee
145	Simon Constable	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.	3	15 (3x5)	8 (4x2)	TBC	Executive Management Team

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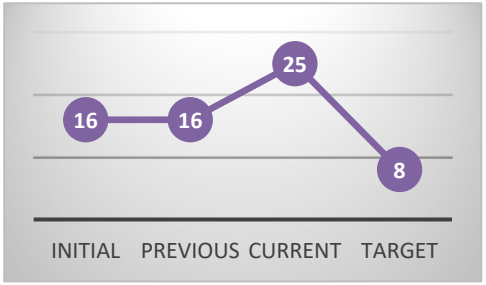
1274	Kimberley Salmon-Jamieson	Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	1	15 (3x5)	5 (5x1)	TBC	Quality Assurance Committee
1331	Daniel Moore	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.	1	15 (5x3)	5 (5x1)	TBC	Quality Assurance Committee
1290	Andrea McGee	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.	3	12 (3x4)	4 (1x4)	TBC	Finance & Sustainability Committee

Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.
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
Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.

Board Assurance Framework

Risk ID:	224	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	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.			**Initial:**	16(4x4)
				Current:	25(5x5)
				Target:	8 (2 x 4)
Assurance Details:	•Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day •Systemwide relationships including social care, community, mental health and CCGs •Discharge Lounge/Patient Flow Team/Silver Command •ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing •Controller •Private Ambulance Transport to complement patient providers out of hours •FAU/Hub operational from June 2018 - Now operating 5 days per week. •Discharge Lounge opened 26th November 2018 •Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. •System actions agreed supporting the Winter Plan •Further development of Rapid Response to avoid admission •Increase IMC provided by the system such as the opening of the Lilycross site •Increase IMC at home •Regular monitored at the Mid Mersey A&E Board •Trust is working with ECIST on a number of Long Length of Stay & Flow improvement projects •Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. •The Trust participates at the system & regional UEC improvement meeting on each Wednesday •Redeveloped ED 'at a glance' dashboard •Trust implemented NHS 111 first successfully in August 2020 allowing for directly bookable ED appointments •Board approval of capital plan to build new £5m purpose built acute Medical Ambulatory Care area aka ED Plaza •Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings •Integrated discharge Team now in place •Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients •ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. •Respiratory Ambulatory Care Facility agreed by CCG •Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved •Collaborative working with Orthopaedics in management ok MSK Minor injuries via Minor's Stream •Reinstated CAU 24/7 •Upgrade to Minor's resulting in Oxygen points in all cubicles •Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 •Operation Re-set undertaken at the end of May 2021 to support flow and discharge •ED Response Group established in August 2021, clinically led by Dr Vondy to review internal ED processes. •Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. •Monthly Focus on Flow weeks scheduled every month until July 2022				
Assurance Gaps:	•Staffing pressure created as a direct result of COVID-19 Global pandemic. •Confirmed exponential growth in types 1 & 3 as a result of population nedd and lack of access to Primary Care				

Board Assurance Framework

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	31/03/2022	
ED Response Group	Executive recommend the formation of Supportive forum for ED to support current issues highlighted during May2021 operation reset.	ED Response Group Formed and TOR agreed and lead assigned	Vondy, Dr Anna	31/03/2022	
DATIX Reporting for Patients Waiting for a Bed	Staff are encouraged to report near misses of patients who have been waiting for a bed for a long period of time.	Review the DATIX and carry out rapid incident reviews.	Field-Delaney, Sheila	31/03/2022	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Field-Delaney, Sheila	31/03/2022	

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Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to deliver the capacity required caused by the on-going COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm			**Initial:** 25 (5x5) **Current:** 25 (5x5) **Target:** 6 (3x2)

Assurance Details:

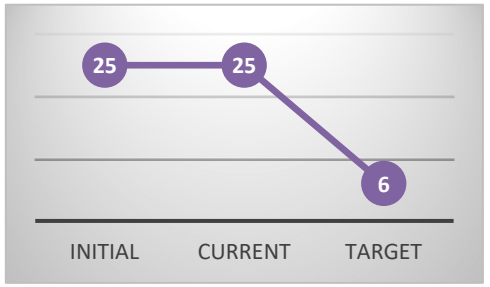
- H2 Planning Guidance submission – October 2021
- Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery
- Operational planning to be monitored by Gold Command on a daily basis, by Cheshire & Merseyside elective restoration meeting weekly and the Clinical Recovery Oversight Committee (CROC) & Clinical Services Oversight Group (CSOG). This relates to elective surgical activity.
- 2021/22 Operational Planning Guidance received in April 2021 outlining planning requirement for the first 6 months.
- Elective Recovery Plan Business Case under development to support waiting list recovery for outpatients, cancer and electives in H2

Radiology

- New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.
- Department has been supported by the Trust through £380K recurrent funding to recruit additional staff. Advert out 11th June 2020. Recruiting 4 Radiographers, 2 Sonographers, 2 Healthcare Assistants.
- Additional staff will support additional capacity through extended working days across all scanners – currently unable to achieve this due to Covid-19 demands.
- Additional CT capacity (15 exams per week) will be provided mid-July 2020 via use of mobile CT scanner supported by the National Imaging Team Covid-19 Response initiative. (this has been extended to mid-September 2021)
- MR business case supported to provide a mobile MR van until October 2021 until the new static MR capacity commences.
- All outstanding requests are clinically reviewed by Senior Consultant Radiologists as per local SOP. Exams are deferred in line with clinical priority. Cancer and Urgent patients are being imaged as per pre-Covid-19 as per national guidance.
- Those deferred patients are sent a letter informing of delay, and to contact their Doctor if any concern. The referrer of delayed patients are also sent a letter informing of delay, but this referrer letter includes a direct telephone number to the Senior Radiology Consultants, and also an email address should there be a concern with delaying. Any exams that are highlighted from referrers as not suitable for delay are appointed on the next available appointment.
- This delay process has been discussed via Medical Cabinet and agreed as most appropriate process.
- This clinical review and delay process is ongoing daily.
- Improvement against all modalities for numbers waiting more than 6 weeks noted in April performance.
- CT Business case approved to increase CT capacity and support expediting recovery.

Unplanned care

- The emergency department has been reconfigured to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance.
- Minor injuries is provided in an area in close proximity but separate to the main emergency department. This has provided an opportunity to use the old minors department as Majors 2 to support management of surge demand and avoidance of corridor care.
- New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.
- In patient capacity is reviewed with the patient flow and CBU teams daily to ensure that there is adequate capacity for all patient groups to be admitted.
- ITU business continuity plans have been agreed to escalate critical care as and when required.



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	• Clinic templates have been revised to ensure social distancing measures are in place and patients are not brought to a face to face appointment unless clinically indicated. Virtual appointments are in place (telephone and video) for use where this is clinically appropriate. • Suspected cancer, cancer and clinically urgent patients are allocated out patients and diagnostic appointments as a priority. • Waiting lists are reviewed through the performance review group weekly – outpatients and diagnostics. • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • NHS 111 First pilot went live on 8th September 2020 to reduce attendances to the emergency department and to support the planning of activity in a more streamlined way to reduce overcrowding and risk of nosocomial infection. • Business Case for ED Plaza Scheme approved in 2021/22 Capital Plan • Reconfiguration of Paediatric ED completed and operational • Phase 2 ED Plaza commenced in October 2021. • Deployment of Bioquell Pods in ICU live and operational Planned Care • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery. • All elective patients have been clinically reviewed and categorised in line with national guidance. • Suspected cancer, cancer and clinically urgent patients are treated as a priority. • Theatre capacity has been reviewed and additional capacity is now available with the de-escalation of the theatre PODs • The Halton site is being developed as a covid secure site and will be run as an Elective Centre. • Elective Surgery Standard Operating Procedure (SOP) in place • Capacity identified and being utilised at spire Healthcare • Clinical Services Oversight Group (CSOG) established • Clinical Recovery Oversight Committee (CROC) established • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward 5 on the Warrington site. This pathway is set to commence w/c 8th February and replaces the B18 pathway. • A separate pathway has been developed for Emergency surgery and future plans and bed base has been agreed as part of the ward reconfiguration process. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Workforce plans are continually reviewed to ensure that all wards and teams are staffed safely. • Waiting lists are reviewed through the performance review group weekly • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • Continued use of the independent sector (Spire Cheshire) under new contract in 2021/22 with support from the CCG. • Participation in national clinical validation exercise commenced in November 2020 to support and inform patient waiting time status and support safe management of waiting lists.	
Assurance Gaps:	Radiology 1. Harm may be caused due to the incompleteness of clinical information on a referral. This may also be compounded by the referrer incorrectly entering the wrong priority code on the referral. • It is thought that the letter to the referrer will highlight the exam has been delayed and that the provision of a direct link to the Radiology Consultant team by phone/email will allow these cases to be expedited where appropriate. 2. Harm may be caused by the delay of a routine examination where there is an unlikley serious pathological finding present.	

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	• This risk is present in all routine exmas as the waiting time for routine diagnostic imaging is up to 6 weeks as per national targets. This risk is hightened due to Covid-19 and the reduced capacity at present. It is thought the letter to the patient advising to contact their Doctor with any concern will reduce this risk. Unplanned care 1. Estates work is required to complete the segregation of paediatric patients in the emergency department. • This is being progressed with the support of the estates and capital planning team. 2. Expansion of the emergency department is required to ensure any increase in demand can be accomodated in line with RCEM guidance 3. Referrals do not include adequate information to triage and prioritise patietns appropriately • Regular meetings and communication with the CCG and GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems 4. Reduction in face to face primary care appointments having a negative impact on increased attendances. 5. Capacity challenge with social workers to keep on top of demand and necessary patient assessments. 6. Estates work required to increase general ICU Capacity & ICU cubicle capacity e.g. Installation of Bioquell cubicles Planned Care 1. Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • This is being progressed with the support of the estates and capital planning team. 2. Waiting list do not include adequate information to triage and prioritise patients appropriately • Regular meetings and communication with the waiting list and scheduling teams and inform them of recovery plans and to highlight/address any identified problems 3. New framework for ISP will not include all specialties currently being undertaken. This will increase waiting list pressure for those specialties on this site.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Install of Bioquell Cubicles	Install of Bioquell Cubicles	Complete Installation	Sharon Kilkenny	28/02/2021	Installation in ICU Complete Jan 2021
Build ED Plaza	Completion of ED Plaza building works	Complete Building work	Sharon Kilkenny	30/04/2022	

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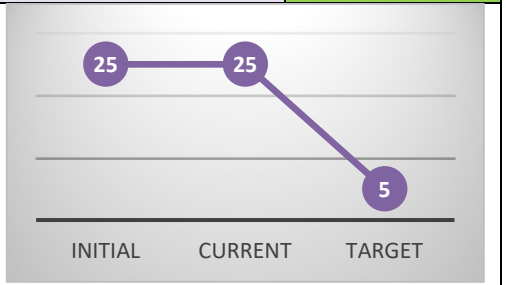
Risk ID:	1273	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.			**Initial:**	25 (5x5)
				Current:	25 (5x5)
				Target:	5 (5x1)
Assurance Details:	Integrated Discharge Team comprising of hospital and Local Authority colleagues from Warrington and Halton to develop systems and process of discharge acknowledging difficulties of Covid-19. Daily system pressures meeting that reviews hospital and wider system bed capacity to support safe and timely discharge of patients from hospital to support flows Trust participates in Mid-Mersey Operational Group which supports Out of Hospital Cell discussions in relation to system discharge planning. The number of discharge delays in relation to Super Stranded patients is reported daily in the Executive Summary and reviewed so that Executive Directors can support and escalate pathway delays. 'Where's best next' event initiated in January 2021 with system partners to support safe discharge of patients with long lengths of stay to create capacity through December and January expected winter pressures and support wave 3. Scheme issued by the Government to support indemnity concerns of care homes in relation to caring for COVID-19 patients. It will support the system in the creation of COVID-19 designated setting capacity. New 'Discharge to Assess' process has gone live to reduce the length of stay for a cohort of patients who would otherwise be assessed in hospital can be assessed in a transitional care bed. Progressing the procurement of a new software programme which will be able to accurately track and share system delays with partners. By improving information, it will enable quicker and more effective decisions on discharges. Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. Monthly Focus on Flow weeks scheduled every month until July 2022 Daily bed meetings organised by the Director of Operations & Performance to provide timely and effective benefits to patient flow Approval of IMC business case which will support a reduction in frailty length of stay and admission avoidance through geriatric input in to the Emergency Department.				
Assurance Gaps:	Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's Covid-19 status. Intermediate Care and other community capacity impacted and restricted by Covid-19 e.g. Care Home and other facility closures due to outbreaks. Access to community capacity impacted by Covid-19 as a result of staff sickness Internal staff shortages to help support discharge planning. Restricted as a result of Covid-19 sickness and self-isolation High number of patients in Warrington awaiting social work assessment, causing a delay in discharges from the acute site in to care homes and intermediate care capacity Significantly reduced capacity in the domiciliary care market due to the high number of vacancies. This is causing package of care delays.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Improve discharge planning skills & knowledge	Undertake educational sessions to improve discharge planning skills & knowledge as part of Focus on Flow sessions	Complete educational sessions	William, Caroline	30/01/2022	
Improve quality and effectiveness of Board Rounds	Undertake educational session to improve quality and effectiveness of Board Rounds to help support reductions in length of saty	Complete educational sessions	Harris, Zoe	30/01/2022	

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Review length of stay data	Undertake en-masse review of length of stay data across the Trust to inform new actions and action plan	Complete review	Harris, Zoe	30/11/2021	

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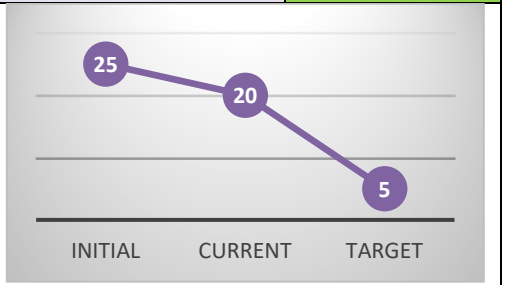
Risk ID:	1272	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 meters apart, resulting in reduced capacity to admit patients and a potential subsequent major incident.			**Initial:** 25 (5x5) **Current:** 20 (4x5) **Target:** 5 (5x1)
Assurance Details:	The Trust has in place a full environmental plan. The Trust has used a risk assessment approach to identify compliance or challenges in meeting the 2-metre requirement. Risk assessments have been completed on each Ward. Clear curtains are in place all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Collapsible screens in some areas 8 weeks environmental visit rota in place, supported by the Health & Safety Team and senior clinical nursing staff Expected deployment of Bioquell Pods in ED & ICU in March/April 2021 Bioquell Pods now in place in ICU Bioquell Pods now in place in ED. Bioquell Pods now in place in B18			
Assurance Gaps:	Individual Ward risk assessments identify challenges in meeting the 2 metre requirement. In October 2021 and increase in community prevalence noted. Increase in formally declared nosocomial infection			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
An environmental inspection plan to be set up to ensure there is monitoring of social distancing.	Clear curtains are in place on all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Bioquell Pods are now in place in ICU. As the number of COVID positive patients has reduced and the nosocomial outbreaks has also reduced, it was agreed at QAC on the 4th May 2021 to reduced the risk from 25 to 20. The situation needs to be continually monitored and therefore the action will remain open and reviewed each month.	Health and Safety to develop and implement an environmental inspection programme in all clinical areas.	Kennah, Ali	31.12.2021	
All wards and departments to have up to date risk assessments in place.	All wards and departments to have up to date risk assessments in place.	Review risk assessments	Wynn, Helen	30.03.2022	

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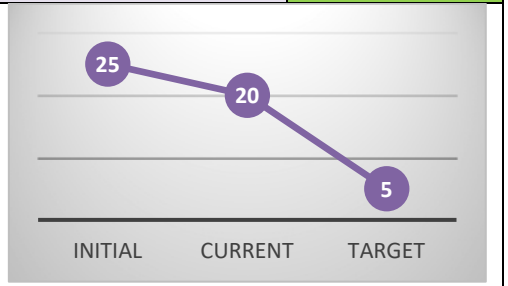
Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks			**Initial:** 25 (5x5) **Current:** 20 (4x5) **Target:** 5 (5x1)
Assurance Details:	Restricted site access is in place to reduce the risk of COVID19 transmission. COVID19 incidents are monitored daily. Risk assessments are in place in all Wards/Departments and rest rooms. Mask stations and santiser is in place at all entrances and designated points throughout the Trust. Agile working policy is in place Information technology infrastructure is in place to support remote working. Risk assessment in place to support safe visiting where appropriate. PPE is monitored daily. Providing and maintaining a clean environment that facilitates the prevention and control of infections. Daily communications through TWSB to staff reinforcing social distancing measures Environmental Safety Action plan in place reported by exception to Silver Infection Control Outbreak meetings held with lessons learned shared across the Trust Signage and written information in place to support social distancing practices Retractable screens between beds spaces in ED PPE audits completed weekly on wards PPE Champions identified Clear curtains are in place all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Process for assurance of 3 and 5 day swabs in place Bioquell Pods now in place in ICU Bioquell Pods now in place in ED Bioquell Pods now in place B18 Trust completed learning from Nosocomial outbreaks sessions. COVID-19 quality metrics in place Cohorting of COVID-19 positive patients recommenced			
Assurance Gaps:	Non-compliance with social distancing & PPE Non-adherence to Trust Staff isolation policy			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Health and Safety inspections to include the monitoring of social distancing and ensure hand sanitiser and masks are located at each entrance.	Findings from inspections reported to the Health & Safety Sub-Committee Health and Safety inspections continue on an 8 week programme.	Health and Safety inspections to be carried out.	Kennah, Ali	31.03.2022	

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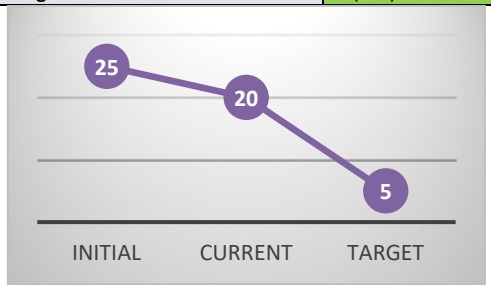
1289	**Executive Lead:**	Moore, Daniel

Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.

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

Rating	
Initial:	25 (5x5)
Current:	20 (4x5)
Target:	5 (5x1)

Confirmed continued use of the private sector (Spire Cheshire) in 2021/22. Under new contracting arrangements.
Waiting lists monitored and measured weekly
Post Anaesthetic Care Unit (PACU) remains open and operational
Continue to undertake harm review process and triangulate with waiting list process and Priority 2 patients
Continue to specifically focus on and monitor patients waiting greater than 52 weeks
Continue to ensure urgent cancers are prioritised in line with national guidance
Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site.
Bioquell Pods in ED live and operational
B18 footprint development to support improved Respiratory & Critical response to peaks in the pandemic is underway and set to complete in September 2021.
Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee.
Safe staffing levels reviewed daily. If necessary this may mean a review of clinical services to support the release of staff on a temporary basis.
The re-start of the Warrington site green pathway commenced w/c 8th February in the newly established ward A5 elective footprint. At present this supports cancer and other green pathways on the Warrington site
Clinical Recovery Oversight Committee (CROC) established
Clinical Services Oversight Group (CSOG) established
Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery.
B18 opened in October 2021
Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care



Theatres 3 and 4 currently used for Endoscopy rather than as Theatres until the Endoscopy rooms are completed in October 2021
Limited bed base within A5 elective footprint
Increase in COVID-19 ICU patients as a result of wave 4 (July 2021) impacted on scheduling for patients requiring ICU post op

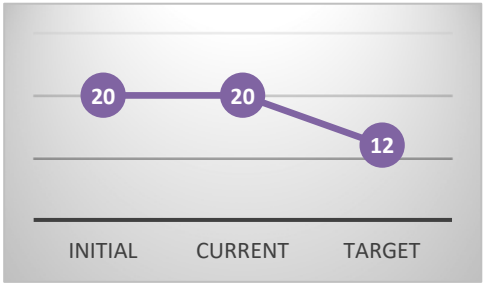
Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop plan for Ward 18 Footprint to support alternative critical care escalation.	Develop plan for Ward 18 Footprint	Kilkenny, Sharon	28/02/2021	28/02/2021
Complete the B18 development	Complete the B18 development	Kilkenny, Sharon	30/09/2021	13/10/2021

Board Assurance Framework

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	12 (4x3)

Assurance Details:

- Monthly workforce information produced via workforce dashboard. Information is reviewed and monitored at the Workforce Group Chaired by the Chief Nurse
- Robust staffing escalation process across WHH to manage staffing daily – This has become the forum for responsive staff management during the COVID 19 pandemic
- Lead Nurse identified daily to co-ordinate staffing supported by a senior nurse rota 7 days a week 8am – 8pm which commenced in April 2020
- 4 hourly update shared as part of Gold Command template
- Wards & Departments use E-Roster and Safecare data to support staffing ratios
- New models of care currently being implemented in Maternity in line with BR+. Business case being developed as there will be a requirement for a staffing uplift
- Recruitment / media plan produced and recruitment campaign ongoing
- Rolling advert for RN's continue. Students who were redeployed to the Trust during the COVID 19 pandemic have been offered substantive posts
- International Nurse Business Case has been approved for 96 Registered Nurses – all nurses have been recruited and will be in post by December 2021
- National staffing guidance has been utilised to inform new staffing models
- Care Hours Per Patient Day (CHPPD) currently 7.6 (Year to date position 7.8)



<u>Recruitment Assurances</u>

- Rolling advert for B5 Nurses paused for 3 months whilst international nurses are placed
- Developing WHH recruitment campaign
- Career advice events in local schools and colleges
- Production of monthly and bi-annual staffing reports received by the Trust Board
- Trust has intensified the HCA recruitment and achieved 0 vacancies by April 21. NHSI funding support received to achieve this aim. Weekly monitoring on progress and reporting to NHSI in place
- The Trust will be placing 96 International Nurses by Dec 21.
- In September 21 we have 0 wte band 5 vacancies.
- Recruitment campaign for ED staffing is active, open day 28th October

HCA

- There are currently 13 Health Care Assistant vacancies within the Trust. All vacancies are being recruited into during November.

<u>Retention Assurances</u>

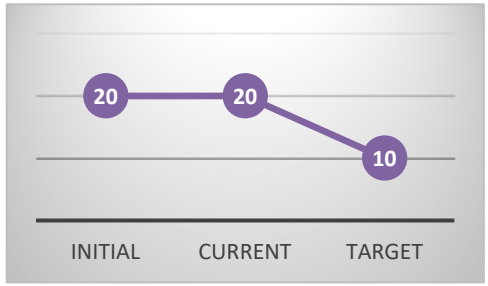
- Workforce Dashboard reporting monthly in relation to leavers
- WHH Nursing retention plan to be refreshed for 2022
- Burdett Nursing Trust award winners
- Highly commended for nursing retention data provision

Board Assurance Framework

	• 'Transfer Window' implemented allowing staff to move to other specialties without having to apply for role • Registered Nurse Turnover 11.59% • International nurses have started to join WHH in March 21. 67 have commenced on the wards. COVID-19 Assurances • Implemented a graduated and planned nurse staffing response to the COVID-19 Pandemic. • Revised staffing models for the expansion of critical care capacity, acute and supportive respiratory wards • Strengthened daily staffing meetings chaired by the Associate Chief Nurse for senior oversight • Increased use of temporary staffing through NHSP and off framework agencies – close monitoring arrangements in place • Implementation of NHSP incentive scheme for staff to improve fill rates – update monitored weekly • Nursing Times Workforce Award winners in November 2021 – Best Recruitment Experience During COVID-19 Pandemic Response • As the number of COVID patients in March 21 reduce the staffing plans are being revised and the number of agency staff is starting to reduce.	
Assurance Gaps:	Increase staffing pressure due to ongoing use of temporary winter wards (B3 & K25) for which there is no funded establishment Recruitment Gaps • 0 RN Vacancies in September 21. ED & B18 are recruiting RNs for increased capacity. Retention Gaps • 11.59% nursing turnover	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
WHH to review international nurse recruitment to support registered nurse vacancy fill.	Targeted recruitment campaign	International nurse recruitment programme in place. Develop a business case. Agreement to join GTECH in partnership with WWL. Business case agreed for 30 nurses. Task and finish group established to support the recruitment campaign and welcome nurses to WHH Application for bid to access financial support for the programme.	Browning, Rachel	30/07/2021	30/07/2021

Board Assurance Framework

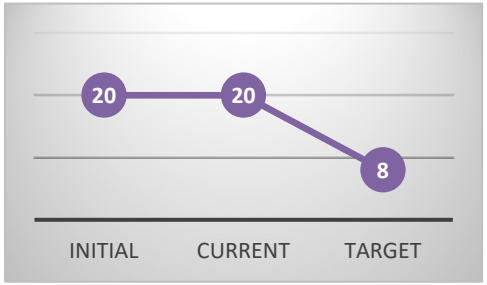
Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	10 (5x2)
Assurance Details:	•Core financial policies controls in place across the Trust •Revised governance structure within the Trust to enable strengthened accountability •Finance and Sustainability Committee (FSC) established overseeing financial planning •Regular financial monitoring with NHSI •Regular review at Executive team meeting and development sessions •Annual plan development process • Achieved 2020/21 Control Total. • Achieved Break Even H1 2021/22 • Unqualified audit opinion (2020/21) •Corporate Trustee Charities Commission Checklist, reporting annually through Board •Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports •Regular updates to Executive Team, FSC and Trust Board •Financial Resources Group (FRG) and Capital Resources Group that report to FSC • Workshop undertaken with - Exec, CBU, Corporate to review 2021/22 cost pressures • 2021 cost pressures supported by Trust Board. Business cases being developed to secure required levels of funding. There are 9 are in progress, 5 are complete, 2 have been closed as the funding is in budget. These are expected to be completed by 28th February 2022. •Completed MIAA Governance Checklist received by Audit Committee •H1 Expenditure Budgets approved by the Trust Board on 31st March 2021 •H2 Expenditure Budgets to be submitted to the Trust Board in October 2021 •Capital Plan approved by Trust Board on 31st March 2021 (£19.75m) •c£34m cash support secured in the form of PDC in March 2021 •Increased assurance gained re: Capital Expenditure for all schemes over £0.5m and reported to FSC •Increased scrutiny of CIP through weekly updates to the Executive Team Meetings and monthly to FSC •Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH submitted an Expression of Interest (EOI) in September 2021 •WHH judged by Cheshire & Merseyside Health & Care Partnership as the top priority for the New Hospital Build Programme in C&M <u>COVID-19</u> • Governance process in place to ensure all additional costs are being approved and monitored – re-introduced for Wave 2 & Wave 3 • Reporting to NHSE/I • Regular attendance to regional and national conference calls • Circulate latest guidance from MIAA Counter Fraud team • Ensure governance and processes in place including checks in place for all expenditure in particular procurement, contracts, payroll and HR. • Highlighted the different methods of fraud/ scam in operation to all staff and share it as widely through Trust				

Board Assurance Framework

	• Monthly Report to Exec & F&SC on COVID Pay Costs • Deloitte Audit completed. Positive report received with one overclaim reported (£112k). Final report received by the Finance & Sustainability Committee in July 2021 and presented to the Audit Committee in August 2021 • Participating in exercise to understand run rate for 2020/21 to support funding envelopes for 2021/22 • Executive review of COVID-19 costs completed and supported as part of budget setting. • Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance. • Submitted plan of breakeven for H1. ERF funding of £2.5m assumed to achieve target. This was updated to £3.1m	
Assurance Gaps:	• Inability to develop a strategic plan to deliver a break-even position over the next 5 to 10 years • Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk that capital needs exceed capital funding resources available. • Hospital Infrastructure Programme (HIP) announcement. WHH not included in with phase 1 or phase 2 funding allocation. However, an expression of interest EOI has been submitted after seeking support from the Trust Board on 25th August 2021 • Need to determine the future run rate which is currently uncertain in order to mitigate risks. • Increased threat of fraud during COVID-19 global pandemic • Uncertainty of the Trust allocation from the Cheshire & Merseyside Health & Care Partnership • Cheshire & Merseyside system is required to break-even • ERF Funding is not guaranteed and is non-recurrent & subject to system performance and achievement of five gateways. • Additional PDC Capital bids still to be confirmed • New revenue request received that were not included in budget setting, currently undergoing a prioritisation exercise.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Submit requested Workforce & CIP information to NW Intensive Support Director	Cheshire and Merseyside Health & Care Partnership in receipt of Tier 1 Intensive Support – Information requested by NHSE/I on workforce & CIP	Submit requested Workforce & CIP information to NW Intensive Support Director	Andrea McGee	30/03/2020	Paused
Monitor all COVID-19 requests	COVID-19 Revenue	All covid expenditure to be reported to Execs and only extended following approval (Currently undertaken monthly)	McGee, Andrea	31/03/2022	
H2 Budget Approval	Approve H2 Budget in line with the planning timetable	Present H2 to the Trust Board in October 2021	McGee, Andrea	33/11/2021	

Board Assurance Framework

Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain			**Initial:**	20 (4x5)
				Current:	15 (3x5)
				Target:	8 (4x2)
Assurance Details:	• The COVID-19 nursing advice line continues to be funded until March 2022 , to provide a range of advice and guidance to the workforce. • The OH call centre continues to be funded until March 2022, which enables all calls to be answered and triaged by a team of administrators. • 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. • An enhanced wellbeing offer continues , linked to learning from Wuhan, Italy and the British Psychological Society. • A specialist extranet page is in place which includes all national wellbeing offers, and links to discounts for our NHS staff during this period of time. • Mental health wellbeing drop in sessions continue across both Warrington and Halton sites, with a specific wellbeing email address created for any enquiries to the wellbeing hub. • Facilitated conversations are available to staff working on COVID-19 wards. • Face to face counselling is available on-site. • Alternative therapies such as relaxation therapy is available. • Additional support put in place for Black, Asian and Minority Ethnic staff including a specific risk assessment • Guidance on risk assessments for various groups of staff has been issued to managers with clear expectation on completion. • Following national guidance, amendments have been made to the pre-employment check process to support speedier recruitment • The Workforce Information Hub has supported the 'real time' reporting of absence, to enable a clear picture of current staffing. • A Temporary Workforce Redeployment Hub was established to support staffing levels by identifying staff who are available for redeployment and match them with demand. This hub increased its capacity as the Trust moved into wave 3 in December 2020. • A deep dive review of all Clincally Extremely Vulnerable Staff was undertaken to ensure that staff were supported back into work and that resource was utilised apporporiately. • Retirement Policy has been temproarily updated to allow a shorter break (24 hours) in service. • All Trust staff were afforded the opporunity to carry over any untaken annual leave from 19/20 providing that they were unnable to take it due to the covid response. • Work to support workforce recovery continues including health, wellbeing, leadership, teams, HR and resourcing with some tailored support being provided to some departments such as ITU and A&E. • Central log in HR Department to capture all clinically extremely vulnerable staff – process in place for on-going updates. A Covid Secure SOP was written to support the safe return of CEV to work or to agree working from home arrangements as appropriate to a completed Risk Assessment signed off by Occupational Health professionals. Covid Secure areas under regular review by Microbiologist via Tactical Group. • Electronic system continues to be available to support the COVID-19 Workforce Risk Assessment Tool in line with Risk Reduction Framework • Regular reporting on compliance with risk assessment requirements is in place and reported at Tactical on a weekly basis.				

Board Assurance Framework

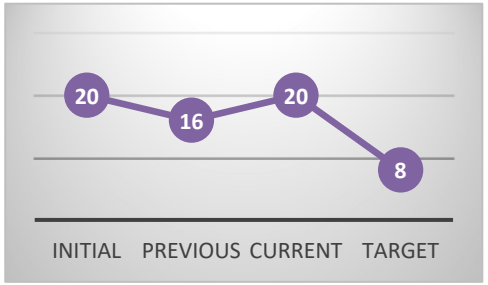
	• Regular training on COVID-19 Workforce Risk Assessment is in place. • A letter was sent out to all staff who have not completed the self-risk assessment in a timely manner, the number of outstanding self-risk assessments reduced by 43%. • Trust continues to be challenged by high sickness absence rates nationally the North West has higher sickness absence rates. Trust has conducted a deep dive into their data and also participated in a NHSE/I deep dive to understand the challenged faced. Improving attendance programme commenced in September 2021 incorporating the data findings and recommendations of both deep dives. • Overall absence rate is 6.36% for Sept 2021 and is therefore reducing. Sept 2020's absence rate was 6.69%. • The Trust has also recently secured funding from NHSI/E to be used to deliver a 4-month project to launch the WHH Supporting Attendance Policy o Preventative measures continue to be implemented including; ▪ Occupational Health and Wellbeing interventions ▪ COVID Booster Campaign ▪ Flu Vaccination Campaign ▪ Asymptomatic staff testing • The Trust continues to promote the importance of Return to Work interviews to support attendance and bespoke Manager training has been undertaken in pilot areas with high levels of return to work non-compliance. • Extensive communications via Trust Safety Huddle and global emails to promote use of PPE, social distancing and compliance with environmental risk assessments restricting numbers within confined staff areas. • Participation in LAMP testing. Due to low update a comprehensive communication and engagement plan has been deployed in order to increase compliance. The Trust is currently planning to move towards an Asymptomatic Testing approach. • Occupational Health opening times have been extended since 4 January 2021. • COVID vaccine programme continues with good uptake from across the workforce, with monitoring arrangements in place. • COVID-19 Workforce Recovery Steering Group commenced. • Supported by funding from NHSI there has been a big push to fill our HCA vacancies, we currently reporting 13 FTE vacancies (30/09/2021) • Extension of existing temporary changes to terms and conditions to support the Covid response; special leave – 31st Dec 2021, Retire and Return – 31st Dec 2021 and Band 8a overtime reintroduced until 31st Oct 2021 • In Sept 2021 overall vacancy rate is 8.18% compared to a peak in Jun 2020 of 10.5%. • 96 of our 96 international Nurses are now in the country. • Therefore, as vacancies and sickness absence reduced it is expected our bank and agency reliance reduce and within Sept 2021 reliance on bank and agency staff increased slightly to 14.72% compared to a peak of 23.3% in Jan 2021. • In response the continuing staff pressures within the care system, national guidance has been released to support organisations to identify fully vaccinated staff who are identified as a contact of a positive COVID-19 case, to return to work, subject to the safeguards put in place. • The Trust introduced a tool to support the decision-making process. This tool was developed following the published guidance: • Infection prevention and control (IPC) guidance on infection prevention and control for COVID-19 • Sustained community transmission is occurring across the UK and COVID-19: management of staff and exposed patients or residents in health and social care settings • To date implementation of the tool has saved the Trust a total of 1610 days, with 215 staff members having been approved by OH to proceed with the approach.	
Assurance Gaps:	• Staff will receive results and instructions from national Trace and Trace service and will have to self-isolate if the contact is from a household member.	

Board Assurance Framework

	• National Policy on sickness absence monitoring and payments are being negotiated nationally - unable to influence outcome. May increase gaps in provision due to additional sickness absence allowances and associated pay arrangements. Negotiations ongoing. National Guidance update provided that it needs to be managed locally. HR team are currently outlining an options appraisal paper outlining legal advice and risks to take to the Trust's Executive committee in September 21 to establish a Trust stance. • Continued lack of national/regional clarity of the management of long covid in the context of the National agreement.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Following an overall reduction in absences, review the trends of each category of COVID-related absence and re-assess risk score.	Review Recent Absence Trends	Data analysis and recommendation relating to risk score	Roberts, Carl	31/03/2022 (Review Ongoing)	30/9/21 – Absent rate starting to increase

Board Assurance Framework

Risk ID:	1114	**Executive Lead:**	Crowe, Alex	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	FAILURE TO provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, CAUSED BY increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber attack, RESULTING IN poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statatory obligations (e.g. Civil Contigency measures) and subsequent reputational damage.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 8 (2x4)
Assurance Details:	**Assurance:** • **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures). • **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee. • **Trust benchmarking** activities including Use of Resources reviews (Model Hospital). • ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021) **Controls:** • **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • Active membership of the **Sustainability Transformation Partnership Cyber Group.** • **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • **Cyber Training** for the Trust Exec Board • Secured annual capital investment to increase Digital skills and capacity. • Digital Board support for profiling of a 7 Year Capital investment based upon asset replacement cycle and strategic roadmap (to deliver the approved Digital Strategy (January 2020)) • The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system (all issues resolved). • Office 2010 being used while end of life due to the N365 deployment plan (100% migrated)				

Board Assurance Framework

	• Secondary secure backup at Halton Data Centre	
Assurance Gaps:	**Gaps In Assurance:** • Mostly achieving of mandated compliance with DSPT, incorporating CE+ (to be confirmed post MIAA audit results) **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Outcome of the Phishing exercise by NHS Digital, lack of awareness of staff. Communications have been sent out to staff members regarding phishing. Arranging second test with NHS Digital. • Current performance of Lorenzo and whether migration to the cloud will provide any benefit. • Not been able to fully recruit to the Digital Service restructure in terms of cyber. Majority of post filled by end of Sept 21. Not being able to recruit to post that are planned in Traunch 2 of the paperless care programme • Development of staff behaviours to protect data evidenced via reduced IG incident report levels, impacted training due to Covid-19 pandemic. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (1 out of 77 servers are at risk of not being migrated in time. The system at risk is Medicorr.) • No local device (PC & laptop) based firewalls in use while on site, dependant on the site boundary firewalls • Using generic logins staff usernames and passwords are stored in browser when selecting “remember me” • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21) •Using no longer supported Exchange 2010 email system for mail archive • Using SharePoint 2010 for the Hub •Remote devices bypassing the proxy • Lack of process to check antivirus alerts in console. MIAA to review processes and tools (July 21) • Administrator accounts still have access to the Internet & email, although only used when required (SIRO to approve process). • No controls in place for Bluetooth connectivity. • Active Directory password set not to expire. • No agreed patching schedule for network equipment with the Trust.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Standardised policies and procedures across the C&M STP using the core documentation from standard of ISO 27001 and the DSPT	Standardise policies and procedures across the C&M STP	• MIAA to map the basic standards to form the minimum and gold standard of documentation for Cyber. MIAA and WHHT to create the documentation templates from the mapping: • ISO 27001 (ISMS) • Data Security & Protection Toolkit (DSPT) • Information Security Standard (ISF) • Centre for Internet Security (CIS) • Information Systems Audit and Control Association (ISACA) • National Institute of Standards and Technology (NIST) • Cyber Security Body Of Knowledge (CyBOK)	Deacon, Stephen	28/02/2022	

Board Assurance Framework

		[Progress has been slow as core members were trying to provide an automated "bot" style document suite. This was too ambitious, and the group decided to scale it down to templates only. MIAA have writing the templates. The workstream are currently reviewing these documents for the 5th review and providing feedback and will be approved by the May C&M STP Cyber Group. Once approved Digital Compliance would rewrite the local documentation and seek approval from the Information Governance and Records Sub Committee.]			
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 [Status June 21] Total Completed % Complete 2003 Servers 22 17 77.3% 2008 Servers 80 57 71.3% [Status July 21] Total Completed % Complete 2003 Servers 22 18 81.8% 2008 Servers 80 54 67.5% [Status Aug 21] Total Completed % Complete 2003 Servers 22 17 95.4% 2008 Servers 80 56 70.0% NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22. [All simple migrations have been completed by IT Services. A report was presented at the October's Digital Board, providing progress made in the	Deacon, Stephen	31/03/2022	

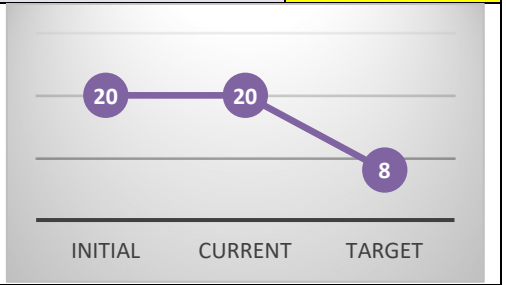
Board Assurance Framework

		decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server. As part of the DSPT requirements we have asked for an update action plan.]			
Deliver fit for purpose Lorenzo EPR Performance and agility of changes to deliver the paperless strategy. [Delivers: Optimisation / Timeliness]	Work with supplier to assure EPR performance	• Work with EPR supplier to safely migrate Lorenzo to the modern cloud solution. The date is subject to national contract changes that our out of our control. [Waiting on the cloud migration]	O'Brien, Emma	12/09/2021	
Implementation of the revised staff structure	Implementation of the revised staff structure	Phase 1 Consultation complete. Process to now to get the staff in place. Contractors are covering the gaps [Review with the DSPT action plan to resources available.]	Deacon, Stephen	30/09/2021	
From the review of the first phishing exercise, provide a comms strategy and send it out to the users. Once finished rerun the phishing exercise next year.	Lessons learnt from previous phishing exercise and rerun phishing exercise	Lessons learnt from previous phishing exercise rerun phishing exercise • Produce a comms plan and send out comms to all staff • Arrange a rerun the phishing exercise • Examine the results and publish at the April IGRSC [Engaged with Templar (NHS Digital) and agreed September for the next phase of the phishing exercise]	Deacon, Stephen	30/09/2021	
Migrate the last 9 endpoints devices to Windows 10	Migrate the last 9 endpoints devices to Windows 10	4 devices migrated with 5 devices left The below endpoint devices can be replaced: 1 x Laptop in Medical Engineering – Unsure why this is still in use. (Deployment contacting ME regarding whether still in use) Endpoint devices more complicated to migrate:	Waterfield, Tracie	30/09/2021	

Board Assurance Framework

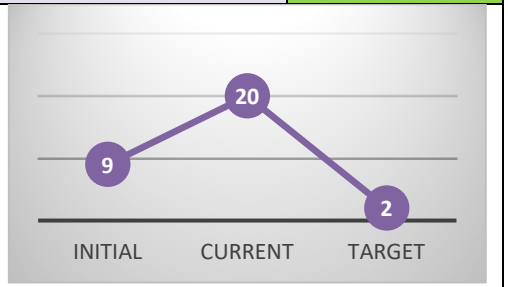
		1 x Dexa Scanner computer – This cannot be replaced at the moment, however, a new dexa scanner has been procured, just waiting on delivery and installation (waiting on date). 1 x Ophthalmology Fundus imaging computer – This cannot be upgraded/replaced as the Fundus camera is not Windows 10 compatible. Conversations on going with the department around replacement camera or removing use of the system altogether. 1 x Pathology Cognos client – This is some sort of information reporting system used in Pathology. They have supposedly purchased a replacement, just not implemented it yet (waiting on date) 1 x Cardiology (can be replaced but need to contact the 3rd party)			
Obtain funding for configuring web protection for remote devices	Obtain funding for configuring web protection for remote devices	Obtain quotes (COMPLETE) Obtain funding (COMPLETE) Configuration [Funding agreed, require date for the configuration]	Deacon, Stephen	29/10/2021	
Ongoing recruitment in the ePR Team	Ongoing recruitment in the ePR Team	Ongoing recruitment in the ePR Team	O'Brien, Emma	30/09/2021	
Enable 90-day password reset for Active Directory	Enable 90-day Password Reset	- Approval from the IGRSC & Medical Director (COMPLETE) - Enable 90-day password reset through CAB - Provide enough staffing for the Service Desk - Enable 90-day password reset	Waterfield, Tracie	30/09/2021	
Turn on device firewalls, to help limit a spread of an infected device infected other devices on the internal network	Turn on local device firewalls	Prioritise workload to look at turning on personal firewalls Create a test group Phase turn on / turn on [Meeting set up for 03/09/21]	Deacon, Stephen	30/09/2021	

Board Assurance Framework

Risk ID:	1125	**Executive Lead:**	Moore, Daniel	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	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			**Initial:** 20 (5x4) **Current:** 20 (5x4) **Target:** 8 (2x4)
Assurance Details:	• Following national EPRR guidance for Cancer & RTT • All patient referrals are being prioritised due to clinical need • Rejected referrals are following recognised procedures particularly ensuring all have a clinical review to determine outcome • Moved a high proportion of OPD activity to virtual. • One elective theatre maintained for cancer and clinically urgent cases • Maintaining monthly reporting for each external standard			
Assurance Gaps:	Some weekly reporting reduced as per guidance			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Monthly reporting	Provide monthly reports to each external standard.	Provide monthly reports to each external standard.	Coalbran, Tom	31/08/2021	
Ensure all cancer patients are within the correct priority group.	Ensure all cancer patients are within one of the three priority groups: 1. Emergency surgery 2. Requires surgery within the next 4 weeks 3. Patients are delayed for 10-12 weeks where there will be no harm.	Ensure all cancer patients are within the correct priority group.	Mason, Karen	31/08/2021	

Board Assurance Framework

Risk ID:	1079	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	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.			**Initial:** **Current:** **Target:**	9 (3x3) 20 (4x5) 2 (2x1)
Assurance Details:	CBU Triumvirate attended Executive financial update board to highlight continuing issues with Lorenzo system Chief Nurse, medical director and head of safety and risk aware of system issue Digital IT paper to QAC and PSCE in collaboration with IT director to highlight system failures and inoperability paper based backup systems introduced Additional administration in significantly affected areas. Site visit to MBFT for lessons learnt in improving system Miro meeting with IT manager to look for interim solutions Scoping new systems with procurement Capital funding meeting attended to seek funds to support alternative maternity specific system New mobile phones for community to support hot spotting in areas with no connectivity IT visited community clinics with Lorenzo connectivity issues Support from lead midwife for IT. To ensure data quality, data is cross-checked to ensure that accurate data is submitted to for screening and Payment By Results Quick reference guides have been created for users to improve data quality related to erroneous input Off line version of Lorenzo to assist Community midwives to input real time data and reduce errors Support currently in place is cleansing historical data staff required to cleanse data going forward In order to ensure health visitors are notified, the current system is a paper based crosschecking system which is dependent on individuals pulling data of current pregnancies at 28 weeks gestation and cross checking the Lorenzo system to confirm ongoing pregnancy. Presentation provided by prospective suppliers on 18th December 2020 Decision on supplier expected by 31st January 2021 EPR Strategic Outline Case supported by the Trust Board in December 2020 Temporary fix for CTG archiving agreed and fitted in December 2020 with review in January & February 2021 Following completion of supplier decision making process, implementation due to complete in September 2021				
Assurance Gaps:	Lack of connectivity to ensure that system can operate Lack of data to provide internet hotspot Poor quality lap tops The current digital solution is contributing to poor data quality and its detrimental care quality and activity income effects, poor staff moral and concerns by regulators. Work related stress due to additional hours required to achieve correct level of data inputting leading to sickness absence Lack of assurance that all women are captured for both operational clinical and financial ends. This leads to uncaptured activity and risk to safety if women are not entered onto the system appropriate due to the above Loss of income due to poor data quality. The cross checking is dependent on time being available for the team to complete this time consuming task.				

Board Assurance Framework

	Ineffective use of midwifery time- midwives continuing to report excessive additional effort to correct omissions and inaccuracies, impacting upon carer/woman relationship and data quality, and leading to concerns that the current situation may impact the Trust's aspirations to achieve outstanding status.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Implementation of new EPR system	New EPR is fully in use and all training completed	Implementation plan Training of staff on new EPR.	Arya, Dr Rita	30/03/2022	

Board Assurance Framework

Risk ID:	1207	**Executive Lead:**	Michelle Cloney, Chief People Officer	**Rating**	
Strategic Objective:	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			**Initial:**	16 (4 x 4)
Risk Description:	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.			**Current:**	16 (4 x 4)
				Target:	8 (2 x 4)

Assurance Details:

The Trust COVID-19 Workforce Risk Assessment Tool was developed by the HR and OD Team and launched in July 2020. The electronic tool enables all members of staff to undertake a self-assessment and followed by a risk assessment with their line manager where required. The implementation of the tool was supported by guidance, virtual training and regular reporting.

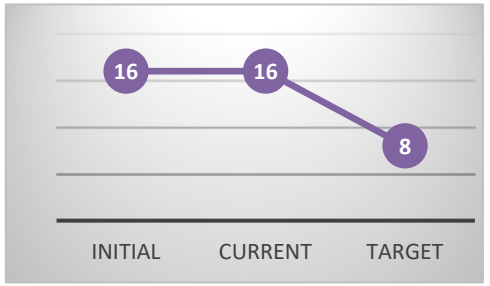
Trust compliance as at 9th November 2021

Have you offered a Risk Assessment to all staff? - **Yes**
What % of all your staff have you Risk Assessed? – **95.04%**
What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary? – **95.52%**
What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary? – **92.44%**

Reports of any outstanding self-assessment and risk-assessments are provided to managers on a daily basis and numbers of outstanding assessments by CBU / Department are escalated to Tactical Meeting. In addition, the HR Team proactively make contact with any managers where there are outstanding assessments.

In late October 2021 at letter was sent out to all staff who have not completed the self-risk assessment in a timely manner, the letter reinforced the message that the self-risk assessment tool is one of a series of safety measures that the Trust has introduced, to ensure the safest possible working environment for all of our staff and patients whilst we continue to respond to the Covid-19 pandemic and healthcare needs of our community.

The number of outstanding self-risk assessments reduced by 43%. A second letter will be sent late Nov-2021 outlining a formal process that will be followed should the self-risk assessment not be completed.



Assurance Gaps:

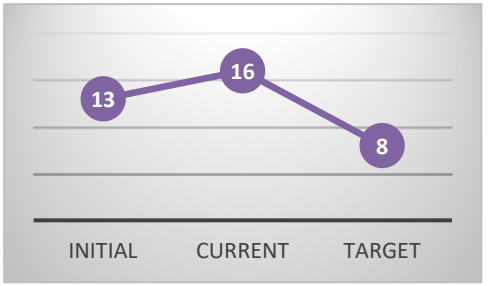
At 9th September 2021:
•131 staff members yet to complete self-assessment (reduced from 231 in September 2021, demonstrating the impact of the letter)
•0 Management Risk Assessments (required when an individual identifies as having a COVID Vulnerability) have been outstanding since at least March 2021
•5 Management Risk Assessments (required when an individual identifies as having a COVID Vulnerability) have been outstanding since at least Apr 2021
•91 Management Risk Assessments have been outstanding since Jul 2021

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Managers must complete all outstanding risk assessments and any new risk assessments that are triggered.	Completion of risk assessments.	• Letter to be sent to Managers • Completion of risk assessments.	Carl Roberts and Laura Hilton Deputy Chief People Officers	30/11/2021	
To encourage the completion of the Self-Risk Assessments	Completion of Self-Risk assessments.	• Further communication to staff re the importance of completing Self-Risk Assessments	Carl Roberts and Laura Hilton Deputy Chief People Officers	30/09/21	Letter sent on 28-Oct-21

Board Assurance Framework

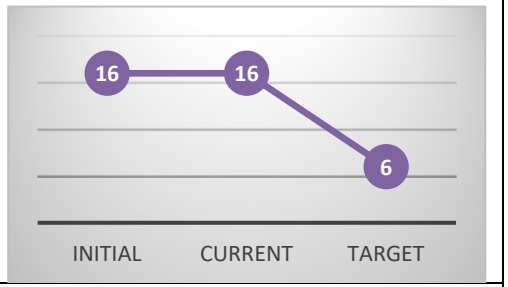
		• Completion of Self-Risk assessments.			
Further encouragement on the completion of the Self-Risk Assessments to be sent, outlining the formal process that will be followed should the self-risk assessment not be completed	Letter sent requesting the completion of Self-Risk assessments.	• Further communication to staff re the importance of completing Self-Risk Assessments • Completion of Self-Risk assessments	Carl Roberts and Laura Hilton Deputy Chief People Officers	30/11/21	

Board Assurance Framework

Risk ID:	1372	**Executive Lead:**	Alex Crowe	**Rating**	
Strategic Objective:	Strategic Objective 3: We will…Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	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 an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case			**Initial:**	12 (3 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	Assurance: • Trust Board approved Strategic Outline Case has moved the project to the Outline Business Case stage • EPR Project Board (and escalation/assurance through Digital and Trust Boards) • Regular, documented conference call with NHSE, NHSX and NHSD • Noted support of the Health Care Partnership Digital Board • Commissioning support of expert third party for development of business cases • EPR SRO and CIO to meet Chief Finance Officer and Trust Chair to agree expectations to assure the support of the Trust Board Controls: • Approved business case for a new 3 – 5 year Lorenzo contract in support of time required to complete the procurement and deployment • Trust financial modelling includes 3 – 5 year Lorenzo costs • DXC working with Trust to migrate Lorenzo to AWS platform in spring 2021 to improve baseline performance • Trust performance Task & Finish group has introduced measures such as auto desktop reboots and Tech Refresh continues to assure all desktops are less than 5 years old •Implementation of approved Principle CCIO and Associate CCIOs to support the business case production •Pre-procurement market engagement with supply chain, against a pre-agreed discussion framework, to inform further costs and benefits opportunities for OBC				
Assurance Gaps:	Gaps In Assurance: • Checkpoint meeting with senior stakeholders to review the potential affordability Gaps In Controls: • Financial modelling of realistic collaboration options to provide genuine 5, 10 and 15 year options to control whole life costs • Identification of further realistic cash releasing benefits • Deployment of dedicated Maternity EPR and thus avoidance of the associated risks • Approved business case for deployment of Lorenzo Theatres • Contracts for tactical solution not yet signed as offer from Dedalus does not matched approved Business Case. • No project manager to manage the project				

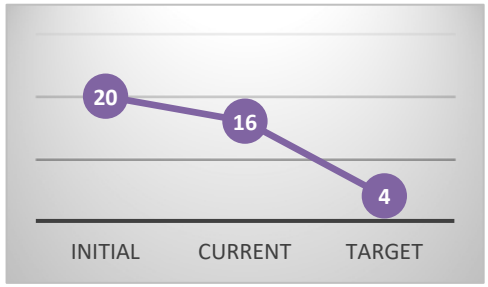
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Signing of tactical agreement	Signing of tactical agreement	Signing of tactical agreement	Deacon, Stephen	29/10/2021	
Maternity go live	Maternity go live	Maternity go live	Deacon, Stephen	30/04/2022	
Recruitment of temporary PM for the financial year and a fixed 2 year term of a Programme Manager	Recruitment of temporary PM d Programme Manager	- Recruit PM - Recruit Programme Manager	O'Brien, Emma	29/10/2021	

Board Assurance Framework

Risk ID:	1233	**Executive Lead:**	Alex Crowe	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	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.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	6 (2 x 3)
Assurance Details:	A surgical ambulatory nurse co-ordinator is supporting surgical emergency admission patients. An admission avoidance clinic is set up but cannot be utilised as we have no where to bring patients back to when CAU is bedded. Regular CAU steering group in place and will continue to review situation.				
Assurance Gaps:	Due to demands on CAU we are limited to the number of surgical patients that can be brought back daily. During bed pressures CAU is likely to be a bedded area which further limits the availability for the surgeons to review any admission avoidance patients. Surgical patients who would usually go to CAU are having to wait in a crowded ED. Surgeons are struggling to find assessment areas in ED to treat patients.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Appointment of 2nd Surgical Ambulatory Nurse	Currently we have one Ambulatory coordinator. Nursing team to review if 2nd Nurse is required.	Senior nursing team to review ambulatory nurse coordinator post and appoint 2nd nurse to ensure 7 day service.	Blackwell, Emma	01/10/2021	27/07/21
Surgical Hot Clinics	Arrange for surgical hot clinics to take place weekly to avoid patients attending CAU.	Find alternative location for hot clinics to be established. Arrange medical and nursing cover for hot clinics.	Blackwell, Emma	01/10/2021	23/09/21

Board Assurance Framework

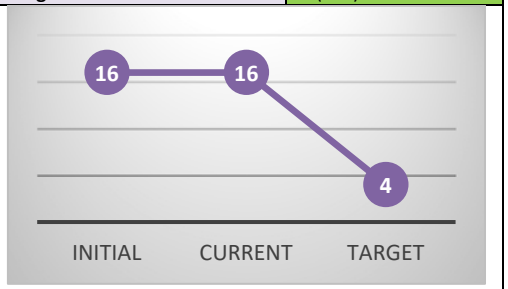
Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited available resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.			**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Controls: 2018 C&M H&CP Estates strategy – updated annually Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Planned Maintenance Program Reactive maintenance regime Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments Assurance: External estates compliance audit carried out in November 2019 which has in formed a number of remedial actions to improve compliance across the estate Monthly Estates compliance audit Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment action plan and monitoring - Capital Planning Group – determine how the trust capital is spent Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks New hospitals for Warrington and Halton groups – providing a platform to address the critical infrastructure and backlog risk 20-21 capital programme approved which includes £2.27m to address backlog maintenance Business Case for ED Plaza Scheme approved and due for completion in March in February 2022 Commencement of Phase 2 (although approved) reliant on capital funding in 2021/22 which is now confirmed. Progress will now be made against the scheme with indicative construction completion date of January 2022. Critical Infrastructure Capital Funding to support schemes with critical and high levels of backlog maintenance approved Cancer Alliance funding of £0.5m for endoscopy enabling work at Halton to improve the environment Phase 1 of CT Buildings work complete Additional staff rest areas deployed to support social distancing and reduce staff nosocomial infection during rest and break times during the Covid-19 pandemic. Approved and recruiting for additional Estates Compliance Manager role to support routine compliance and routine small estates works. New MRI build set to be completed in October 2021 New Endoscopy roofing infrastructure at Halton set to be completed in November 2021 Capital schemes to improve paediatric outpatients due for completion in December 2021 Capital schemes to develop a Urology Investigation Unit set to be completed by March 2022 Mortuary refurbishment set to be completed by November 2021				

Board Assurance Framework

	Ward B18 refurbishment completed in October 2021 Moving clinical services out of the Kendrick Wing and new Breast clinic opened at Halton in September 2021 Residual screening service to be opened at Bath Street by March 2022	
Assurance Gaps:	Estates staffing - reduced staffing numbers since 2011 has impacted on ability to carry out elements of essential maintenance – review to be undertaken in 2021 Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of maintenance in I&E budget Use of Resources - benchmarking against backlog maintenance and critical infrastructure risk are below national medium Threat to the delivery of capital schemes due to the pandemic e.g. manufacturing delays, additional costs of construction relating to IPC guidelines and the unavailability of an appropriately skilled workforce.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Complete Premises Assurance Model by April 2021	Set up working group with Estates and Finance team to complete the documentation and file the evidence required to complete the PAM)	By completing, analysing and actioning any gaps in compliance	Lamb, Robert	25/06/2021	25/06/2021

Board Assurance Framework

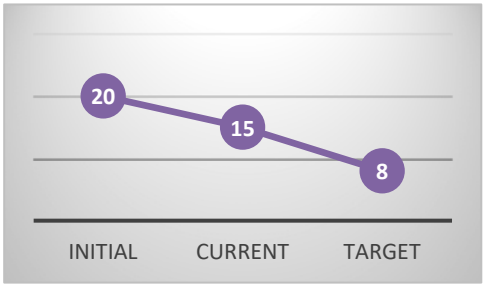
Risk ID:	1108	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to maintain staffing levels, caused by high sickness 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.			**Initial:** 16 (4x4) **Current:** 16 (4x4) **Target:** 4 (4x1)
Assurance Details:	Provided listening events and 1:1 meetings for all staff. This has resulted in accumulated feedback to identify key themes to be addressed. Review of all processes. Interim Head of Midwifery in post New CBU manager appointed and in post. Appointment of 9.2 WTE midwives. Daily staff meetings taking place to intensively monitor staffing. NHSP and agency staff are being used to back fill shifts where possible. Nursing staff utilised for C23 when it is not possible for a midwife to fill the post. When short staffed on C23, an extra maternity support worker is asked to work. NICE staffing red flags linked to Safecare implemented at beginning of June 2021 Midwifery management team strengthened – Two matrons in acting posts until end September 2021 All additional 9.2 WTE Midwives in post. Midwives redeployed across the unit as appropriate 1:1 care rate currently @ 92% Birth suite Manager appointed and in post 9th June 2021 Additional 3 Band 7 Birth suite Co-ordinators appointed 1st Feb 2021. Interview for permanent posts 27th June 2021 Birthrate plus full review funded by Local Maternity System to be carried out by 31st Dec 2021 3 X Interim managers extended until 30th June 2021 Board approved 6 recurrent additional band 7 WTE midwife posts and 1.58 band 6 WTE in March 2021 to support the roll out of the Continuity of Carer model – recruitment on going Daily staffing meeting and redeployment of staff to maintain safe staffing levels Birth Rate plus review has been undertaken and awaiting draft report end of October. This will incorporate Halton staffing and acuity in the report. Midwifery Staffing challenges continue and reviewed daily. Cheshire and Mersey Escalation and Divert Policy updated to support internal and external escalation. Weekly LMS gold command staffing meeting to identify staffing hotspots and need for mutual aid. Staffing vacancies appointed awaiting start date.			
Assurance Gaps:	Potential for uncertainty across the services as a result of COVID-19 pandemic Short term sickness 1 matron in maternity - 1 matron has stepped down Covid pressures remain and are exacerbated by the current annual leave absences this is a regional and national concern. Gold command and a daily / weekly sit rep has been created. Transfer of maternity service from Halton to WHH from 1st November 2021 including staff transfer and need to complete local induction which will add to current staffing pressures. Current sick rate IRO 8%			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continue to review staffing on a regular basis with daily reviews, and monitor vacancy rates closely to ensure prompt recruitment to any midwifery vacancies. Birth rate plus is currently in	Actions to monitor staffing	daily reviews	Owens, Catherine	30/11/2021	

Board Assurance Framework

progress to be completed by the end September.					

Board Assurance Framework

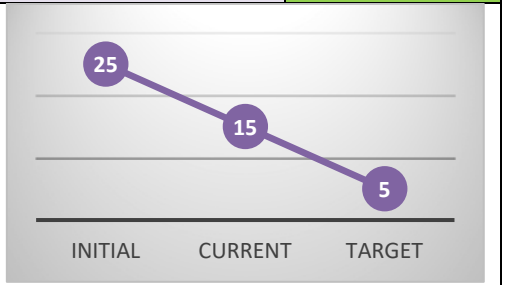
Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			**Initial:**	20 (5x4)
				Current:	15 (5x3)
				Target:	8 (4x2)
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the C&M Health and Care Partnership plans. The Trust has developed effective clinical networking and integrated partnership arrangements. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. Agreement with key stakeholders to progress single programme and proceed with OBC development. - Agreement of sustainability contract with Warrington CCG and subsequently Warrington & HaltonSystem Financial Recovery Plan - Regular Strategy updates are provided to the Council of Governors - Clinical strategy wide engagement - Clinical Strategy approved by Trust Board - CBU specialty level strategies complete and incorporated in business plans. - Initial talks held with Elective Care C&M Lead in relation to the suitability of Halton as a potential Elective Care Hub. Opportunity to accelerate elective hub as part of Covid recovery - Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. - NHSE and local Commissioners supportive of draft strategy for breast screening. Breast Centre of Excellence being implemented as a priority to support COVID-19 recovery. - DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. Phase 3 of the HIP announced. WHH drafting an Expression of Interest (EOI) for submission in September 2021 - Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. - Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. Pathology OBC supported by the Trust Board - Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services to commence from January 2022.				

Board Assurance Framework

	- Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington - Town Deal plan for Warrington submitted. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. - The Trust is leading the development of the detailed plan for the Health & Wellbeing Hub. - Strategy refresh completed and approved at Trust Board to confirm 2020/21 priorities. Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. - In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. - The Trust Board agreed in March 2021 that a transaction between BCH and WHH is no longer required, given that the White Paper enables an acceleration of place-based integration including all commissioners and providers. - The Trust has been awarded Social Value Award status recognising the contribution to the outcomes of local populations. It is one of only two organisations in Cheshire & Merseyside to receive the award. - £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington - WHH commenced a focussed programme of work on addressing health inequalities, the green agenda and our role as an anchor instiution. Initial work recognised as the exemplary within Cheshire & Merseyside.	
Assurance Gaps:	Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress. Risk to securing capital funding to progress new hospitals Progress in collaboration with Alderhey to repatirate activity hindered due to COVID-19. Focus on addressing waits within organisation prioritised	

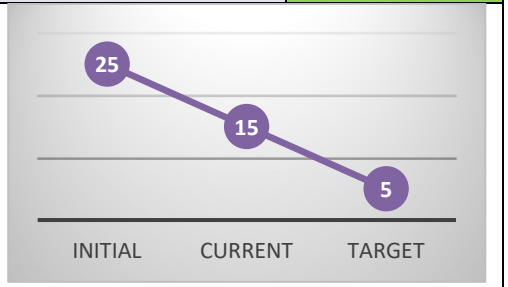
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Progress plans for new hospitals to be best placed to secure funding when available	Develop SOCs and participate in competitive process for HIP funding	Develop SOCs and participate in competitive process for HIP funding	Lucy Gardner	SOCs – April 2020 Expression of Interest due September 2021	SOCs – March 2020
Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	31/03/2022	

Board Assurance Framework

Risk ID:	1274	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	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.			**Initial:**	25 (5x5)
				Current:	15 (3x5)
				Target:	5 (5x1)
Assurance Details:	Plan in place to carry out Asymptomatic testing of staff. There is a high-level rationale for testing due to the level of community transmission in the North West as well as nosocomial infection rates. Staff are being tested over a ten-day period. All staff to wear face masks in both non-clinical and clinical areas. Use of effective messaging and communication. Risk stratification in place so there is no service level disruption to provision. Staff groups have been split to ensure only 5 members of staff from each service are tested at any one time. Lateral flow self-testing twice weekly in place – 1.8% positivity rate Loop-mediated Isothermal Amplification (LAMP) testing introduced. LAMP testing introduced across the Trust and actions in place to increase uptake Internal review of Clinically Extremely Vulnerable (CEV) completed to expedite return to work and ensure staff safety. Updated guidance in place to support staff return to work Review of CEV staff continue to support returns to work New self-isolation guidelines received, and SOP developed. SOP circulated and effective from 23.08.2021				
Assurance Gaps:	Potential for unsafe staffing levels. Requirement to improve uptake of LAMP testing across the organisation				

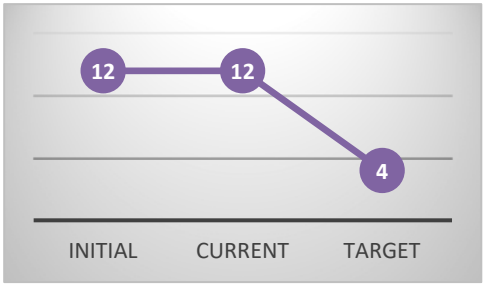
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Improve compliance with uptake of LAMP testing across the Trust	Campaign to increase awareness	Campaign to increase awareness	Rylett, Louise	31/08/2021	

Board Assurance Framework

Risk ID:	1331	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	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.			**Initial:**	25 (5x5)
				Current:	15 (5x3)
				Target:	5 (5x1)
Assurance Details:	•Creation of additional appropriate clinical areas with appropriate clinical staff; •Non-urgent elective procedures stepped down to help support sufficient staffing levels and provide additional clinical areas. •Daily submission of Critcon score to SEOG, Gold Command and the wiser network to optimise the deployment of mutual aid as required. •National 'Call to Arms' to encourage experienced ICU Nurses & Doctors to return to work; - 2 staff joined ICU from external providers •Internal 'Call to Arms' for staff who have previous experience of the ICU setting and communications with Managers to support release - 15 staff identified – worked in Wave 1 and 2 on a part and full time basis depending on availability and release from current role. 86 staff identified in the re deployment process under Category A (category A are staff in the trust with Critical care experience or transferable skill suitable for critical care) •AHP, Proning & Transfer Teams created to support ICU staff •Transfer out of ICU via the Critical Care Network to support decompression; •Mutual aid in place to ensure adequate provision of essential equipment e.g. Non-Invasive Ventilation (NIV) •Incentive scheme in place to help support sufficient staffing levels; •Off framework agency usage to help support sufficient staffing levels; •Nurse buddy system in place; •Opening of B18 in October 2021 & approval of Respiratory Business case supports provision of bed capacity for ICU patients				
Assurance Gaps:	•Limited estate •Limited O2 flow capacity •Limited staffing				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Creation of additional appropriate clinical areas with appropriate clinical staff.	Additional Clinical Areas	Creation of additional appropriate clinical areas.	Martlow, Sharon	30/06/2021	30/04/2021

Board Assurance Framework

Risk ID:	1290	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices, technology products and services, clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.			**Initial:**	12(3x4)
				Current:	12 (3x4)
				Target:	4 (1x4)
Assurance Details:	• The Brexit Sub Group has been stepped up with key leads for the associated work streams (Procurement, Pharmacy, EPRR, Finance, Communications, HR and Information). • The Procurement Department has undertaken a review of all suppliers as part of the national self-assessment exercise which was completed as C&M HCP system. Whilst this piece of work has been completed with no apparent adverse impact the Procurement Department continues to monitor fulfilment of orders to adopt a process of early investigation where supply appears to be disrupted. In addition, the Procurement Department is implementing processes to monitor prices to determine if there has been any financial impact upon exit from the EU. To date there are no significant price increases; for the period January to March 2021 there has been a net price impact of £621. This work will continue for Q1 and Q2 of 2021/22. • The Pharmacy department has contacted the Regional Procurement Pharmacist who has advised that there will be monitoring of medicines purchases and usage centrally to manage medicines continuity. Issues / concerns / actions required will be communicated via regular updates to the Chief Pharmacist network. To date there have been no medicines supply issues linked to the end of the EU transition period, however recent logistical changes have impacted on the way some items are delivered. This has not caused much of an impact on the service and will be monitored through Brexit Subgroup or escalated if there is an impact on business continuity. • Nationally, lessons in supplies and medicines have been captured from the COVID-19 period and there has been assurances made around national supplies of PPE and consumables. • Service level business continuity plans continue to be refreshed. • The majority of Pathology consumable suppliers are being checked by DHSC for supply assurances. Suppliers not on this list have been identified to procurement and are being address through the procurement department. • The Digital department has reviewed all the Trust key IT systems and data flows. To date no issues have been identified which will impact upon data flows. A time limited 'bridging mechanism' has been agreed which will allow personal data to continue to flow as it does now from the EEA whilst EU adequacy decisions for the UK are discussed. A UK data adequacy decision was reached in June 2021 enabling personal health data to continue to flow legally from the EU to the UK. The Information Governance Lead will now only update by exception only. • Assurance letters and communication regarding the EU settlement scheme have been circulated as a reminder about the settlement scheme. An assurance exercise based on the EU settlement scheme was submitted to NHSE in May 2021, indicating no significant risks. The HR and OD team continue to monitor settlement status, impacts on leavers and new starters and the robust recruitment process includes reference to EU settlement status. • Re-instigated the Brexit Sub-Group on 9th September 2020 and the group continues to meet bi-monthly, this will be quarterly from January 2022. • In December 2020 NHSE/I completed an assurance exercise with NHS Trusts to ensure EU Exit SRO and EU Exit Team in place. • Processes developed by UEC and Finance to ensure chargeable patients are managed appropriately. From the Chargeable Patients point of view, there are no risks to financial procedures, patients or staff. Additional processes and a dashboard have been shared for assurance purposes. Additional communications plans continue with clinical teams to ensure the Chargeable Patients SOP is embedded. • Daily SitRep reporting was stepped down on 08/06/21 as per communication from NHSE. • Single point of contact in place for operational response, aligned with the regional Level 3 incident expectations.				

Board Assurance Framework

	• An EU Exit deal was established on 24th December 2020. The impacts of the terms of this deal and the implications on the supply of medicines and consumables are under review nationally and locally. The Brexit Subgroup continues to meet to monitor the implications of the established deal. • The subgroup continues to meet bi-monthly to monitor national changes, including the current logistical challenges associated with EU exit.	
Assurance Gaps:	Continued national uncertainty on the terms of the EU exit. Trusts being requested not to stockpile supplies. Potential price increases to supplies. Winter pressures, COVID-19 pressures and increase demand on Workforce and UEC.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Reinstate Brexit Sub Group	Reinstate Brexit Sub Group	Reinstate Brexit Sub Group	Andrea McGee	01/02/2021	09/09/2020

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/162**	
SUBJECT:	**Formal Public Consultation Outcomes Report – Runcorn Shopping City**	
DATE OF MEETING:	24th November 2021	
AUTHOR(S):	Pat McLaren, Director of Communications + Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications + Engagement	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	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)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability, #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In July 2019, Halton Borough Council (HBC) secured £1m through the Liverpool City Region Town Centre Commission to develop schemes to further regenerate Halton Lea. The Trust has worked in partnership with HBC to develop a scheme as part of this bid to create an out of hospital health hub within Runcorn Shopping City. The Trust proposed relocating its Audiology and Ophthalmology outpatient service from Halton Hospital to this health hub and relocate its Dietetics service from Halton Hospital AND St Paul's to this hub also. As this was a significant service change – ie cease provision at current location and commence provision at Runcorn Shopping City formal public consultation was required in line with the Gunning Principles. The Trust worked in partnership with Commissioners NHS Halton and NHS Warrington CCG to conduct a period of pre-consultation engagement and preparation work before carrying out formal public consultation. The Halton Health Performance Board (scrutiny) received and approved the consultation plans.	

	The outcomes of the consultation follow in this report. A comprehensive equality impact assessment was also carried out and is included in the appendices. We are grateful to the 569 respondents who took the time to share their views which have been incorporated in the further design and development of the service.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	It is recommended that the Board note the outcomes of the recent public consultation.			
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			

Development of a Health Hub in Runcorn Shopping City

Public Consultation Outcomes Report

17th September 2021

CONTENT

1. INTRODUCTION

1.0 Town Centre Commission Bid

In July 2019, Halton Borough Council (HBC) secured £1 million through the Liverpool City Region Town Centre Commission to develop schemes to further regenerate Halton Lea. The Trust has worked in partnership with HBC to develop a scheme as part of this bid to create an out of hospital "health hub" within Runcorn Shopping City.

This bid is based on the strategic direction of the NHS, as set out in NHS Long Term Plan, and reflected within the One Halton Health and Wellbeing Strategy, of improving access and delivering services within the community. It is designed to support and increase access to some diagnostic and outpatient services in a more convenient location.

In addition, the proposed expansion and/or relocation of these services delivered in a non-hospital setting is more convenient and accessible for patients and limits the risk of hospital-acquired infection, critical in the Covid-era.

1.1 Service Identification

An extensive programme of clinical engagement was undertaken to determine the most appropriate services to take advantage of this opportunity. This identified services that are "low risk", "clinically suitable", and that have consistent levels of activity, as appropriate for the proposed location. Ophthalmology, Audiology, and Dietetics worked up plans to be the first services to deliver from this location. Each service has a different strategy for how best to deliver their additional or relocated services at Runcorn Shopping City. These initial plans are described below.

It is important to note that the proposed relocation of the identified services to the Shopping City is intended to expand and simplify patient access. In some cases, these services are relocating by a distance of 300 metres from the rear of the hospital to the entrance to Runcorn Shopping City. Some Dietetics services are planned to move from St Paul's Health Centre to Runcorn Shopping City, which is a distance of around 3.5km and is accessible by public transport.

The clinic space that would be vacated by these services at Halton would be replaced by other clinical services – either those that require additional space or those that are relocating from Warrington, in line with the Trust's plan of expanding and further developing Halton as its dedicated elective site – much of which is already underway as a result of the Covid-19 pandemic.

1.2 Current Service Delivery

1.2.1 Ophthalmology

Currently, the Trust's ophthalmology and orthoptics services are delivered entirely from clinics at Daresbury Wing, Warrington Hospital and the Nightingale Building at Halton Hospital. This service is delivered by a range of clinicians, including consultants, nursing staff, AHPs and more.

Current issues with the delivery of this service include the lack of service expansion space, which is impacting service delivery in the context of a growing population, backlog of patients following the Covid-19 pandemic and referral base. There is also currently a lack of provision of certain services at the Halton Hospital site, meaning that a number of patients must travel out of area to access cataract and glaucoma services.

1.2.2 Audiology

Currently audiology provision is delivered from both Halton and Warrington Hospitals. At the Halton Hospital site there is insufficient audiology booth capacity to accommodate the activity required for both Audiology and ENT.

1.2.3 Dietetics

The Trust's Dietetics service currently deliver their outpatient services in Halton from Halton Hospital's Nightingale Building and St Paul's Health Centre, in Runcorn.

1.3 Proposed Future Service Delivery

The table below outlines the proposed services to be delivered from Runcorn Shopping City.

Ophthalmology	Audiology	Dietetics
•Paediatric Orthoptic and Optometry clinics and Paediatric Visual Processing Clinics. Proposed move from HGH. •Glaucoma assessment clinics, cataract pre and post-operative clinics, ophthalmic primary care clinics (new patients only) and neuro-ophthalmology clinics. Services only provided at Warrington hospital to be replicated at Shopping City. •Hydroxychloroquine Screening Service. New service.	•Assessment, fitting and repair of hearing aids, helping to reduce waits for these appointments and enabling provision in a potentially more convenient location. A proposed expansion of services currently provided at HGH.	•Two general paediatric clinics and five general adult clinics per week. Consolidation from HGH and St Paul's Health Centre with intention of improving accessibility and consistency of service.

Table 1: Proposed Services to be Delivered from Runcorn Shopping City

1.3.1 Ophthalmic Services

Ophthalmology's proposed initial plan is to **move** services currently being delivered at Halton Hospital to Runcorn Shopping City. This includes Paediatric Orthoptic and Optometry clinics and Paediatric Visual Processing Clinics.

This plan also includes **replicating** some services that are currently delivered only at Warrington Hospital at Runcorn Shopping City. These include: Glaucoma assessment clinics, cataract pre-and post-operative clinics, ophthalmic primary care clinics (new patients only) and neuro-ophthalmology clinics.

There are also plans to introduce a new service not currently provided by the Trust at Runcorn Shopping City, which is the Hydroxychloroquine* Screening Service. This new service is currently being developed in order to screen rheumatology patients to ensure their suitability for hydroxychloroquine treatment, and to routinely monitor those patients currently on the treatment for any visual complications.

** Hydroxychloroquine is a medication used to treat several conditions including rheumatoid arthritis, systemic lupus erythematosus, some skin conditions (especially photosensitive ones) and others that involve inflammation. It is known that some people who take hydroxychloroquine for more than five years and/or in high doses are at increased risk of damage to their retina, the light sensitive layer of cells at the back of the eye. This is known as retinal toxicity or retinopathy*

1.3.2 Audiology Services

Audiology plans an expansion of current services that are currently offered (and would continue to be offered) at Halton Hospital. This will allow more patients to be seen each week. The planned services for potential provision within Shopping City include assessment, fitting and repair of hearing aids, helping to reduce waits for these appointments and enabling provision in a potentially more convenient location.

1.3.3 Dietetics Services

Dietetics' initial proposed plan is to consolidate clinics that are currently held at both Halton Hospital and St Paul's Health Centre and deliver these instead at Runcorn Shopping City.

This includes two general paediatric clinics and five general adult clinics per week.

This consolidation will provide a consistent and more accessible base for this service.

1.4 Impact of Proposed Service Developments

The proposed service developments will enable at least 3,318 additional outpatient appointments per year.

A summary of the proposed annual activity is in the table below:

Specialty	Clinic	Activity moving from current location to Shopping City	Additional activity in Shopping City	Total Activity
Ophthalmology	New Glaucoma	0	588	588
Ophthalmology	Glaucoma monitoring	0	882	882
Ophthalmology	Ophthalmic Primary Care	0	588	588
Ophthalmology	Cataract Primary Care	0	588	588
Ophthalmology	Paediatric Orthoptic	1176	0	1176
Ophthalmology	Joint orthoptic/optometry	294	0	294
Ophthalmology	New Paediatric joint orthoptic/optometry	294	0	294
Ophthalmology	Visual processing	1176	0	1176
Audiology	Hearing Aid Assessment	0	672	672
Dietetics	Paediatric Dietetics	588	0	588
Dietetics	Adult Dietetics	1260	0	1260
	Total	**4788**	**3318**	**8106**

Table 2: Annual Activity Resulting from Proposed Service Delivery at Runcorn Shopping City

This increase in activity within ophthalmology will reduce current long waits in the Glaucoma Monitoring Service and the Ophthalmic Primary Care Clinic.

1.5 Additional Benefits

There are considerable additional benefits to the provision of these services within Shopping City:

Service	Benefit
Ophthalmology	Improved estate will reduce risk around paediatric waiting (risk 1212)
	Glaucoma patients will no longer travel out of borough for routine ophthalmic appointments
	Equitable delivery of cataract pre-operative and post-operative appointments across both Warrington and Halton boroughs
	Expected reduction of Did Not Attend / Was Not Brought rates for patients no longer traveling out of borough
Audiology	Attraction of additional Any Qualified Provider tariff patients to community setting
	Additional audiology booth capacity available for ENT at Halton Hospital
Dietetics	Embed established clinics in a setting closer to the community
	Consolidate service in one location

Table 3: Additional Service Benefits Through Proposed Move

1.6 Future Opportunities

There are additional Opportunities that become available following the commencement of service delivery from Runcorn Shopping City. These include:

- Provision of additional capacity for outpatient services within fallow sessions or at weekends in a 'COVID-light', non-hospital environment. This could be utilised by the Trust or partnering healthcare organisations where appropriate. The Trust will continue to engage with partners throughout the project lifespan to identify these opportunities.
- There is room for the Trust and/or partners to occupy currently fallow space, expanding the number of services offered from the venue and potentially offsetting some of the ongoing revenue funds this business case is requesting. The Trust will continue to engage with partners throughout the project lifespan to identify these opportunities.
- High street space to advertise Trust and complementary NHS services directly to members of the public.

2. APPROACH TO LOCAL INVOLVEMENT, ENGAGEMENT AND CONSULTATION

2.1 Requirement for Consultation

NHS commissioning organisations have a legal duty under the National Health Service Act 2006 (as amended) to 'make arrangements' to involve the public in the commissioning of services for NHS patients ('the public involvement duty'). For CCGs this duty is outlined in Section 14Z2 (and Section 13Q for primary care services) of the Act to fulfil the public involvement duty, the arrangements must provide for the public to be involved in (a) the planning of services, (b) the development and consideration of proposals for changes which, if implemented, would have an impact on services and (c) decisions which, when implemented, would have an impact on services.

Further to this the Consultation Institute states "…there are many statutory requirements for consultation, but the truth is that ALL significant changes to long-standing services need consultation.

The Courts provide their own incentive to engage. It's called the '*doctrine of legitimate expectation*'. If the public has a sound basis for expecting to be consulted, then failure to do so can lead to losing a Judicial Review. And Judges have ruled that if people have been accustomed to the benefit of a service, then its withdrawal without consultation can in many circumstances, be unlawful".

2.2 Local involvement, engagement and consultation plans

The Trust, working with NHS Halton and NHS Warrington CCGs and Halton Borough Council, undertook a period of pre-consultation prior to full public consultation on the proposed model. The process for this was as follows:

Defined objectives of pre-engagement and formal consultation

1. To ensure the local population is made aware of the proposals and provided with a number of platforms to engage and participate
2. To ensure the local population are able to make recommendations and suggestions relating to the proposed development of the Health Hub at Runcorn Shopping City
3. To ensure any emerging issues and themes are taken into account and any potential mitigating actions are considered
4. To inform the Public Consultation documentation, questions and answers using initial feedback from the first round of engagement
5. To prepare engagement reports for the appropriate stakeholder and advisory groups.

2.3 Equality Impact Assessment

The full rationale and results for the statutory Equality Impact Assessments are detailed in Appendix 4.

The proposals for Runcorn Shopping City have had significant and consistent input at both initial service development and post-consultation analysis stages from the Trust's service leads and the Equality, Diversity and Inclusion leads. The proposed service offering at Runcorn Shopping City has been subject to scrutiny through the appropriate governance and review protocols at WHH, NHS Halton and NHS Warrington CCGs and Halton Borough Council to ensure the principals of equality, diversity and inclusion are strongly upheld, evidenced and delivered at the Runcorn Shopping City health hub.

It is accepted that the EIA implications inherent in this project are diverse and evolving, and as such the project and operational teams will view this report as well as the existing EIA as detailed in Appendix 4 as an active document. The project and operational teams will address the actions as set out in Appendix 4 while also reacting and responding to additional impacts as they arise.

A brief summary of the Equality Assessment arising from the consultation is as follows:

- The majority of respondents supported the proposal and rich feedback provided relating to equality concerns
- Public Sector Equality Duty will be met subject to actions and mitigations being actioned.
- Consultation was conducted and responses were received across the demographic spectrum
- No appreciable discrimination was discerned although people who were unsure or disagreed with the proposal had legitimate concerns about accessibility – chiefly transport, and mitigations have been set out to resolve this, predominately awareness raising of the alternative methods available

2.4 Methodology

The methodology for the pre-engagement and consultation exercises was designed based on the Gunning Principles (see appendix 1) and comprised:

2.4.1 Pre-consultation engagement (25th February 2021 – 17th March 2021) 3 weeks

- Drafting of comprehensive communications plan, an information and engagement document, FAQs and questionnaire
- Development of Easy Read, Additional Language and other format materials
- Local engagement with patients attending Outpatient appointments at Warrington and Halton Hospitals, and staff
- Promotion of the proposed plans for initial input
- Media release
- Briefing to MPs and other key stakeholders
- Collation of feedback, analysis to inform public consultation
- Collection of respondent data for Equality Impact Assessment
- Report on the pre-engagement exercise to relevant governance bodies

The aims of the pre-consultation engagement were to ensure the local population were aware of the proposals, to ensure the local population were able to be involved in the development of the proposals, to give an opportunity for the public to share their initial views of the proposals to relocate three outpatient services to Runcorn Shopping City and to feed into the formal consultation process.

Please see appendix 6 for a summary of pre-consultation outcomes.

2.4.2 Formal Public Consultation 7th May 2021 – 18th July 2021 (6 weeks)

- Engagement at outpatient clinics with patients across all sites
- Engagement with the public in Runcorn Shopping City
- Promotion of the proposed plans for initial input
- Media release
- Delivery of three virtual presentations (day, evening and weekend) by the head of Strategy and partnerships and three service leads on their plans, with a real time Q&A session
- Briefing to MPs and other key stakeholders
- Collation of feedback, analysis to inform public consultation
- Collection of respondent data for Equality Impact Assessment
- Report on the outcomes of the consultation to relevant governance bodies

The aims of the formal consultation were:

- To inform and involve all current and new patients of the three services of the proposals and seek their input and views
- To ensure the local population was made aware of the proposals and provided with multiple platforms to engage and participate by sharing their views and opinions
- To ensure the local population (including those people that were harder to reach) were able to make alternative recommendations and suggestions relating to the proposed changes to the services
- To ensure any emerging issues and themes were taken into account by the project team and any potential mitigating actions were considered
- To inform a final decision about the proposed changes following the conclusion of the consultation period.

2.5 Engagement

The formal public consultation took place over six weeks (see timeline above). The methods of engagement and communications for the consultation were diverse. Please see Appendix 2 for the completed log of engagement activity. Key points:

- Comprehensive and inclusive communications plan
- Summary Document and on-line/paper survey
- Attendance at events and meetings
- Holding live virtual public briefing sessions
- Face-to-face engagement sessions at Warrington and Halton Hospitals sites and Runcorn Shopping City.
- Stakeholder briefings
- Attendance at wellbeing boards and health scrutiny committees.

2.6 Respondents

Details of respondents can be found at Appendix 5

3. MAIN FINDINGS

The following section highlights the main findings from all the engagement activity. The information is from the survey results, attending various groups and meetings and the public engagement events and have been themed to form the findings.

3.1 Responses

569 responses were received in total - 254 during the formal consultation period and a further 315 during the period of pre-consultation engagement:

- 507 from online survey (221 during consultation and 286 during pre-consultation).
- 62 from paper forms returned to Trust (33 during consultation and 29 during pre-consultation).

51% of respondents to the formal consultation that provided an answer have accessed at least one of the three services provided by the Trust.

Service	Online		Paper		Total	
Audiology	73	33%	9	27%	82	32%
Ophthalmology	87	39%	13	39%	100	39%
Dietetics	26	12%	3	9%	29	11%
None	116	52%	8	24%	124	49%

Table 4: Service Access

75% of respondents to the formal consultation said they were aware of the proposals to provide outpatient services from Runcorn Shopping City.

Response	Online		Paper		Total	
Yes	168	76%	22	69%	190	75%
No	51	23%	10	31%	61	24%
I Don't Know	2	1%	0	0%	2	1%

Table 5: Proposal Awareness

62% of respondents felt they had been given enough information to form an opinion on the proposed changes

Response	Online		Paper		Total	
Yes	132	60%	24	75%	156	62%
No	54	24%	6	19%	60	24%
I Don't Know	20	9%	2	6%	22	9%
If no, what else would you like to know?	15	7%	16%	16%	20	8%

Table 6: Able to form an opinion

Respondents were asked where they would prefer to have to attend each of the three proposed outpatient services.

58% of respondents would be happy to access Ophthalmology at Shopping City

Location	Online		Paper		Total	
Current location at the hospital	98	44%	3	9%	101	40%
Runcorn Shopping city Health Hub	58	26%	24	75%	82	32%
Any of these locations	57	26%	8	25%	65	26%
None of these	8	4%	0	0%	8	3%

Table 7: Ophthalmology Location

58% of respondents would be happy to access Audiology services at Shopping City

Location	Online		Paper		Total	
Current location at the hospital	98	44%	2	6%	100	40%
Runcorn Shopping city Health Hub	58	26%	24	75%	82	32%
Any of these	58	26%	7	22%	65	26%
None of these	7	3%	0	0%	7	3%

Table 8: Audiology Location

55% of respondents would be happy to access Dietetics services at Shopping City

Location	Online		Paper		Total	
Current location at the hospital	87	39%	2	6%	89	35%
Runcorn Shopping city Health Hub	70	32%	25	78%	95	38%
St Paul's Health Centre	15	7%	6	19%	21	8%
Any of these	44	20%	0	0%	44	17%
None of these	5	2%	0	0%	5	2%

Table 9: Dietetics Location

62% of respondents supported or somewhat supported the proposals to deliver outpatient services from Runcorn Shopping City

Response	Online	Paper	Total

Yes	99	45%	29	91%	128	51%
No	90	41%	0	0%	90	36%
Somewhat	26	12%	2	6%	28	11%
I don't know	6	3%	1	3%	7	3%

Table 10: Proposal Support

3.2 Key Themes from Public Comments

The key areas requiring a response following comments received during the public consultation period are reflected in Table 11 below.

Themed Feedback

COMMON THEMES	***REPRESENTATIVE FEEDBACK***	***PROPOSED SOLUTIONS/ACTION***
PRIVACY	1. *Be considerate for people's privacy.* 2. *For the unit to be made private for those attending.* 3. *Confidentiality is my prime concern. Going to a hospital you could be there for many reasons or any conditions. At the shopping city health hub with its limited services you are more likely to be seen by others attending.*	Front entrance doors will be in place, with frosting on any glass to ensure privacy for those in the waiting space inside. The glass fronting for the unit will have decals to cover the window and provide privacy for those within from those passing by. The reception desk is set back from the entrance to the unit. The Unit itself is no more than 50 steps from Car Park 3, so patients will not need to walk through the complex to access the Unit.
FUNDING ARRANGEMENTS	1. *We are continually told how strapped for cash the trust is and yet you insist on wasting money on rent at the shopping city. These funds could easily be used to improve the current hospital.* 2. *I don't understand why as a Trust you are willing to spend money renting a unit at the shopping city, wasting funds once again.* 3. *Utilise existing infrastructure so it will save the nhs money* 4. *It wouldn't affect me, but can't understand why you would pay rent to a private landlord rather than use the hospital, invest the money in the NHS*	On publication of the consultation, clearly describe the process for appraisal behind the business case, including the funding received from Liverpool City Region, the additional appointments available due to improved waiting spaces and additional clinics, and the impact of the project on the regeneration of Halton Lea.

COMMON THEMES	REPRESENTATIVE FEEDBACK	PROPOSED SOLUTIONS/ACTION
FUTURE OF HALTON HOSPITAL	1. *Stop. Dismantling. Halton. Hospital. And. Invest. Into. It.* 2. *Continue to use the facilities that are already in place.* 3. *I would like to know if these changes are made would it mean the hospital closing eventually* 4. *It won't have any benefit. If the Halton hospital site shuts as there is nothing there then that is extremely negative.* 5. *I believe by moving any services out of Halton hospital will flag up the closure. I don't think I should go ahead* 6. *Moving service from the hospital will eventually lead to the closing of the hospital.*	Upon publication of the consultation result, reiterate the Trust's commitment and plans for Halton Hospital site, including significant investment in the last 18months into the Captain Sir Tom Moore building – new breast centre, creation of PACU to support more surgeries and the new Pre-Op centre. Further, explain planned expansion of the newer estate as part of the WHH New Hospitals programme.
LOCATION AND TRANSPORT	1. *Would not travel to Runcorn due to distance, unfamiliar with the roads and time taken to get there plus additional cost of crossing the bridge* 2. *It is harder to get there. Depending on where you live in Warrington if you wanted to use the free shuttle bus you would have to get to Warrington hospital then wait for the shuttle bus. This will take more time and if a patient is not well, I do not think it is fair for them to travel further. Surely there is a place in Warrington to accommodate all these services. Just because it will probably be cheaper to move there I think you are not thinking from an ill patient's point of view or a parent with children.* 3. *Such basic services should be available at both sites given the size of the towns they serve* 4. *Distance from disabled car parking to the new hub* 5. *Ensure that parking is still free and not make a charge because hospital patients using it.* 6. *Road signs. These need to be put in place before you start these services. So no one gets confused with where they are going.*	Transport options and directions will be provided to patients within appointment letters when the clinics begin from the new location. It will be reiterated when the results are published that this is a service expansion and Ophthalmic, Audiology and Dietetics services will still be provided on the Warrington site. Patients will continue to be able to choose where to access their care. Disabled parking is available in the car park with the designated spaces next to the entrance to the complex. There are no plans for any parking for attendees to the clinic to be charged for parking. Discussions regarding wayfinding will be had with Halton Borough Council and Shopping City management.
FUTURE EXPANSION	1. *I think other services like physio, blood tests, minor injuries and mental health facilities would be fab* 2. *Dental & Oral care would complement the services already planned* 3. *The INR clinic. Could that be moved too?*	Providing services closer to the community is a key strategic aim for the Trust. Future expansion into the space and provision of additional services is being actively considered in conjunction with partner organisations. Patient and service user views will be sought to help shape and affirm our future plans.

COMMON THEMES	REPRESENTATIVE FEEDBACK	PROPOSED SOLUTIONS/ACTION
COMMUNICATION	*In general there was some confusion about whether services were relocating from the Warrington site, despite attempts to resolve this in the consultation. This appeared to be as a result of people clicking straight on the survey link without reading the summary booklet, attending a meeting for more information or speaking with staff.*	Upon publication of the consultation outcomes, reiterate details of the services planned to operate from within the hub, and emphasise that there are no planned changes to services currently delivered at Warrington. Patients currently accessing care will have the option, where available, to attend at either site. Future specialty-level consultations will highlight services that are remaining on sites as well as those planned to move to reduce possible confusion.

Table 11: Themed Feedback

4. NEXT STEPS

The consultation outcomes have been shared with both Halton and Warrington Health and Wellbeing Boards, and with a multi-agency group comprising commissioners, specialist commissioners and the acute Trust:

- Share outcomes from formal consultation with Halton HWBB – 7th July 2021 - model and the approach to consultation were endorsed by the Board
- Submit consultation outcomes report to NHS Halton and Warrington CCG – September 2021 for input and approval
- Full consultation report to Trust Board for assurance – November 2021
- Publish consultation outcomes report – November 2021

The main findings and appropriate mitigations will be shared as part of the publication and service change process to ensure that actions required are achieved.

5. APPENDICES

APPENDIX 1. ADHERENCE TO THE GUNNING PRINCIPLES

When undertaking any public consultation in the UK the Gunning Principles must be applied. This has been confirmed by the Court of Appeal in 2001 (Coughlan case).

When assessing this consultation, the four principles will be applied as below.

1. When proposals are still at a formative stage - Public bodies need to have an open mind during a consultation and not already made the decision but have some ideas about the proposals.

The model proposed was developed following detailed discussions with clinical leadership within the Trust to identify the most clinically appropriate services to be delivered from the new location.

During the pre-consultation engagement, general questions were asked to gather views and experiences of service users and the wider public to ensure opinion was congruent with direction of travel for the proposals. During the pre-consultation stage it became clear that the messaging around the service provision across the two Trust sites, specifically that services would not be discontinued at the Warrington site. The supporting documents for the full consultation were revised to make this much clearer.

The consultation questions enabled people to give their opinions on the proposals, set out how the proposals would affect themselves or their loved ones and suggest any additional considerations.

During the consultation phase the proposals were still in design stage with scope to make amends to the plans based on any feedback or suggestions received.

2. Sufficient reasons for proposals to permit 'intelligent consideration' - People involved in the consultation need to have enough information to make an intelligent choice and input in the process. Equality Assessments should take place at the beginning of the consultation and published alongside the document.

The consultation documents made the reasons for the proposals clear, as below:

- The case for change;
- Full description of the proposed service model;
- Information on the location including travel options.

Throughout the consultation a Frequently Asked Questions document was produced and added to, to ensure that any additional questions or concerns were addressed.

An Equality Impact Assessment was undertaken to determine where specific engagement should be undertaken and to consider any potential impact to protected characteristics. As well as general engagement and communications focused work was undertaken. This included:

- Attending a wide range of meetings, holding pop up and drop in sessions (Covid-19 restrictions were in place hence many virtual attendances)
- Targeted engagement at Third Sector Organisations who represent the wider community;
- Targeted communications at service users (paper copy and QR code for virtual survey), with materials in clinics;
- Electronic online questionnaire advertised via Trust channels incl. social media;
- Face-to-face consultation at Warrington Hospital, Halton Hospital and Runcorn Shopping City (adhering to current social distancing requirements);
- Teams Live sessions (daytime, evening and weekend) with an open invite to all interested parties.

3. Adequate time for consideration and response - *Timing is crucial – is it an appropriate time and environment, was enough time given for people to make an informed decision and then provide that feedback, and is there enough time to analyse those results and make the final decision?*

There was a planned period of pre-consultation followed by a six-week consultation. Halton's Health Policy and Performance Board and Warrington Health Scrutiny Committees were briefed on the pre-consultation and consultation plans.

Respondents were able to take the paper survey away to fill in and return at their own convenience or complete the survey immediately if they wished. The paper survey booklet also contained details of the online survey, giving choice of how and when respondents could complete the survey.

The engagement and communications methods used were wide and varied. The full communications activity log can be seen in Appendix 2.

Full analysis of the outcomes of the consultation and the equality impact assessment and the feedback from partners will inform a final decision ('go/no go') on proposed changes by WHH Trust Board.

4. Must be conscientiously taken into account - *Think about how to prove decision-makers have taken consultation responses into account.*

Full analysis of the outcomes of the consultation and the equality impact assessment and the feedback from partners will inform a final decision ('go/no go') on proposed changes by WHH Trust Board.

Where respondents voiced concerns or raised queries these have been addressed or will form part of the formal response. For example concerns raised over privacy have been addressed with the design team through the design of window graphics to obscure the view through the frontage.

APPENDIX 2. ENGAGEMENT AND CONSULTATION – ACTIVITY LOG

Phase	Task	Date	Task lead	RAG
1	Halton Health Policy and Performance Board	24/11/20	Lucy Gardner	
1	Full suite of Engagement and Involvement materials developed in line with Communications and Engagement Plan	15/02/21	Comms	
1	Deploy Comms and Engagement Plan -including creation of website page, online survey and printed engagement document and questionnaire	01/03/21	Comms	
1	Press release to announce start of engagement period for Runcorn Shopping City proposals	03/03/21	Comms	
1	Stakeholder update issued – including item on engagement on Runcorn Shopping City proposals - to governors, partners, advocacy groups, MPs	5/03/21	Comms	
1	Virtual engagement sessions, hosted by Strategy and Services, via MS Teams	09/03/21 @ 18:30 & 10/03/21 @ 10:30	Services/ Strategy team	
1	'Tuesday Chat' at Halton Healthwatch, via ZOOM	09/03/21	Strategy	
	Engagement period ends	15/03/21		
1	Evaluate feedback from qualitative and quantitative engagement	18/03/21	Strategy	
2	Share outcomes of pre-engagement with Halton Health and Wellbeing Board and proposals for consultation	24/03/21	Lucy Gardner	
2	Share outputs from pre-consultation engagement shared with WHH Exec team and local CCGs	27/05/21	Strategy	
2	Approval of public consultation paper at WHH Execs (SEOG)	27/05/21	Lucy Gardner/SEOG	
2	Public consultation commences	07/05/21		
2	Deploy comms plan including public consultation webpage, online questionnaire, paper consultation document and questionnaire and posters and pull-up banners	07/05/21	Comms	
2	Website updated with all consultation materials including consultation documentation and link to online questionnaire	07/05/21	Comms	
2	Stakeholder and governor comms announcing start of consultation period and virtual	10/05/21	Comms	

Phase	Task	Date	Task lead	RAG
	consultation events to governors, partners, advocacy groups, MPs.			
2	Press Release announcing start of consultation period and virtual consultation events	10/05/21	Comms	
2	Posters advertising consultation displayed in Outpatient Clinics at Warrington Hospital and Halton Hospital. Paper FAQ booklets containing survey distributed to 3x clinical services.	10/05/21	Comms/Strategy	
2	Email to CCG Engagement lead re start of public consultation – asking for suggestions of groups to contact to increase representation *(response received 8th June and all suggested contacts already on WHH stakeholder list and contacted)* Followed up with email containing consultation resources	07/05/21	Comms	
2	Series of social media posts announcing consultation and inviting responses and also sharing details of the dates listed below where people can come and talk to us (see below)	07/05/21 to 18/06/21	Comms	
2	Face-to-face consultation (within social distancing) – Warrington Hospital Main Entrance	18/05/21 (AM) & 19/05/21 (PM)	Strategy	
2	Face-to-face consultation (within social distancing) – Captain Sir Tom Moore Building, Halton Hospital	24/05/21	Strategy	
2	Face-to-face consultation (within social distancing) – Halton Hospital Outpatients Clinic	25/05/21 (PM) & 26/05/21 (AM)	Strategy	
2	Face-to-face consultation (within social distancing) – Runcorn Shopping City main square	25/05/21 (AM), 26/05/21 (PM) & 29/05/21 (AM)	Strategy	
2	Daytime virtual consultation session, hosted by Strategy and services, on MS Team Live	01/06/21	Strategy, Services	
2	Evening virtual consultation session, hosted by Strategy and services, on MS Team Live	02/06/21	Strategy, Services	
2	Weekend virtual consultation session, hosted by Strategy and services, on MS Team Live	05/06/21	Strategy, Services	
2	Virtual consultation session with Healthwatch Halton	10/06/21	Strategy	

Phase	Task	Date	Task lead	RAG
2	Press Release announcing final call for consultation responses – accompanied by social media	14/06/21	Comms	
2	Stakeholder bulletin including item on final call for consultation responses -to governors, partners, advocacy groups, MPs.	16/06/21	Comms	
2	Public consultation ends	18/06/21		
2	Write up consultation outcomes	21/06/21 - 25/06/21	Strategy/Comms	
2	Consultation outcomes to Halton HWBB	07/07/21	Lucy Gardner	
2	Consultation outcomes scrutinised by WHH Executive Team – confirmed viable.	13/07/21	Strategy/Lucy Gardner	
2	Top line consultation outcomes report to WHH Trust Board	28/07/21	Lucy Gardner	
2	Consultation outcomes report to NHS Halton and NHS Warrington CCGs for input	23/09/21	Pat McLaren	
2	Final consultation outcomes report to WHH Trust Board	November 2021	Lucy Gardner	
2	Publish consultation outcomes and issue accompanying press release and stakeholder update	November 2021	Strategy/Comms	
2	If supported, proceed with movement of services	Winter 2021/22	Strategy/Operations	

Key:

1: Phase 1 – pre-consultation engagement

2: Phase 2 – public consultation

APPENDIX 3. STAKEHOLDERS INVOLVED

ADVOCATES/THIRD SECTOR GROUPS
Red Cross
Halton Red Cross
Halton Carers
Wired Carers
Deafness Resource Centre
Warrington Disability partnership
Speak Up, Warrington
Wellbeing enterprise
Healthwatch Warrington
Healthwatch Halton
Council of Faiths
Age UK Mid Mersey
Warrington MENCAP
Warrington Voluntary Action
Halton and St Helen's VCA
Halton Older People Empowerment Network (OPEN)
Warrington Deaf Centre
Warrington Lifetime (older people)
Bipolar Group
Alternative Futures
Deafness Support Network
Older Persons Forum
Warrington MS Society
Warrington Mencap Leisure
Cheshire Autism Practical Support ChAPS
Citizens Advice Warrington
Clair's Parents Meeting Parents ADHD Supp
Community Integrated Care
MNDA South Lancs Branch
Muscular Dystrophy Lymm & Warrington
Room at the Inn
Spinal Injuries Association
SWAN uk syndromes with no name
Talking Matters Warrington
The Brain Charity
Torch Trust for the Blind
Warrington & Vale Royal College
Warrington BSL Signing Choir
Warrington Stroke Association
Warrington Wolves Charitable Foundation
Wired
Veterans Hearing Support
Autism Together
Young Disabled Persons Forum
Warrington Parents & Carers
Home Start Warrington
Families United

WYC - Warrington Youth Club
Arty Smarty
Accent Warrington & Halton Music Ed Hub
Young Carers Service
Warrington Speak Up
Warrington Armed Forces Community Support
WECA - Warrington Ethnicity Community Assoc
The Proud Trust Warrington
Conservative Cllr and Helping Hands
Directions for Men (male group)
Offload via Wolves Foundation
CAB Halton
CAB Warrington
Arthritis Action.

MEMBERS PARLIAMENT	Party	Constituency
Andy Carter	CON	Warr South
Charlotte Nichols	LAB	Warr North
Derek Twigg	LAB	Halton
Mike Amesbury	LAB	Weaver Vale

PARTNERS	ORGANISATION
Prof Steven Broomhead	Warrington Borough Council
Cllr Russ Bowden	Warrington Borough Council
David Parr	Halton Borough Council
Cllr Rob Polhill	Halton Borough Council
Dr Andy Davies	Warrington CCG and Halton CCG
Maria Austin	Warrington CCG and Halton CCG
Simon Kenton	Warrington Together
Colin Scales	Bridgewater Community Healthcare
Simon Barber	North West Boroughs/Merseycare
Jackie Bene	C&M Healthcare Partnership Chief Officer
Alan Yates	C&M Healthcare Partnership Chair
General	C&M Healthcare Partnership
Edna Boampong	C&M Healthcare Partnership
Enquiries Team	University of Chester
Communications colleagues	All local system partners

ADVOCATES/THIRD SECTOR GROUPS
Red Cross
Halton Red Cross
Halton Carers
Wired Carers
Deafness Resource Centre
Warrington Disability partnership
Speak Up, Warrington

Wellbeing enterprise
Healthwatch Warrington
Healthwatch Halton
Council of Faiths
Age UK Mid Mersey
Warrington MENCAP
Warrington Voluntary Action
Halton and St Helen's VCA
Halton Older People Empowerment Network (OPEN)
Warrington Deaf Centre
Warrington Lifetime (older people)
Bipolar Group
Alternative Futures
Deafness Support Network
Older Persons Forum
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Warrington Mencap Leisure
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Warrington Stroke Association
Warrington Wolves Charitable Foundation
Wired
Veterans Hearing Support
Autism Together
Young Disabled Persons Forum
Warrington Parents & Carers
Home Start Warrington
Families United
WYC - Warrington Youth Club
Arty Smarty
Accent Warrington & Halton Music Ed Hub
Young Carers Service
Warrington Speak Up

Warrington Armed Forces Community Support
WECA - Warrington Ethnicity Community Assoc
The Proud Trust Warrington
Conservative Cllr and Helping Hands
Directions for Men (male group)
Offload via Wolves Foundation
CAB Halton
CAB Warrington
Arthritis Action.

APPENDIX 4. EQUALITY IMPACT ASSESSMENTS

The law requires that any new service, significant change in service, reduction or removal of service has an equality impact assessment to see if there are negative impacts, i.e. direct or indirect discrimination on particular people because of their protected characteristic, relating to the action.

Any change to function, provision or policy that may have an effect on people would automatically be subject of the Equality Act 2010. The parts of the acts that are 'engaged' (i.e. that would be active in relation to this proposal) would be:

- Section 4 – protected characteristics
- Section 13 - direct discrimination
- Section19 – indirect discrimination
- Section 20 – duty to make adjustments
- Section 29 – provision of a service
- Section 149 – Public Sector Equality Duty

Equality Impact Assessment documents:

- Set out the detail of the change in relation to the equality legislation.
- Analyse the input from interested parties.
- Identify any concerns and worries related to equality issues.
- assess the impact of change against the health inequalities duty
- Propose recommendations for committees to consider.
- Determine if the Public Sector Equality Duty (PSED), section 149 Equality Act 2010 has been met.

Summary: Equality Assessment (EA)

- The majority of consultees supported the proposal and rich feedback provided relating to equality concerns
- Public Sector Equality Duty will be met subject to actions and mitigations being actioned.
- Consultation was conducted and responses were received across the demographic spectrum
- No appreciable discrimination was discerned although people who were unsure or disagreed with the proposal had legitimate concerns about accessibility – chiefly transport, and mitigations have been set out to resolve this, predominately awareness raising of the alternative methods available
- Further awareness raising relating to the continuation of the outpatient services at Warrington Hospital site is required to reassure those who misconstrued that services would be ceasing at Warrington.

Full Equality Impact Analysis (EiA)

Overview Details			
CBU/Department	**Strategy**	**Date of This Assessment**	27.09.21
Title and overview of what is being assessed / considered	Outpatient Services in Runcorn Shopping City	**Review Date**	
Who will be affected by this activity? (Please tick)	Patients ☒	Staff ☒	Public ☒
Author of Equality Impact Analysis	Viviane Risk	**Equality Analysis Assessed by**	

The purpose of undertaking an equality impact analysis and assessment is to understand the potential and/or actual impact that a service or policy may have on protected groups within the Equality Act (2010). The protected groups are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and / or belief
- Sex (gender)
- Sexual orientation

Support:

- For Patient and Public Equality Impact Assessments please contact Adam.Harrison15@nhs.net
- For Workforce and Public Equality Impact Assessments please contact Ryan.Lamey-McArthur@nhs.net

Impact Analysis		
1	**What evidence have you used to think about any potential impact on particular groups?** (Please highlight any evidence that you have considered to help you address what the potential impact may be) **Example evidence:** • ONS Census data • Regional or local demographic information • WHH Equality reports available via website here • National guidance from NHS England, NICE or Department of Health and Social Care • Joint Strategic Needs Assessement • Risk Assessments	Halton Borough is one of the most deprived areas in the region, with a Deprivation Score of 32.3 compared to the rest of England at 21.7: **Figure 1 – Comparison of Public Health Profiles for Deprivation across North West local authorities** Source: Public Health Fingertips, Public Health Profiles - PHE

Indicator	Period	England	North West region	Blackburn with Darwen	Blackpool	Bolton	Bury	Cheshire East	Cheshire West and Chester	Cumbria	Halton	Knowsley	Lancashire	Liverpool	Manchester	Oldham	Rochdale	Salford	Sefton	St. Helens	Stockport	Tameside	Trafford	Warrington	Wigan	Wirral
Fuel poverty	2018	10.3	12.1	14.6	15.2	11.9	10.6	9.8	10.6	13.3	10.9	12.7	12.0	15.6	15.5	11.7	12.2	11.2	12.5	11.3	9.8	10.7	10.4	9.1	10.8	12.2
Children in low income families (all dependent children under 20)	2016	17.0	18.1	21.4	25.8	20.4	14.9	10.0	12.6	12.1	19.4	24.8	15.1	26.4	27.8	22.6	21.6	21.2	16.8	19.3	13.4	19.0	11.7	11.5	15.0	18.9
Inequality in life expectancy at birth (Male)	2017 - 19	9.4	11.3	10.5	13.4	11.2	12.4	8.9	10.6	8.5	9.9	9.9	10.3	10.2	8.1	11.5	11.3	11.1	12.5	11.7	11.2	9.9	8.8	9.7	11.3	13.0
Inequality in life expectancy at birth (Female)	2017 - 19	7.6	9.6	9.8	10.9	8.6	7.9	7.3	8.8	8.0	8.5	9.2	7.8	9.8	7.3	9.9	7.5	8.9	11.8	8.8	10.2	9.2	7.9	7.2	9.3	11.1
Inequality in healthy life expectancy at birth LA (Male)	2009 - 13	-	-	18.0	16.6	19.8	14.8	13.5	15.8	15.0	16.2	15.2	15.8	16.7	12.8	18.4	17.1	16.0	18.2	15.2	17.3	13.7	15.8	15.8	13.5	21.6
Inequality in healthy life expectancy at birth LA (Female)	2009 - 13	-	-	17.5	14.5	19.2	13.4	12.6	15.2	14.2	17.3	16.1	15.6	16.4	12.4	18.6	17.2	14.3	17.3	14.2	16.6	13.4	16.1	15.0	14.0	20.5
Inequality in life expectancy at 65 (Male)	2017 - 19	4.9	6.0	6.1	5.2	5.8	7.3	4.3	5.2	4.1	6.4	4.1	4.6	5.4	4.6	6.7	6.3	7.2	6.5	5.9	6.3	5.9	5.5	4.5	5.6	6.6
Inequality in life expectancy at 65 (Female)	2017 - 19	4.7	6.2	6.4	4.1	5.7	5.2	4.6	6.1	4.5	6.9	5.9	4.6	6.2	5.2	6.8	4.9	7.1	7.3	5.5	7.1	5.7	4.7	4.2	6.2	7.0
Percentage people living in 20% most deprived areas in England	2014	20.2*	31.9*	50.0	49.6	38.7	20.5	8.5	16.3	16.3	48.3	60.4	21.9	60.5	59.2	43.6	44.5	43.8	27.1	40.1	14.0	36.7	9.5	18.5	28.6	30.7
Deprivation score (IMD 2019)	2019	21.7	28.1	36.0	45.0	30.7	23.7	14.5	18.1	21.3	32.3	43.0	23.4	42.4	40.0	33.2	34.4	34.2	27.0	31.5	20.8	31.4	16.1	18.9	25.7	29.6

	• NHS Staff Survey Results • Research / epidemiology studies • Updates to legislation • Engagement records or analysis	**Figure 2 – Count and Percentages of Ethnic Groups in Halton Local Authority**

Ethnic group

	Persons	
	Halton Local Authority	
	count	%
All usual residents	125,746	100.0
White	123,041	97.8
English/Welsh/Scottish/Northern Irish/British	121,210	96.4
Irish	654	0.5
Gypsy or Irish Traveller	41	0.0
Other White	1,136	0.9
Mixed/multiple ethnic groups	1,356	1.1
White and Black Caribbean	465	0.4
White and Black African	253	0.2
White and Asian	330	0.3
Other Mixed	308	0.2
Asian/Asian British	943	0.7
Indian	282	0.2
Pakistani	44	0.0
Bangladeshi	60	0.0
Chinese	308	0.2
Other Asian	249	0.2
Black/African/Caribbean/Black British	260	0.2
African	95	0.1
Caribbean	134	0.1
Other Black	31	0.0
Other ethnic group	146	0.1
Arab	54	0.0
Any other ethnic group	92	0.1

In order to protect against disclosure of personal information, records have been swapped between different geographic areas. Some counts will be affected, particularly small counts at the lowest geographies

Source: ONS - 2011 Census (KS201EW)

Source: [Local Area Report for areas in England and Wales - Nomis (nomisweb.co.uk)]

Figure 3 – Main Household Languages across Halton Local Authority

Household language

Households

	Halton Local Authority	
	count	%
All households	53,312	100.0
All people aged 16 and over in household have English as a main language (English or Welsh in Wales)	52,558	98.6
At least one but not all people aged 16 and over in household have English as a main language (English or Welsh in Wales)	383	0.7
No people aged 16 and over in household but at least one person aged 3 to 15 has English as a main language (English or Welsh in Wales)	58	0.1
No people in household have English as a main language (English or Welsh in Wales)	313	0.6

In order to protect against disclosure of personal information, records have been swapped between different geographic areas. Some counts will be affected, particularly small counts at the lowest geographies

Source: ONS - 2011 Census (KS206EW)

Source: [Local Area Report for areas in England and Wales - Nomis (nomisweb.co.uk)]

Figure 4 – Religious Beliefs across Halton Local Authority

Religion

	Persons Halton Local Authority	
	count	%
All usual residents	125,746	100.0
Has religion	95,393	75.9
Christian	94,314	75.0
Buddhist	216	0.2
Hindu	194	0.2
Jewish	44	0.0
Muslim	267	0.2
Sikh	55	0.0
Other religion	303	0.2
No religion	23,543	18.7
Religion not stated	6,810	5.4

In order to protect against disclosure of personal information, records have been swapped between different geographic areas. Some counts will be affected, particularly small counts at the lowest geographies

Source: ONS - 2011 Census (KS209EW)

Source: [Local Area Report for areas in England and Wales - Nomis (nomisweb.co.uk)]

Figure 5 – Activity Limitation, Health and Carer Rates across Halton Local Authority

Health and provision of unpaid Care

	Persons	
	Halton Local Authority	
	count	%
All usual residents	125,746	100.0
Day-to-day activities limited a lot	14,556	11.6
Day-to-day activities limited a little	12,309	9.8
Day-to-day activities not limited	98,881	78.6
Day-to-day activities limited a lot: Age 16 to 64	7,370	5.9
Day-to-day activities limited a little: Age 16 to 64	6,979	5.6
Day-to-day activities not limited: Age 16 to 64	67,989	54.1
Very good health	58,684	46.7
Good health	39,693	31.6
Fair health	17,504	13.9
Bad health	7,732	6.1
Very bad health	2,133	1.7
Provides no unpaid care	110,728	88.1
Provides 1 to 19 hours unpaid care a week	8,009	6.4
Provides 20 to 49 hours unpaid care a week	2,440	1.9
Provides 50 or more hours unpaid care a week	4,569	3.6

In order to protect against disclosure of personal information, records have been swapped between different geographic areas. Some counts will be affected, particularly small counts at the lowest geographies

Source: ONS - 2011 Census (KS301EW)

Source: [Local Area Report for areas in England and Wales - Nomis (nomisweb.co.uk)]

Figure 6 – Age Spread Across Halton Local Authority

Age structure

Persons

	Halton Local Authority	
	count	%
All usual residents	125,746	100.0
Age 0 to 4	8,354	6.6
Age 5 to 7	4,563	3.6
Age 8 to 9	2,820	2.2
Age 10 to 14	7,577	6.0
Age 15	1,613	1.3
Age 16 to 17	3,339	2.7
Age 18 to 19	3,130	2.5
Age 20 to 24	8,024	6.4
Age 25 to 29	8,141	6.5
Age 30 to 44	25,004	19.9
Age 45 to 59	26,192	20.8
Age 60 to 64	8,508	6.8
Age 65 to 74	10,370	8.2
Age 75 to 84	6,132	4.9
Age 85 to 89	1,349	1.1
Age 90 and over	630	0.5
Mean Age	38.9	-
Median Age	39	-

- These figures are missing.

Source: ONS - 2011 Census (KS102EW)

In order to protect against disclosure of personal information, records have been swapped between different geographic areas. Some counts will be affected, particularly small counts at the lowest geographies

		Source: Local Area Report for areas in England and Wales - Nomis (nomisweb.co.uk) **Figure 7 – Marital and Civil Partnership Status across Halton Local Authority** **Marital and civil partnership status** Persons Halton Local Authority count / %	
		All usual residents aged 16+ — 100,819 — 100.0 Single (never married or never registered a same-sex civil partnership) — 35,659 — 35.4 Married — 45,287 — 44.9 In a registered same-sex civil partnership — 217 — 0.2 Separated (but still legally married or still legally in a same-sex civil partnership) — 2,470 — 2.4 Divorced or formerly in a same-sex civil partnership which is now legally dissolved — 9,880 — 9.8 Widowed or surviving partner from a same-sex civil partnership — 7,306 — 7.2 In order to protect against disclosure of personal information, records have been swapped between different geographic areas. Some counts will be affected, particularly small counts at the lowest geographies Source: ONS - 2011 Census (KS103EW) Source: Local Area Report for areas in England and Wales - Nomis (nomisweb.co.uk)	
2	**Do you have all the evidence you need in order to make an informed decisions about the potential impact?** (Please tick)	**Yes ☒** If you feel that you have enough evidence then you will **not** need to undertake any engagement activity	**No ☐** If you feel that you do not have enough evidence to make an informed decision then you **will need to** undertake engagement activity with the patients, staff or members of the public as applicable
3	**What engagement is taking place or has already been undertaken to understand any**	A pre-consultation engagement exercise and full public consultation have been undertaken. The pre-consultation engagement exercise took place between 25th February and 17th March 2021 and included: • FAQ booklet with pull out questionnaire;	

	potential impact on patients, staff or members of the public? Examples include: <u>Patients and public</u> • Interviews • Focus groups • Carer Forums • Friends and Family Test questions • Complaints, comments, compliments <u>Staff</u> • Staff event / workshop • Existing staff meetings / committees • Staff Networks (BAME, LGBTQA+, Disability) • Staff Side • Annual Staff Survey questions • Staff Friends and Family Test questions	• Easy read, additional language and other format materials • Engagement with patients and service users attending Outpatient departments at both Warrington and Halton Hospitals; • Virtual engagement sessions, held via MS Teams; • Online survey. The aims of the pre-consultation engagement were to ensure the local population were aware of the proposals, to ensure the local population were able to be involved in the development of the proposals, to give an opportunity for the public to share their initial views of the proposals to relocate three outpatient services to Runcorn Shopping City and to feed into the formal consultation process. The formal public consultation took place between 7th May and 18th July 2021 and included: • Engagement at outpatient clinics with patients across all sites • Engagement with the public in Runcorn Shopping City • Promotion of the proposed plans for initial input • Media release • Delivery of three virtual presentations (day, evening and weekend) by the head of Strategy and partnerships and three service leads on their plans, with a real time Q&A session • Briefing to MPs and other key stakeholders • Collation of feedback, analysis to inform public consultation • Collection of respondent data for Equality Impact Assessment • Report on the outcomes of the consultation to relevant governance bodies The aims of the formal consultation were: • To inform and involve all current and new patients of the three services of the proposals and seek their input and views • To ensure the local population was made aware of the proposals and provided with multiple platforms to engage and participate by sharing their views and opinions • To ensure the local population (including those people that were harder to reach) were able to make alternative recommendations and suggestions relating to the proposed changes to the services • To ensure any emerging issues and themes were taken into account by the project team and any potential mitigating actions were considered • To inform a final decision about the proposed changes following the conclusion of the consultation period.

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		Advocates and Third Sector Groups were engaged and invited to participate to ensure a broad range of voices were captured. Please see Appendix 1 for the full list. Staff have been involved and any adjustments taken in to account through service leads via monthly project meetings and have been able to provide their thoughts via the consultation survey. A HR representative has been in attendance at each meeting to provide guidance and support on staff communication.
4	**Will there be an impact against the protected groups as described in the Equality Act (2010)?** Summarise what impact there may be against each of the protected groups. Embed or provide a hyperlink to any reports or electronic files to which you are referring. If there is **no impact** please state that there is no impact.	What is the **actual** or **potential** impact on **age?** (if no actual or potential impact then add N/A) Figure 6 demonstrates the age spread across Halton Local Authority. The largest age group is 45 – 59 (20.8%), followed by 30 – 44 (19.9%). The third largest age group is 65 – 74 (8.2%). Potential positive - the Outpatients Hub in Runcorn Shopping City has both paediatric and adult waiting rooms, accessible toilet facilities and is step free from both the car park and bus stop. Dementia friendly elements have been incorporated in to the design. Potential positive - the availability of Ophthalmology and Audiology appointments will increase by 3,500 across the two services. While patients of all ages access these services this may have a positive impact in particular on the aging population who may experience hearing or eye problems as a result of aging.
		What is the **actual** or **potential** impact on **disability?** Figure 5 demonstrates that 11.6% of Halton residents find their day-to-day activities limited a lot, and 9.8% of residents note their day-to-day activities limited a little. Within the 16 – 64 age range 5.9% of residents state their day-to-day activities as limited a lot, and 5.6% state their day-to-day activities are limited a little. Potential negative - Patients with a physical disability that requires the use of a mobility scooter will not be able to access the audiology equipment in the new Hub at Shopping City. Halton General Hospital will still be available for these patients. This will be assessed at the point of referral. GP referrals state whether a patient is a wheelchair user so appointments will be booked at Halton Hospital's Audiology department. Potential positive - The Outpatients Hub in Runcorn Shopping City has accessible toilet facilities and is step free from both the car park and bus stop. The Unit is also less than 50 steps from the disabled spaces in the closest car park.

		Potential neutral - Door and hallways are wheelchair accessible as in the current service location in Halton Hospital Outpatients department. A hearing loop is being considered for those who are hard of hearing in line with the offer currently available in Halton Hospital Outpatients department. Mitigation - for any patients or service users who use British Sign Language, interpreters can be booked through the Deafness Resource Centre.
		What is the **actual** or **potential** impact on **gender reassignment?** Neutral impact – there are accessible toilets available as a gender neutral facility if required as on both hospital sites.
		What is the **actual** or **potential** impact on **marriage and civil partnership?** Figure 7 demonstrates that in the population aged 16+, the majority are married at 44.9%. Single residents follow at 35.4%. 0.2% of the population aged 16+ are in same-sex civil partnerships. Potential positive – The waiting areas have been designed to allow social distancing and partners to attend with patients in line with the visiting policy and guidance in place at the time.
		What is the **actual** or **potential** impact on **pregnancy and maternity?** Potential positive – pushchair/buggy storage will be available and a lactation room has been included in the design. Parent and baby changing facilities will be available.
		What is the **actual** or **potential** impact on **race?** Figure 2 shows that the majority of the population (97.8%) in Halton local authority identify as White. The remaining 2.2% identify as being from a diverse range of ethnic groups. Potential impacts on race have been considered and none have been identified.

Figure 3 demonstrates that in 98.6% of households all those over 16 have English as a main language. 313 households have no people with English as a main language. Within the past year the following calls were made to language line for interpreter requests:

Ophthalmology

Language	Calls
Polish	12
Arabic	9
Turkish	3
Cantonese	6
Albanian	2
Slovak	3
Sorani	2

Audiology

Language	Calls
Sorani	1
Portuguese	1

		Potential neutral – information will be available in alternative languages and a translation service called 'Language Line' is available 24/7 as an on-demand audio and video service, with over 200 languages available as currently available on both Hospital sites.
		What is the **actual** or **potential** impact on **religion and / or belief?** Figure 4 shows that 75.9% of the population in Halton have a religion/religious beliefs. Of that number 75.0% note their belief as Christian. The remaining 0.9% contains individuals from the faiths of Islam, Buddhism, Hinduism, Judaism, Sikhism. Potential positive – Chaplaincy services are available within Runcorn Shopping City. Potential negative – Users from faiths other than Christianity may struggle to access the Chaplaincy service within Runcorn Shopping City, however a multi-faith room is available in Halton General Hospital if required. Mitigation – Ophthalmology and Audiology staff will be rotating their coverage of the clinic at Runcorn Shopping City. Any religious or spiritual adjustments will be considered when placing staff. Dietetics service does not currently have any staff requiring adjustments for religious/spiritual reasons. Should this change the future mitigations will be assessed, such as time to access the multifaith room at Halton Hospital or the Chaplaincy centre in Runcorn Shopping City. In this situation, the clinic timings may be reviewed in line with operational demand.
		What is the **actual** or **potential** impact on **sex (gender)?** Neutral impact – there are accessible toilets available as a gender neutral facility if required as on both hospital sites.
		What is the **actual** or **potential** impact on **sexual orientation?** The 2018 LGBT Foundation Pride in Practice Patient Survey found that "LGB patients were 24% more likely to share their sexual orientation with health care professionals…when services displayed LGBT posters" and that "Patients using a pharmacy displaying LGBT posters were 10% more likely to have their needs met as an LGBT person."*

		In addition the 2017 LGBT Foundation Primary Care Survey found that 62% mentioned the importance of improving LGBT visibility in healthcare, for example having LGBT literature and posters or a Pride in Practice award…displayed in primary care practices."* * LGBT Foundation - Hidden Figures Potential positive – There will be notice boards where LGBTQA+ literature can be displayed in the waiting areas and consultation rooms.
5.	**Will there be an impact against any other vulnerable groups?** Summarise what impact there may be against each of the protected groups. Embed or provide a hyperlink to any reports or electronic files to which you are referring. If there is **no impact** please state that there is no impact.	What is the **actual** or **potential** impact on **carers?** Figure 5 shows that 6.4% of the population of Halton provide 1 – 19 hours of unpaid care a week, 1.9% provide 20 – 49 hours of unpaid care a week and 3.6% provide 50 or more hours of unpaid care a week. Potential positive – the expansion in services currently delivered in Warrington hospital will enable residents to stay in Borough for their care, reducing the need to travel to Warrington. Potential positive – The waiting areas have been designed to allow social distancing and partners to attend with patients in line with the visiting policy and guidance in place at the time. Halton Carers Centre will also continue to have a presence to offer support and guidance to both patients, carers and staff.
		What is the **actual** or **potential** impact on deprived communities? Figure 1 demonstrates that Halton has a deprivation score of 32.3, which is worse than the England average of 21.7. Potential positive – the Hub is regenerating a currently unused retail unit in an underutilised retail complex. The increased footfall into the complex, potentially providing economic regeneration for the area. The new Hub also brings healthcare into a community centric location, therefore bringing access to healthcare closer to the local population. Locating the services closer to the community may also result in reduced travel costs via car or public transport and is walking distance from Halton Lea.

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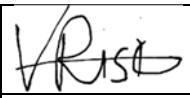
		What is the **actual** or **potential** impact on military veterans? No impact

Action Plan

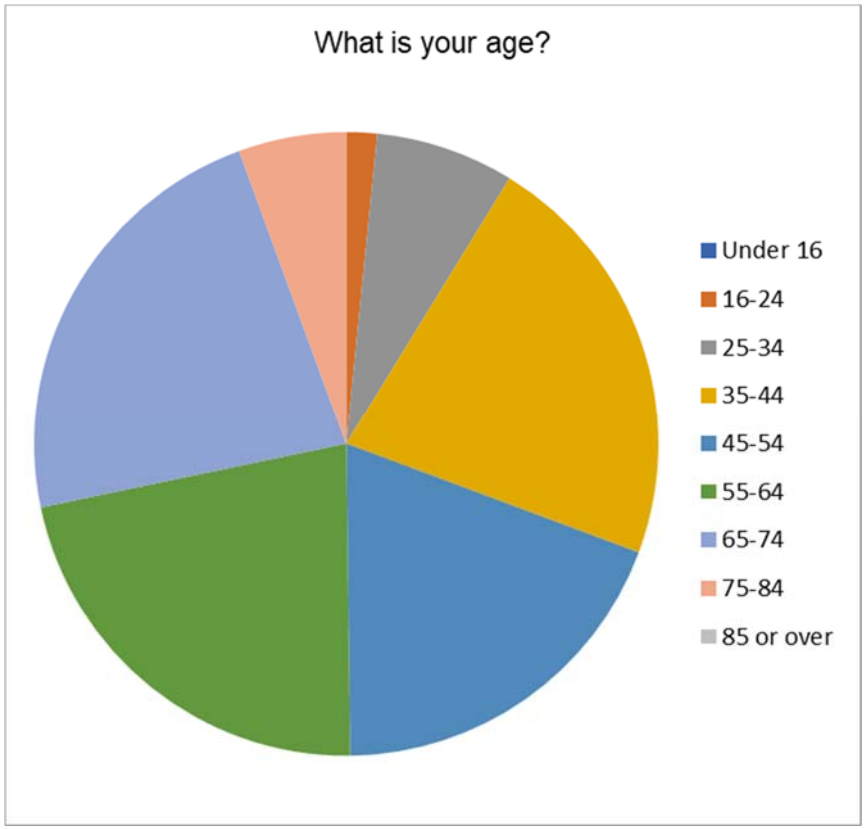
What actions need to be taken in order to mitigate the impacts identified in sections 4 and 5?

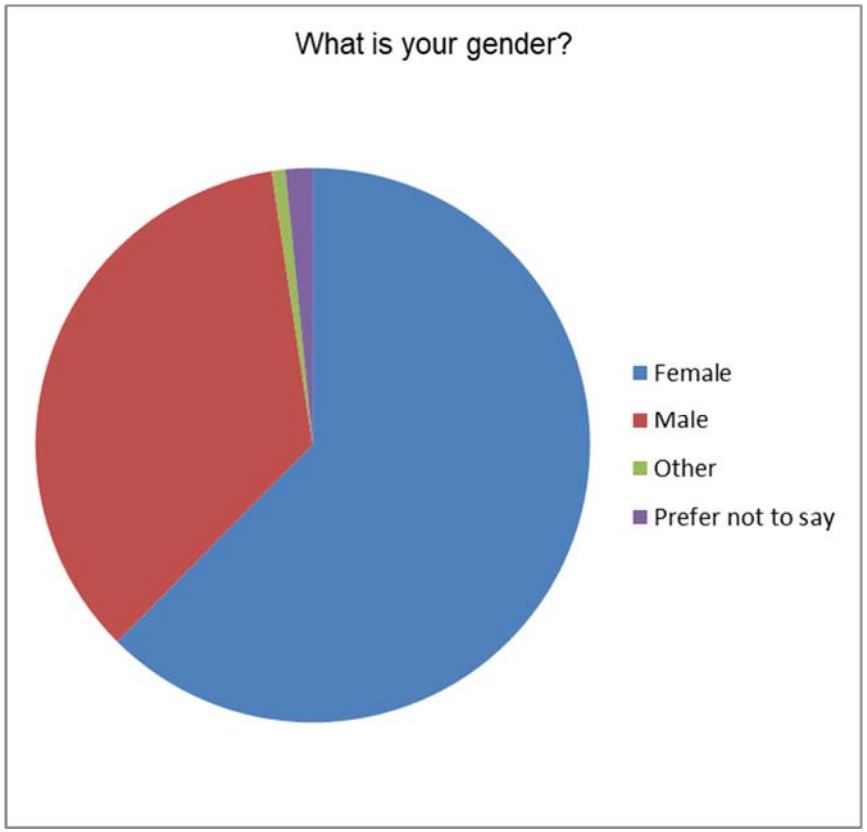
Impact	Action Required	Target Date	Responsibility
Patients using mobility scooters will not be able to access the Audiology equipment at Shopping City	Assessment of patients at the point of referral to determine access requirements. Patients will be advised that they need to access the Audiology service at Halton Hospital.	Feb 2022	Paula Atherton, Audiology Service Manager
Patients of non-Christian faith may struggle to access area for prayer in Runcorn Shopping City.	Signposting to alternative multi-faith space in Halton General Hospital. Assess suitability of staff areas for private prayer	Feb 2022	Hub Manager

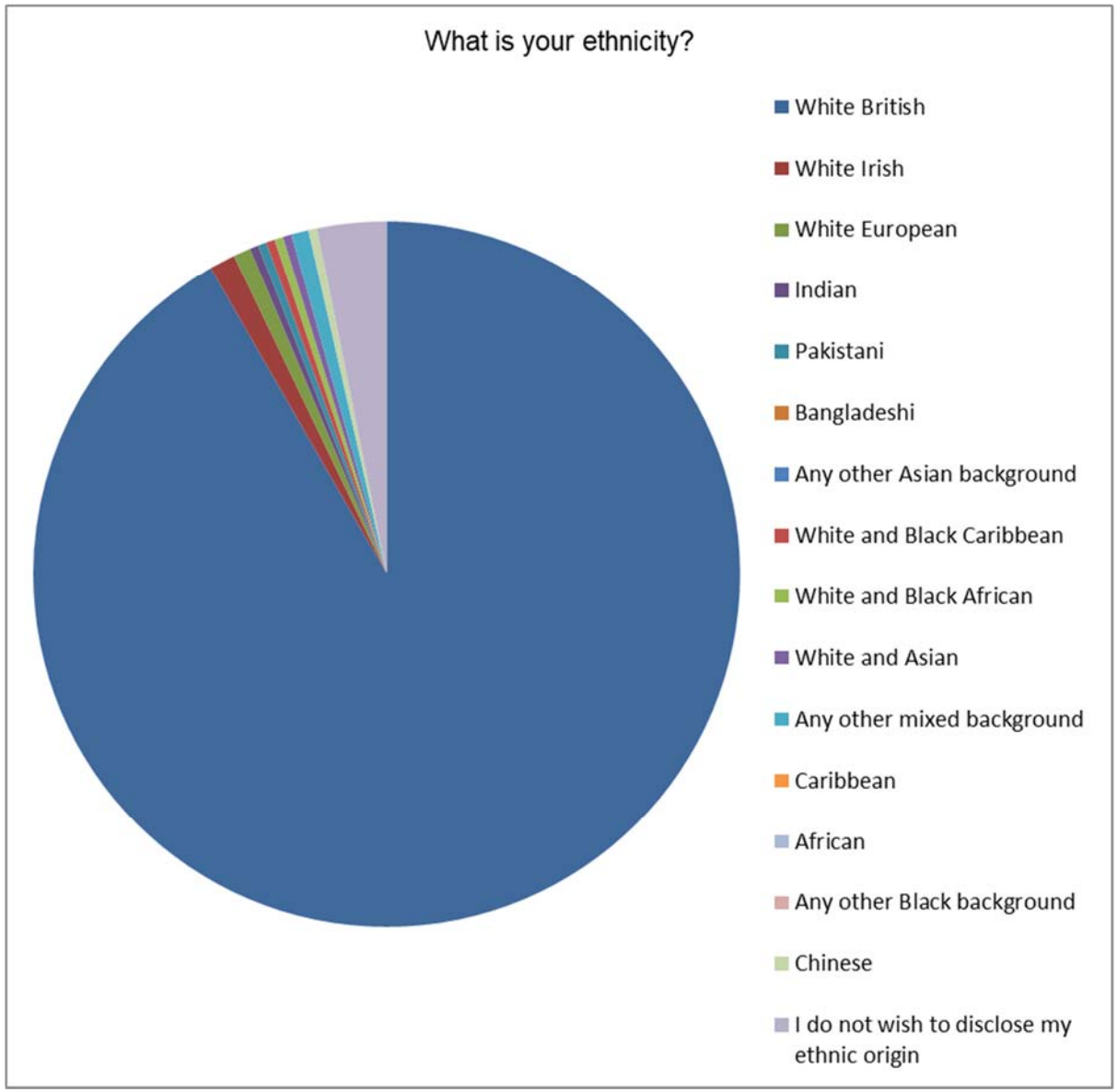
How will these actions be monitored and where will the outcomes be reported?
(Please describe below)

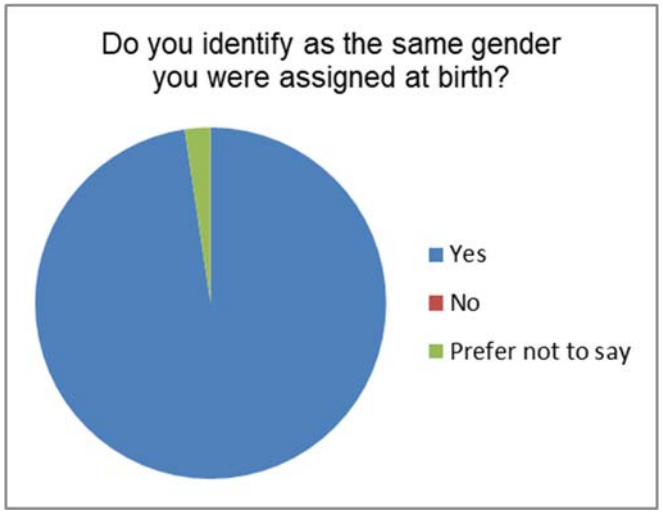
Completed by (Please print name /Designation)	Viviane Risk	**Signature**	
		Date	27.09.21

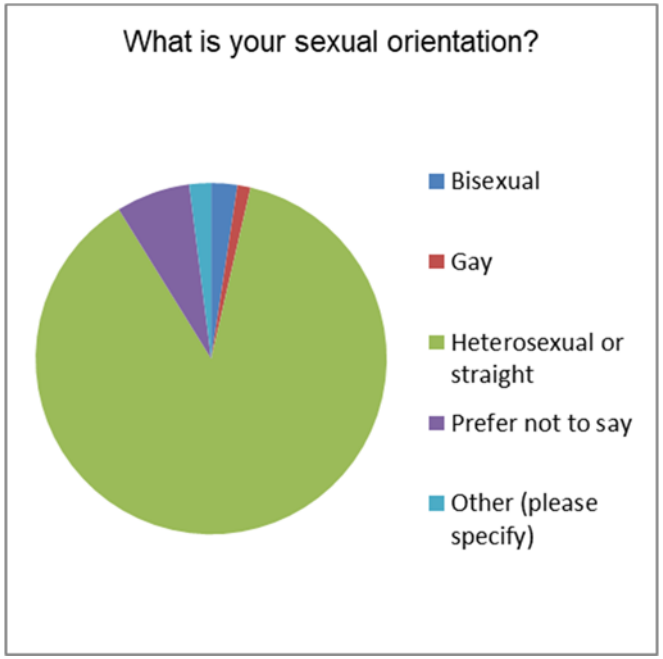
APPENDIX 5 CONSULTATION RESPONDENT DEMOGRAPHICS

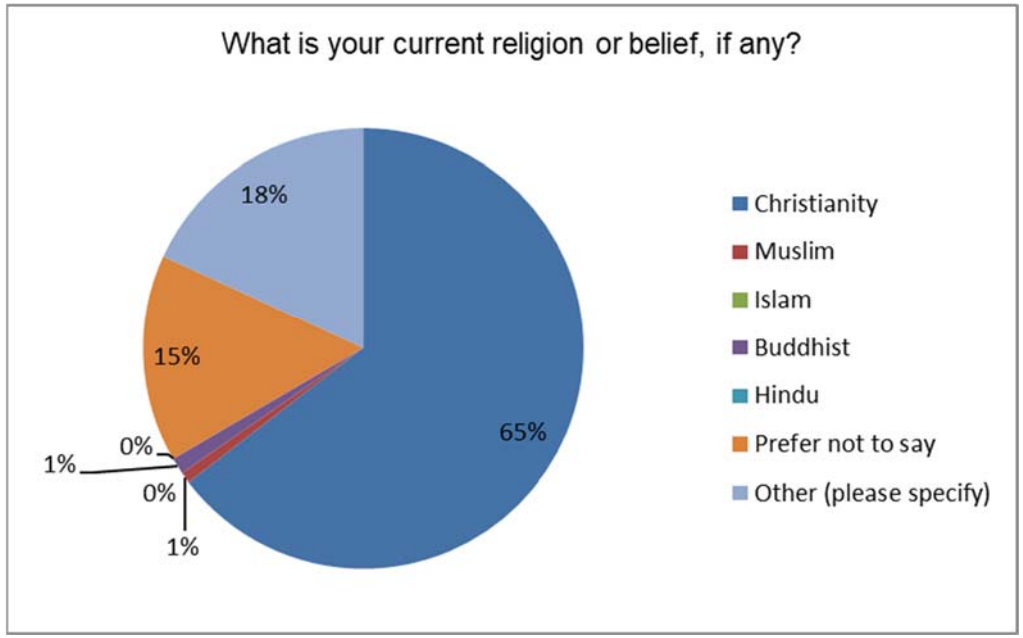


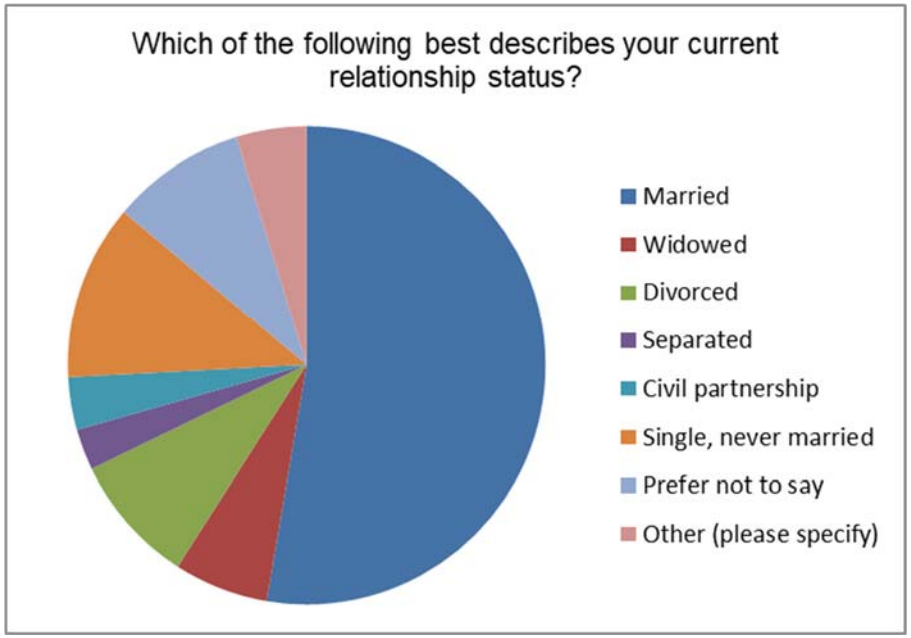



What is your ethnicity?
White British
White Irish
White European
Indian
Pakistani
Bangladeshi
Any other Asian background
White and Black Caribbean
White and Black African
White and Asian
Any other mixed background
Caribbean
African
Any other Black background
Chinese
I do not wish to disclose my ethnic origin


Do you identify as the same gender you were assigned at birth?
Yes
No
Prefer not to say

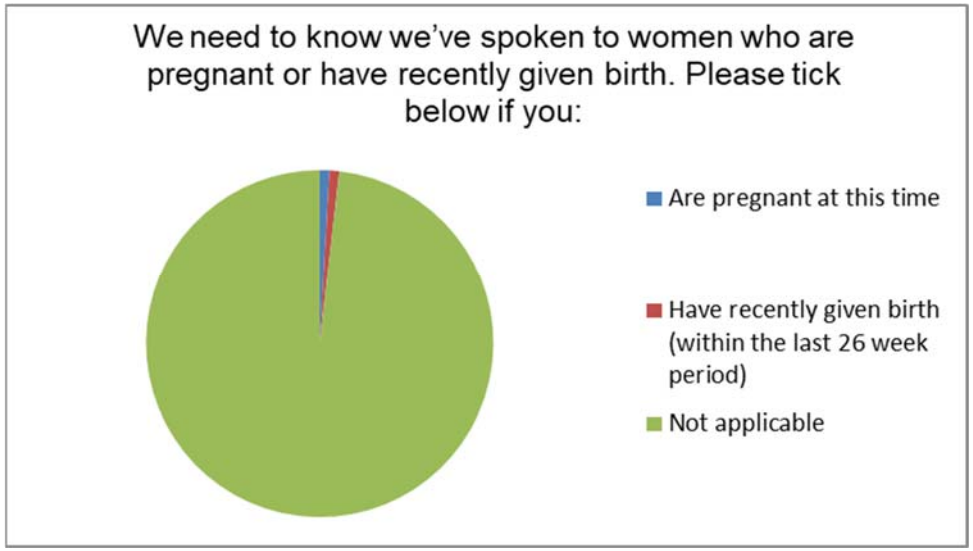

What is your sexual orientation?
Bisexual
Gay
Heterosexual or straight
Prefer not to say
Other (please specify)

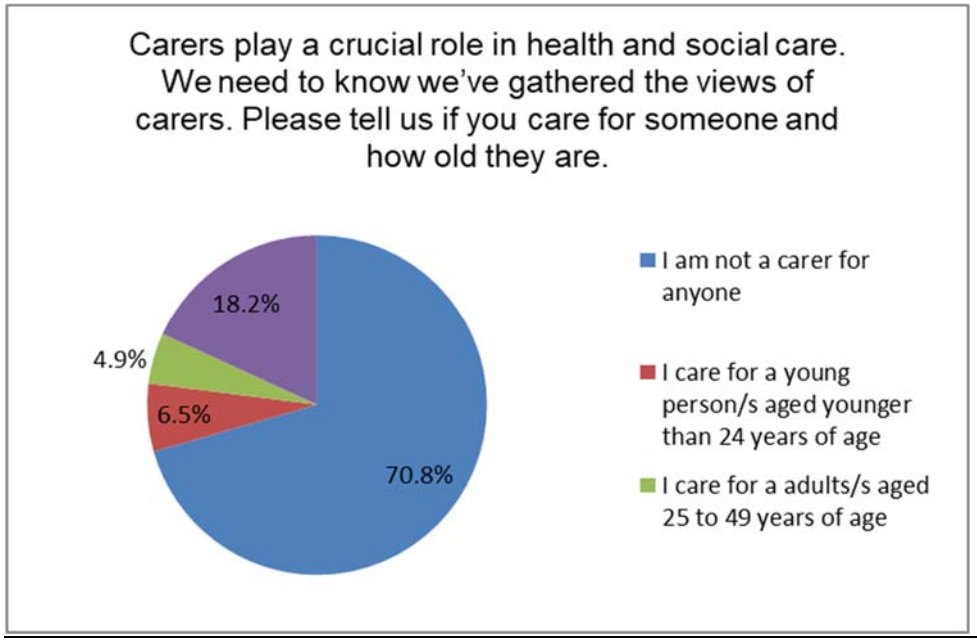


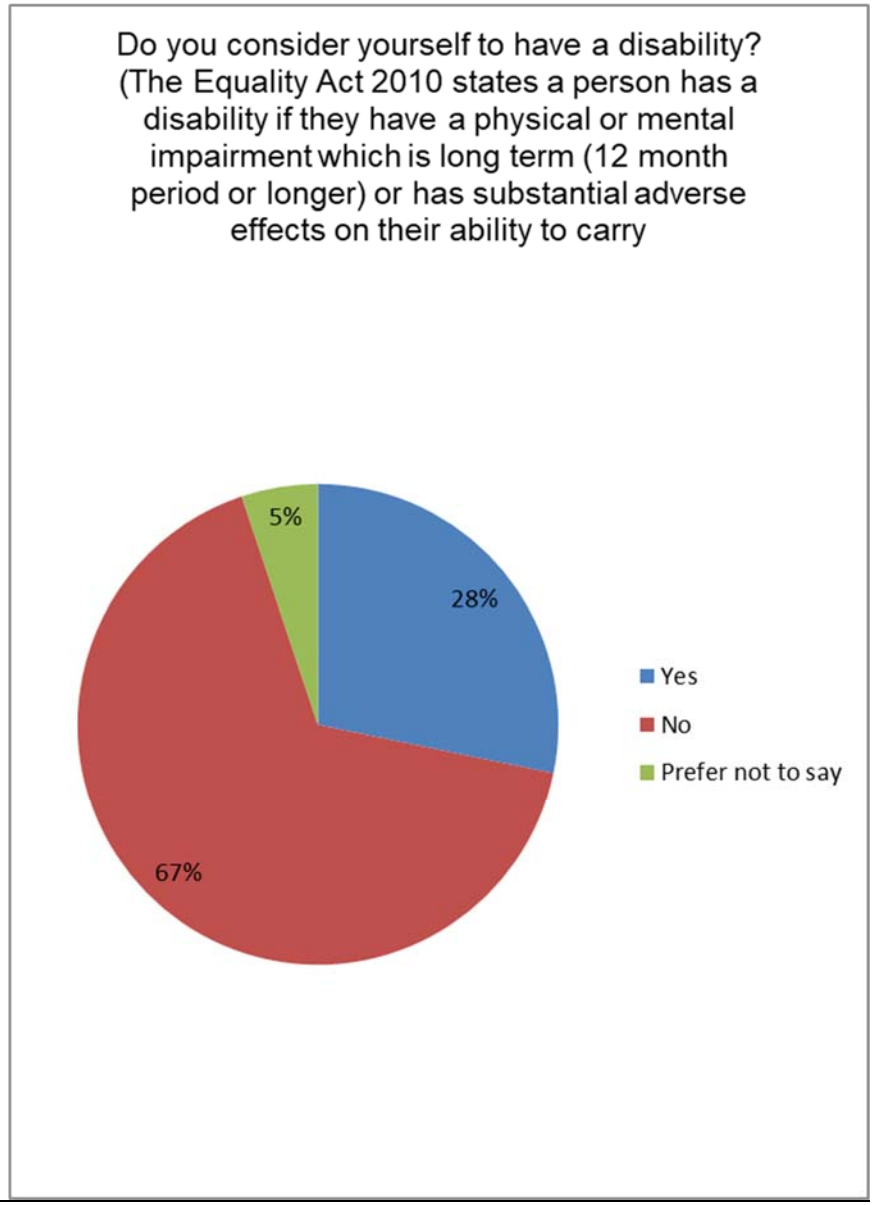


N.B. There were 42 responses to the “Other” option within “What is your current religion or belief, if any?” demographic question. These responses are listed here:

Response	Count
A Follower Of Evidence	1
Agnostic	3
Atheist	4
Catholic	1
Human	1
Humanist	1
Jedi	1
No Religion	1
No Religious Belief	1
None	23
None In Particular	1
Pagan	2
Spiritualist	1
Totally Irrelevant	1


We need to know we've spoken to women who are pregnant or have recently given birth. Please tick below if you:
Are pregnant at this time
Have recently given birth (within the last 26 week period)
Not applicable


Carers play a crucial role in health and social care. We need to know we've gathered the views of carers. Please tell us if you care for someone and how old they are.
18.2%
4.9%
6.5%
70.8%
I am not a carer for anyone
I care for a young person/s aged younger than 24 years of age
I care for a adults/s aged 25 to 49 years of age


Do you consider yourself to have a disability? (The Equality Act 2010 states a person has a disability if they have a physical or mental impairment which is long term (12 month period or longer) or has substantial adverse effects on their ability to carry
5%
28%
67%
Yes
No
Prefer not to say

APPENDIX 6. PRE-CONSULTATION ENGAGEMENT OUTCOMES

Pre-consultation engagement took place during March using the following three methods:

- Electronic online questionnaire advertised via Trust channels incl. social media.
- Hard copy paper questionnaire available at service outpatient clinics
- MS Teams Live sessions with an open invite to all interested parties

Total Responses

315 responses were received
286 from online survey
29 from paper forms returned to Trust

56% of respondents had used at least one of the three services provided by the Trust.

Service	Online		F2F		Total	
Audiology	105	37%	15	52%	120	38%
Ophthalmology	117	41%	17	59%	134	43%
Dietetics	30	10%	0	0%	30	10%
None	137	48%	1	3%	138	44%

Awareness

- 64% of respondents said they were aware of the proposal to provide outpatient clinics at Runcorn Shopping City.
- 51% said they had been given enough information to form an opinion on the proposed changes.

Preferred Location

There was a range of responses to the question of where people would prefer to access each of the three proposed outpatient services.

Overall, all respondents would be happy to attend the appointment at Runcorn Shopping City.

Ophthalmology

Location	Online		Paper		Total	
Current location at the hospital	98	44%	3	9%	101	40%
Runcorn Shopping city Health Hub	58	26%	24	75%	82	32%
Any of these locations	57	26%	8	25%	65	26%
None of these	8	4%	0	0%	8	3%

58% of respondents would be happy to have their ophthalmology outpatient appointment at Runcorn Shopping City.

Audiology

Location	Online		Paper		Total	
Current location at the hospital	98	44%	2	6%	100	40%
Runcorn Shopping city Health Hub	58	26%	24	75%	82	32%
Any of these	58	26%	7	22%	65	26%
None of these	7	3%	0	0%	7	3%

58% of respondents would be happy to have their audiology outpatient appointment at Runcorn Shopping City.

Dietetics

Location	Online		Paper		Total	
Current location at the hospital	87	39%	2	6%	89	35%
Runcorn Shopping city Health Hub	70	32%	25	78%	95	38%
St Paul's Health Centre	15	7%	6	19%	21	8%
Any of these	44	20%	0	0%	44	17%
None of these	5	2%	0	0%	5	2%

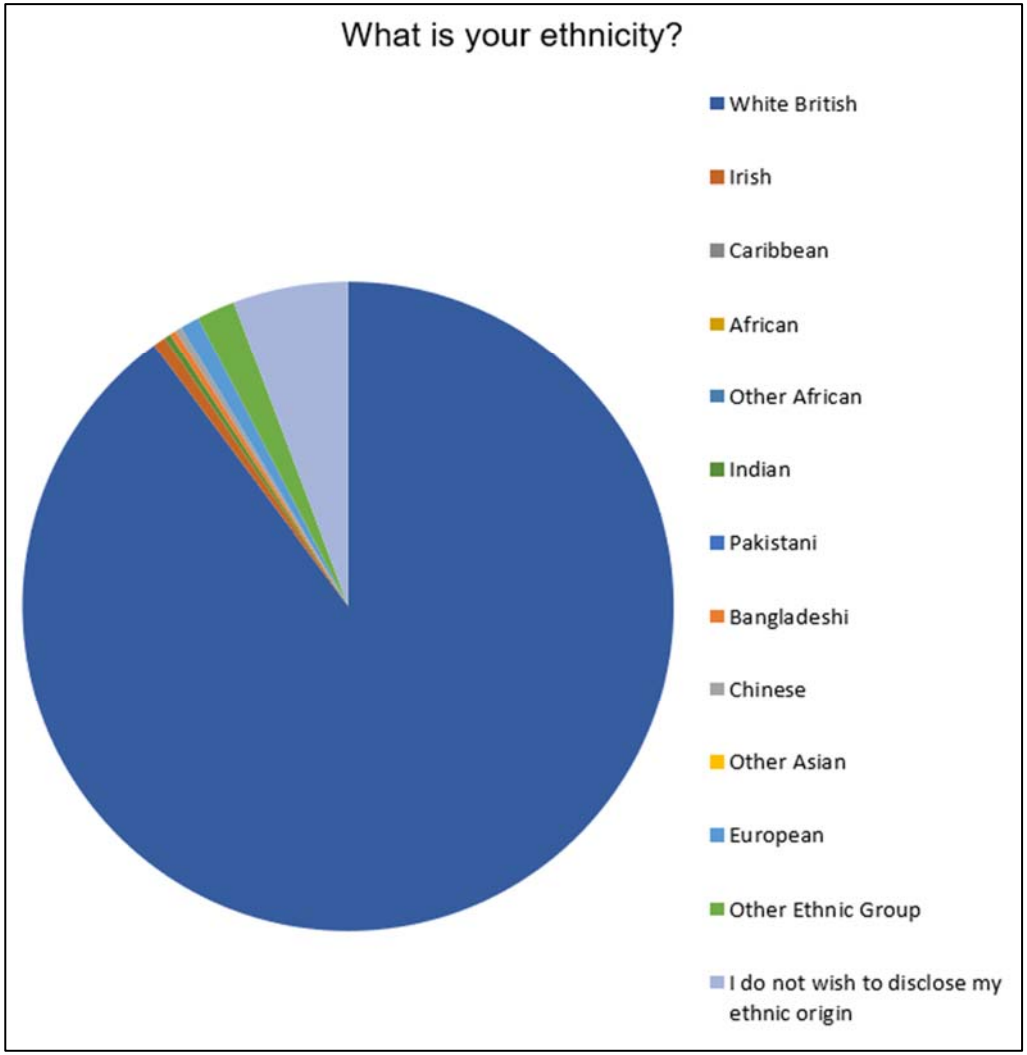
55% of respondents would be happy to have their dietetics outpatient appointment at Runcorn Shopping City.

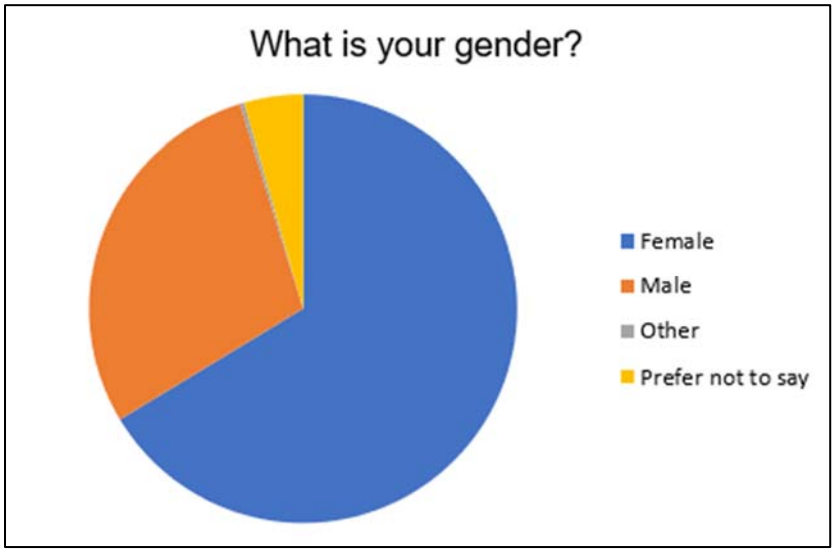
Overall Support

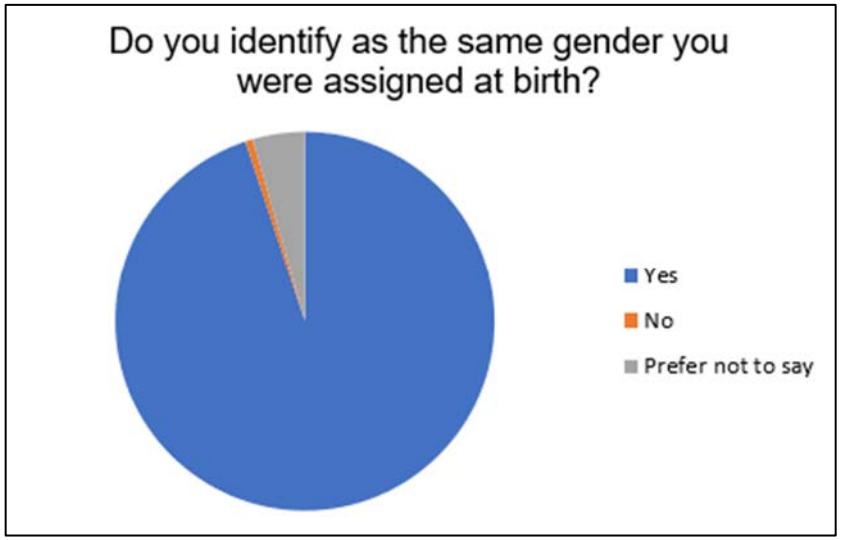
51% of respondents support the relocation to or provision of additional hospital services at the Health Hub at Runcorn Shopping City.

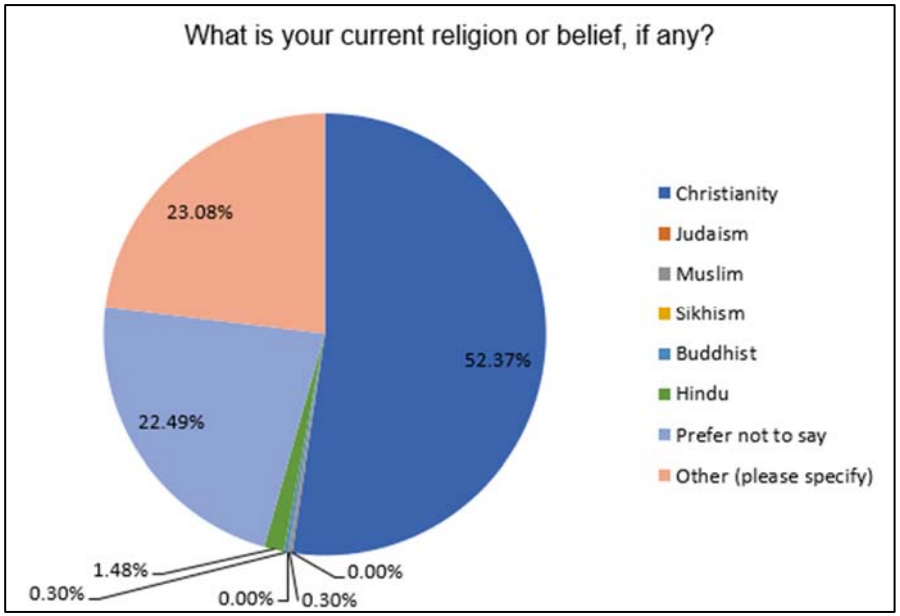
Response	Online		Paper		Total	
Yes	99	45%	29	91%	128	51%
No	90	41%	0	0%	90	36%
Somewhat	26	12%	2	6%	28	11%
I don't know	6	3%	1	3%	7	3%

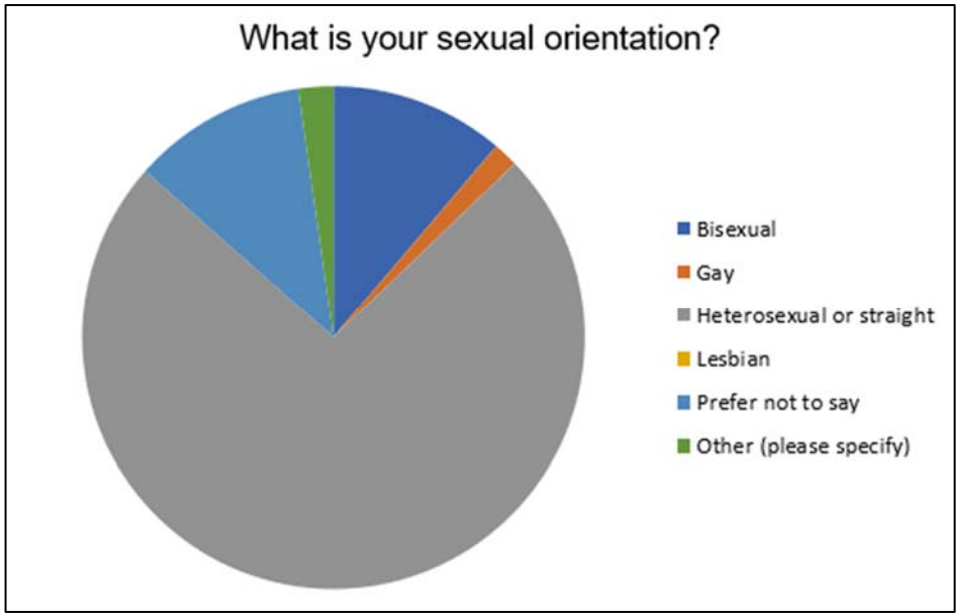
Respondent demographics





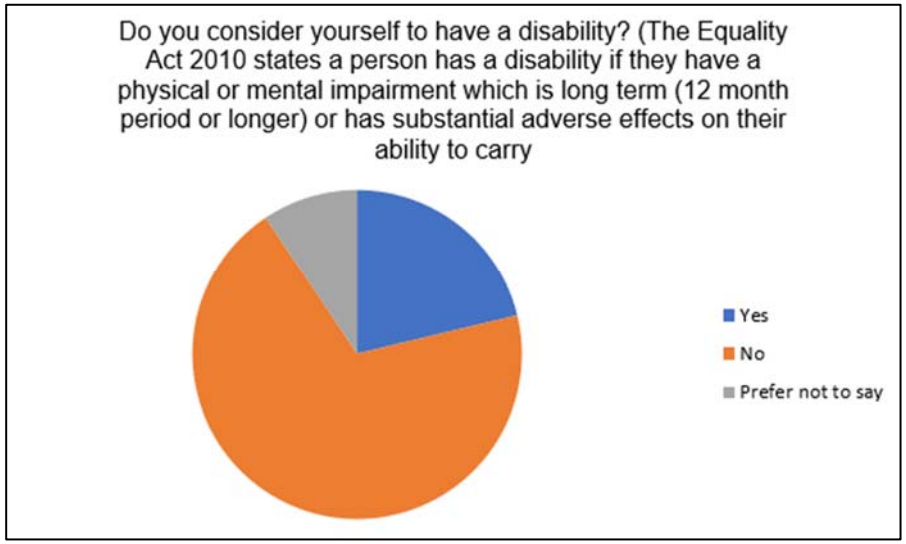


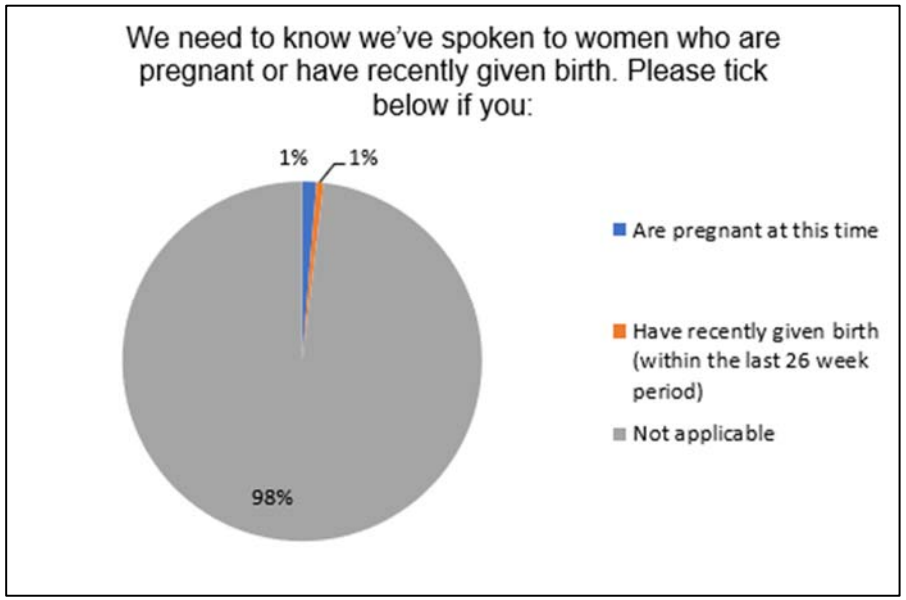


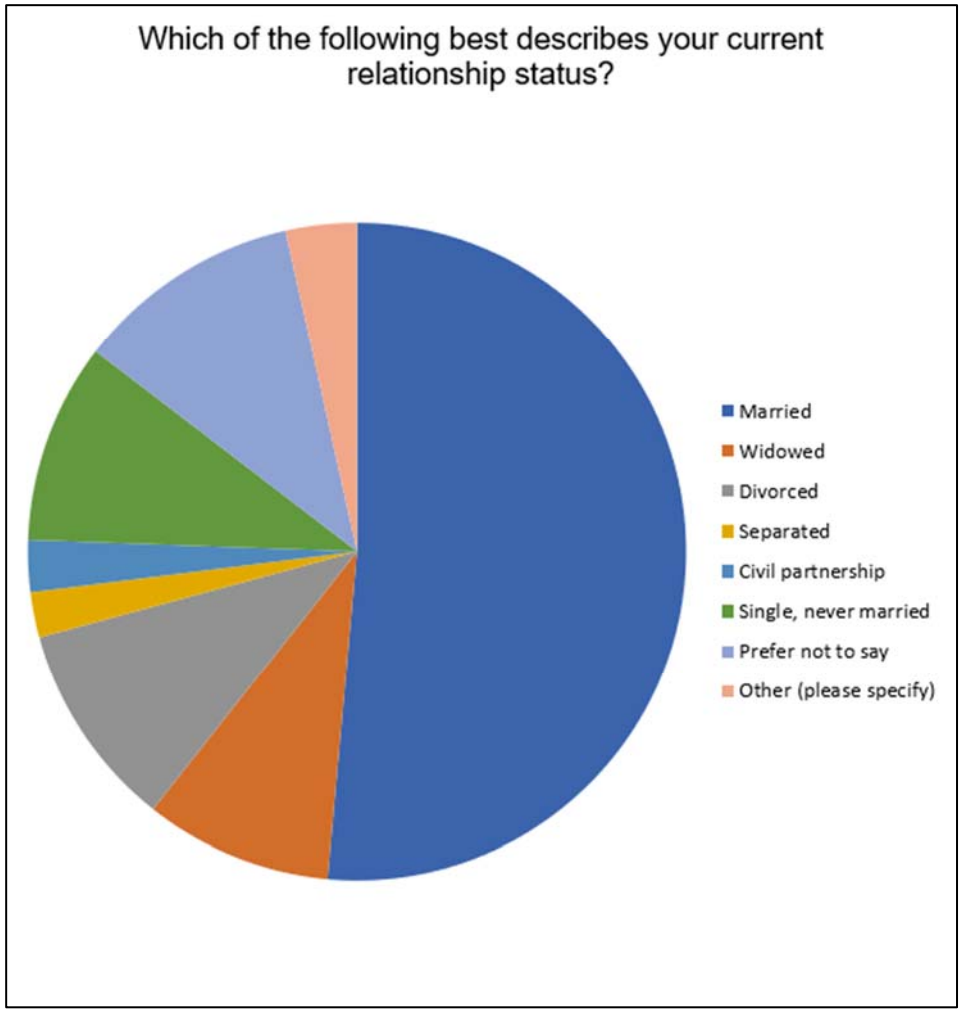


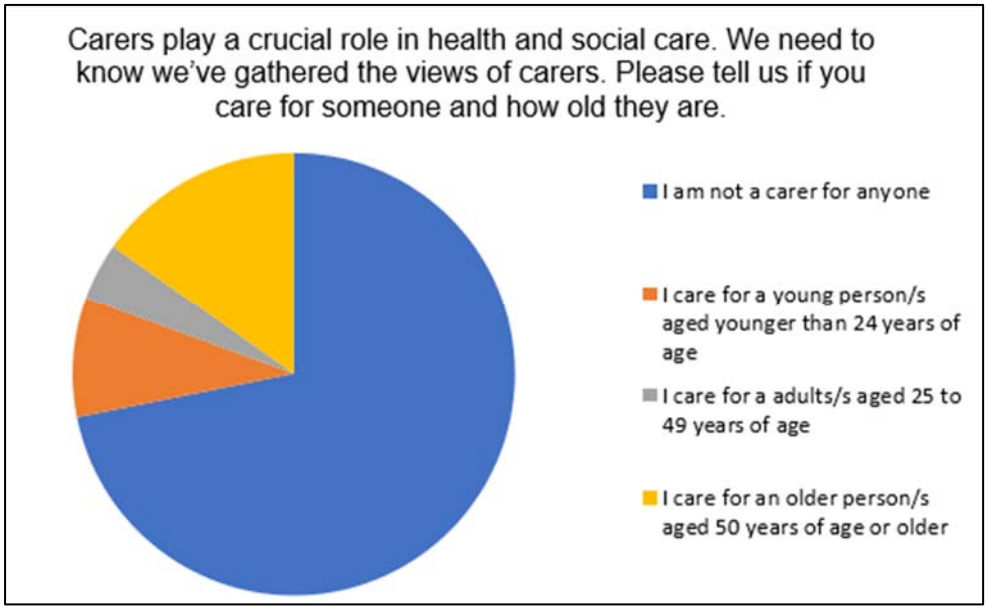
N.B. There were 29 responses to the “Other” option within “What is your current religion or belief, if any?” demographic question. These responses are listed here:

Comment	Count
None	11
Atheist	4
Agnostic	2
Roman Catholic	2
Agnositic	1
Atheist	1
Humanism, no religious belief	1
Humanist	1
I believe in people not gods	1
Jedi	1
No primary religion	1
No religion	1
Pagan	1
Penguin	1


Do you consider yourself to have a disability? (The Equality Act 2010 states a person has a disability if they have a physical or mental impairment which is long term (12 month period or longer) or has substantial adverse effects on their ability to carry
Yes
No
Prefer not to say


We need to know we've spoken to women who are pregnant or have recently given birth. Please tick below if you:
1%
1%
98%
Are pregnant at this time
Have recently given birth (within the last 26 week period)
Not applicable


Which of the following best describes your current relationship status?
Married
Widowed
Divorced
Separated
Civil partnership
Single, never married
Prefer not to say
Other (please specify)



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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/164**	
SUBJECT:	**Medical Appraisal and GMC Revalidation Annual Report: September 2021**	
DATE OF MEETING:	24 November 2021	
AUTHOR(S):	Janice Fazackerley – Associate Medical Director and Deputy Responsible OfficerAndrea Stazicker – Revalidation LeadPaula Harris – Medical Workforce Development AdministratorKate Davidson – Medical Education Operational Manager	
EXECUTIVE DIRECTOR SPONSOR:	Anne Robinson, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	 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. **#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. **#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.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides assurances to the Board that the system for medical appraisal and the processes for monitoring the completion of annual appraisals to support GMC revalidation for the medical workforce are robust. Doctors who practise medicine in the UK must be registered and hold a licence to practise Both registration and licensing are delivered by the GMC. Every licensed doctor who practises medicine must revalidate. Revalidation is an evaluation of a doctor's fitness to practise. It supports professional development, drives improvements in clinical governance and gives patients confidence that the doctor is up to date. GMC revalidation is based on annual whole practice appraisals; information from systems of clinical governance and a five yearly revalidation recommendation. All doctors have a legal	

	obligation to revalidate and failure to comply with the requirements may result in withdrawal of their licence to practice Most licensed doctors are supported with their appraisal and revalidation through connection to a 'designated body'. Within that organisation, a 'responsible officer' oversees the process of revalidation and makes a recommendation to the GMC about whether a doctor should be revalidated. The designated body is the organisation in which the doctor undertakes most, or all of their practice and their responsible officer is a senior doctor within that organisation. The relationship between a doctor, their designated body and responsible officer is known as their 'connection details'. The Trust maintains the list of doctors for whom it is the designated body. There has been a change in the responsible officer since the paper was presented to SPC IN September 2021. Dr Anne Robinson took over the role from Dr Alex Crowe on 8/11/2021. The responsible officer must: 1. Make sure doctors have access to appraisal systems and processes for collecting and holding information 2. Make a recommendation to the GMC every five years, indicating whether the doctor is up to date, fit to practise and should be revalidated. The GMC sets clear guidance on the requirements for annual appraisal and the supporting information that a doctor must present. Doctors at WHHFT collate their supporting information using CRMS - a web based system enabling the secure storage of documentation. Since 2012 WHHFT has had processes and systems in place to enable, track and monitor appraisal completion rates.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note X	Decision
RECOMMENDATION:	For the Committee to note and approve the year-on-year results that have been achieved for completion of annual medical appraisals. Annual Board report and Statement of compliance sign off for submission to NHSEI.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/21/09/72		
	Date of meeting	22.09.21		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Medical Appraisal and GMC Revalidation Annual Report: September 2021	AGENDA REF:	BM/21/11/164

1. BACKGROUND/CONTEXT

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

Most licensed doctors are supported with their appraisal and revalidation through a connection to a 'designated body'. Within that organisation, a 'responsible officer' oversees the process of revalidation and makes recommendations to the GMC about whether a doctor should be revalidated. The designated body is the organisation in which the doctor undertakes most, or all of their practice and their responsible officer is a senior doctor within that organisation. The relationship between a doctor, their designated body and responsible officer is known as their 'connection details.' The Trust maintains the list of doctors for whom it is the designated body. The responsible officer is Dr Alex Crowe [up to 7/11/21] Dr Anne Robinson has taken over this role in a permanent capacity from 8/11/21.

The responsible officer must:

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

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

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

The GMC sets clear guidance on the requirements for annual appraisal and the supporting information that doctors must present. There are 5 types of supporting information that doctors must collect reflect on and discuss at their annual appraisal. These are:

- Quality improvement,
- Continuing education,
- Feedback from colleagues and patients,
- Compliments
- Serious incidents, complaints and claims

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

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

2. KEY ELEMENTS

See appendix 1 - annual board report and statement of compliance

2.1 Effective Appraisal

All doctors are offered an appraisal, which reviews supporting evidence and reflection on;

- Quality improvement,
- Continuing education,
- Feedback from colleagues and patients,
- Compliments,
- Serious incidents, complaints and claims

In keeping with the ethos of the Pearson review which recommended that doctors be selective with uploaded evidence, and choose examples to illustrate a point, and also with NHSE's 2018 guidance of minimum paperwork for maximum benefit, we planned to discontinue provision of some of this evidence. Reports of serious incidents, complaints and claims were continued, along with completed audit projects, and clinical effectiveness data.

All doctors are programmed to have an appraisal covering the full scope of their work. Any doctor who continues to have an overdue appraisal receives 3 non-engagement letters in keeping with Trust policy and is then contacted by the Associate Medical Director to seek mitigating factors and offer relevant support. Where appropriate doctors are referred to and monitored by the Trust Triangulation Group

The Medical Appraisal Policy has been agreed and is displayed on the Trust extranet

Key Results

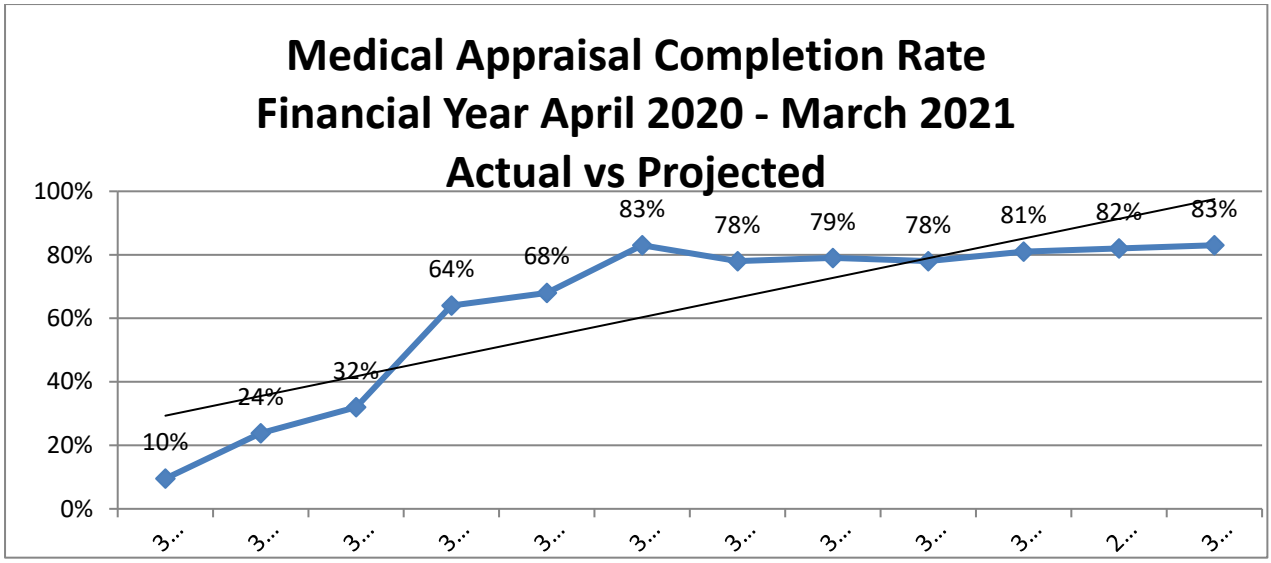
The Trust Maintains 70 trained appraisers;

Name of organisation: Warrington & Halton Teaching Hospitals NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	279
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	186
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	61
Total number of agreed exceptions	56

The 56 agreed exceptions include doctors allowed an 'approved-missed' appraisal in the pandemic, doctors on parental leave and career breaks, and those who completed appraisal later than 31st March 2021.

The remaining 5 doctors who did not complete appraisal in this period are being tracked by our non-engagement procedures and Trust Triangulation group and offered appropriate support.

Figures 1 show the medical appraisal completion rates for the financial year. The completed percentage reflects medical appraisals completed by scheduled monthly cohort, not the total medical workforce to be appraised.



2.2 Recommendations to the GMC

Doctors who are becoming due for revalidation are identified from the list of those for whom this Trust is the Designated Body via GMC Connect. Supporting evidence is collated for each doctor and presented at the next Revalidation Decision Making Panel. This consists of the Responsible Officer, Deputy RO & Appraisal Lead, Revalidation Lead and Non-Executive Director. Doctors are considered for revalidation in time for any shortfalls to be addressed whenever possible. All recommendations have been submitted to the GMC either ahead of time or on the actual submission date.

2.3 Medical governance

The Trust maintains and displays a policy for Maintaining High Professional Standards for Medical & Dental Staff, in keeping with the framework from the Dept of Health 2003. The policy states procedures to deal with conduct performance and complaints relating to medical and dental staff.

Regular contact is maintained between the appraisal and revalidation group and the Governance department. The governance department supply information on request including

- Three reports for annual appraisal documentation relating to any serious events in which the doctor has been named in the appraisal review period. Ongoing claims are reported and any complaints which remain unresolved. Reflection on each area is expected in appraisal documentation and should be covered in appraisal discussion.
- Reports to inform the Revalidation Panels in supporting revalidation recommendations, which contain all serious incidents and ongoing claims
- Ad-hoc reports to inform governance requests on individual doctors.

2.4 Employment Checks

The system for ensuring pre-employment checks including qualifications are undertaken for fixed term/permanent doctors is completed via the Trust employment services team.

The trust has a separate Professional Clinical Registration Policy which contains further details.

Locum, bank and agency staff require the same employment checks as those undertaken for permanent staff.

This information is maintained and available for reference via the Trust Recruitment and Selection Policy

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

See appendix 1 - annual board report and statement of compliance

General review of actions since last Board report :

- Since the 2020 report, we introduced 'Appraisal 2020' with emphasis on reflection and wellbeing, and informed our appraisers by an on-line forum, published guidance, e-mails and personal discussion.
- Trust supplied information for appraisal has been reviewed to remove any which is no longer relevant, thereby reducing the administrative burden of preparing and uploading reports.
- A full review of appraiser allocations has taken place after several years unchanged. The template developed facilitates easy forward planning to change appraiser after three appraisals, in keeping with best practice
- 8 new appraisers were trained and have taken up an allocation of appraisees.
- Quality assurance of appraisal summaries (PROGRESS tool) has commenced.
- Revalidation panels have resumed after a pause by the GMC
- The appointment of a new Medical Education Operations Manager has brought stability after a stressful period for doctors and Appraisal & Revalidation staff

Actions still outstanding & Current Issues :

- Continue the review and development of Trust policies relating to appraisal and revalidation, in keeping with nationally accepted guidance.
- Improve contact with Human Resources to refine information flows between our departments, and work together in identifying the assignment of doctors, including locums.
- We aim to offer each doctor the most appropriate management of their appraisal and revalidation situation.
- Identify the pathway for exchange of information relating to doctors starting and leaving the Trust and develop a robust SOP around this.

4. IMPACT ON QPS?

- There is good evidence that annual appraisal improves quality of care delivered to patients. Reflection on incidents/ complaints is mandatory. Each doctor includes their involvement in quality improvement/ research as part of their appraisal
- The focus over the past year at appraisal has very much on the well-being of the doctor as the COVID 19 pandemic has had a profound effect on some medical staff

5. MEASUREMENTS/EVALUATIONS

In spite of new challenges from the Covid-19 pandemic affecting both doctors and members of the Appraisal & Revalidation team, we have been able to maintain business as usual, but also to develop using the positive ideas from pandemic working. We have supported doctors to achieve a less onerous but more useful appraisal and those due to revalidate have been recommended on time, except for one short deferral.

Staffing of the team is improved, after a prolonged period without a manager, and we are better placed to work efficiently, share information, and build good relations with the departments of governance and human resources which are fundamental to the smooth running of our work.

6. TRAJECTORIES/OBJECTIVES AGREED

New Actions:

- Staffing: Appointment of a Deputy to the Associate Medical Director, and extra clerical support post currently out for recruitment. This should facilitate succession planning, allow more cross-cover and avert single points of failure in the working practices.
- Review and explore systems options to support appraisal and revalidation, seeking a more up to date, more user friendly and more efficient on-line system.

7. MONITORING/REPORTING ROUTES

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

8. TIMELINES

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

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

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

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

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

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

Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

1. The Revalidation Lead contacts the doctor prior to their revalidation becoming due to inform them that evidence to support a decision is being gathered. The doctor is made aware of any deficiencies by e-mail, asked to provide additional information or documentation required and informed that they cannot be given a positive recommendation for revalidation if they do not meet the criteria and that this would require a deferral being requested.
2. Once a revalidation decision has been made, this is submitted to the GMC via GMC Connect. Each doctor is e-mailed to inform them of the decision.
3. Those who do not receive a positive recommendation are given details of what remains outstanding and what they need to do. If the shortfall in what is required is likely to be achieved before the submission deadline, for example, the 360 MSF report isn’t yet available, then the

decision would be held back internally and reviewed again by the Responsible Officer nearer to the submission deadline.

4. Non-engagers are normally dealt with via the appraisal policy rather than through the revalidation process.

9. ASSURANCE COMMITTEE

n/a

10. RECOMMENDATIONS

For the Committee to note and approve the year-on-year results that have been achieved for completion of annual medical appraisals. Annual Board report and Statement of compliance sign off for submission to NHSEI.

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The executive management team of Warrington & Halton Hospitals NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Dr Alex Crowe is appointed Medical Director and Responsible Officer for the Trust. He will leave his post in autumn 2021, and interviews for a successor will take place in September 2021

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

The Responsible Officer is supported by **a.** An Associate Medical Director & Deputy Responsible Officer, Dr Janice Fazackerley, resourced 3PAs **b.** A Revalidation Lead, Andrea Stazicker **c.** A Medical Workforce Development Administrator, Paula Harris **d.** Medical Education Operational Manager, Kate Davidson, who manages the Revalidation Lead and Medical Workforce Development Administrator in addition to duties in Medical Education. The Trust provides on-line systems for the management of all doctors' annual appraisals, (CRMS / System C) A 360 degree feedback is provided in every 5 year cycle (Premier IT) to support the necessary colleague and patient feedback for revalidation The Trust's appraisers are remunerated 0.125PAs per 4 appraisees or 0.25 for more than 4. The Trust supports appraisers with forums to update, and training for both new and established appraisers Action for next year: 1.Appointment of a Deputy to the Associate Medical Director, to assist, shadow, and possibly succeed her in the role. This post will be resourced within the 3 PAs allocated to the role.

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2. Adjustment of workload of Revalidation Lead and Medical Workforce Administrator, with inclusion of extra clerical support currently out for recruitment. This should facilitate more cross-cover and support and avert single points of failure in the working practices.

3. Review and explore systems options to support appraisal and revalidation, seeking a more up to date, more user friendly and more efficient on-line system.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Connections to, and removals from, the Designated Body are managed by the Revalidation Lead. The Associate Medical Director also has GMC Connect access to cover absences.

Lists of connected doctors and revalidation dates are shared and discussed at monthly meetings of the Appraisal & Revalidation Group (ARG) and a representative from Human Resources. Lists are stored in electronic format in a secure area of the Trust server, which is accessible to ARG members, and updated before each monthly meeting.

Action for next year:

1. Development of a robust policy which describes the process of accepting or declining doctors to or from the Designated Body.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The Medical Education Operational Manager will oversee the Revalidation Process and ensure that related procedures and practices are regularly reviewed in line with changes in legislation. She will ensure that appropriate protocols, processes and records are developed and in line with National Guidance.

The Medical Workforce Development Administrator and the Trust's Revalidation Lead, co-ordinate and provide administrative support to the appraisal and revalidation process. The Service will maintain the records/electronic data systems and ensure that they are held securely.

Current policies to support appraisal and revalidation are displayed on the Trust Extranet and were last reviewed in autumn 2019. A process of updating and reviewing all policies at monthly ARG meetings has begun.

Action for next year:

1. Completion of policy reviews

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

A representative of our Trust, usually the Associate Medical Director, Revalidation Lead or Responsible Officer engages in NHSE/I regional forums to report and compare our procedures during the pandemic with those of other Trusts. All changes in process were discussed, and favourable comments were received from the Medical Director of NHSE/I North on our appraisal conduct and completion rates during the pandemic. The changes to Trust provided supporting information, have been discussed nationally by the RO.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

The Appraisal & Revalidation Group receive monthly updates of new starters, leavers, doctors on periods of prolonged leave. A recent addition has been to add a 'change of assignment' category, which helps identification of the exact capacity in which doctors are employed. The Trust employs oral surgeons who all work in other practices, or Trusts, but are supported with study leave allowance, and learning opportunities. They are not subject to GMC regulation, but the Trust supports their appraisal to maintain their recognition by the General Dental Council. Governance information is received and reviewed from their other employers Working practices of doctors have changed so that many trainees take years out of training and work variable hours in the Trust in a variety of named posts, including e.g. Trust Grade, Trust Bank, LAS, Clinical Fellow, FY3, FY4 and locum in all of these grades. They want increased flexibility and freedom from the structure of a training programme, exams and excessive hours, and this makes them more difficult to track. Some also seek the enhanced rates of pay afforded to locum doctors. The Trust continues to rely on these doctors to meet service commitments, and their increasing numbers and variation in terms of employment is a challenge to us. The Trust is keen to employ more junior locums on Trust contracts, rather than hourly rates. This would offer them appraisal, and other supportive services which they need at such an early stage in their careers, and also benefit the Trust in reducing wage bills Action for next year: Work with HR and medical staffing aiming to:

2. Refine information flows between our department and better identify the exact assignment of each doctor,

3. Maintain accurate databases of doctors for appraisal,

4. Offer each doctor the most appropriate management of their appraisal and revalidation situation.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

All doctors are offered an appraisal, which reviews supporting evidence and reflection on

- Quality improvement,
- Continuing education,
- Feedback from colleagues and patients,
- Compliments,
- Serious incidents, complaints and claims

Shortly before the pandemic began, plans were in place to re-assess and streamline the Trust-supplied supporting information for appraisal. Some of this information was onerous to produce in several Trust departments yet contributed little to the evidence for revalidation and the appraisal discussion. In keeping with the ethos of the Pearson review which recommended that doctors be selective with uploaded evidence, and choose examples to illustrate a point, and also with NHSE's 2018 guidance of minimum paperwork for maximum benefit, we planned to discontinue provision of some of this evidence.

The reduction in document preparation reduced workload for several Trust departments, and the Medical Workforce Development Administrator spent less time in uploading documents to appraisal folders. Work to identify the

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less useful supporting information went ahead during the early months of the pandemic and was discussed with the Medical Cabinet before implementing in October 2020.

Reports of serious incidents, complaints and claims were continued, along with completed audit projects, and clinical effectiveness data.

Doctors working for other employers declare this and are expected to supply independent sector checklists or similar governance reports for each employer.

In March 2020, members of the ARG were able to continue business as usual. Some, but not all doctors were at the forefront in treating Covid-19, so it was agreed to send appraisal notices out as usual in birth months, with an offer of extra support, extra time to complete, or a substitute appraiser as required. After 8 weeks, doctors with incomplete appraisals were offered an 'approved-missed appraisal' for 2020. Some doctors chose this option between March & September 2020 citing reasons of increased clinical workload, but most doctors opted to complete appraisal as usual. Data are shown in Section 2b.

From October 2020, appraisal re-started for all, using new guidance derived from the MAG 2020 Guidance, with an emphasis on reflection and wellbeing. Less uploaded evidence was required, and our revised supporting information practice began. Appraisers were notified of changes by e-mail, guidance documents and information videos. Doctors being appraised received accompanying guidance with their appraisal notice. It was unfortunate that the re-start coincided with a new wave of Covid-19, which continued until spring 2021. Therefore, a supportive and tolerant attitude to appraisal deadlines continues.

On-line forums for discussion and information were held in April 2021, and appraisers were appreciative of efforts to make appraisal more relevant.

Since appraisal is an annual process, it takes considerable time to embed change. Therefore, in October 2021 we will continue using a similar framework to 2020, encouraging doctors to focus on reflection and discussion, and adapt to existing change.

Action for next year:

1. Continue refining the process to make appraisal discussions more relevant and supportive of doctors' wellbeing.

2. Listen to doctors' views in appraisal forums.

3. Review the provision of on-line systems for appraisal, looking at ease of use by all stakeholders, cost of systems and new functionality available to reduce the administrative support required.

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2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

All doctors are programmed to have an appraisal covering the full scope of their work. Any doctor who continues to have an overdue appraisal receives 3 non-engagement letters in keeping with Trust policy and is then contacted by the Associate Medical Director to seek mitigating factors and offer relevant support. Where appropriate doctors are referred to and monitored by the Trust Triangulation Group.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

The Medical Appraisal Policy has been agreed and is displayed on the Trust extranet

The Medical Education Operational Manager ensures that appraisal procedures and practices are regularly reviewed in line with changes in legislation. The post holder will ensure that appropriate protocols, processes and records are developed and in line with National Guidance.

The Medical Workforce Development Administrator and the Trust's Revalidation Lead, co-ordinate and provide administrative support to the appraisal process. They maintain the records/electronic data systems securely. Regular quality control checks ensure that the appraisal documentation submitted meets the agreed standards

Action for next year:

1. Review and update all policies annually.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The Trust maintains around 70 trained appraisers. A training course run by MIAD for 8 new appraisers was held in October 2020 to replace those who left, retired or withdrew. No appraiser forums were held in 2020, but informational videos were produced and frequent updates and new guidance were circulated by trust e-mail in support of the re-start of appraisal in October 2020. An appraiser forum was held in April 2021. The Appraisal and Revalidation group are all available either by phone or email, as points of contact for advice and support.

Action for next year:

1. A further course run by MIAD for new appraisers will be run, along with a refresher course for existing appraisers.

2. Twice yearly appraiser forums will be held using on-line technology

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Development events for appraisers are listed in 4 above.

The Associate Medical Director completes a Quality Assurance calibration on each appraisal at the time of final sign-off, using the NHSE recognised EXCELLENCE or PROGRESS tools. These score each appraisal summary out of 20. To date the average score is around 15. Appraisers were made aware of the use of the scoring system. Those receiving persistently low scores are contacted, and all scores will be fed back when a complete year is done.

Action for next year:

1. Inform appraisers of their individual scores and use scoring system to drive up the standard of appraisal and summaries.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

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The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

The ARG team have continued to track appraisal completion and collate completion data throughout the pandemic. A report was submitted to the Trust's Strategic People Committee in November 2020.

Doctors completing their appraisal make an evaluation, scored 1 -5 of their appraiser and the organisation of the process. General themes are fed back to appraisers during forum meetings.

Action for next year:

1. Aim to drive up the evaluation scores by feedback, support and learning.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Warrington & Halton Teaching Hospitals NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	279
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	186
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	61
Total number of agreed exceptions	56

The 56 agreed exceptions include doctors allowed an 'approved-missed' appraisal in the pandemic, doctors on parental leave and career breaks, and those who completed appraisal later than 31st March 2021.

The remaining 5 doctors who did not complete appraisal in this period are being tracked by our non-engagement procedures and Trust Triangulation group and offered appropriate support.

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Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Doctors who are becoming due for revalidation are identified from the list of those for whom this Trust is the Designated Body via GMC Connect. Supporting evidence is collated for each doctor and presented at the next Revalidation Decision Making Panel. This consists of the Responsible Officer, Deputy RO & Appraisal Lead, Revalidation Lead and Non-Executive Director. Doctors are considered for revalidation in time for any shortfalls to be addressed whenever possible. All recommendations have been submitted to the GMC either ahead of time or on the actual submission date.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

The Revalidation Lead contacts the doctor prior to their revalidation becoming due to inform them that evidence to support a decision is being gathered. The doctor is made aware of any deficiencies by e-mail, asked to provide additional information or documentation required and informed that they cannot be given a positive recommendation for revalidation if they do not meet the criteria and that this would require a deferral being requested. Once a revalidation decision has been made, this is submitted to the GMC via GMC Connect. Each doctor is e-mailed to inform them of the decision. Those who do not receive a positive recommendation are given details of what remains outstanding and what they need to do. If the shortfall in what is required is likely to be achieved before the submission deadline, for example, the 360 MSF report isn't yet available, then the decision would be held back internally and reviewed again by the Responsible Officer nearer to the submission deadline. Non-engagers are normally dealt with via the appraisal policy rather than through the revalidation process.

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Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The Trust maintains and displays a policy for Maintaining High Professional Standards for Medical & Dental Staff, in keeping with the framework from the Dept of Health 2003. The policy states procedures to deal with conduct performance and complaints relating to medical and dental staff.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Regular contact is maintained between the appraisal and revalidation group and the Governance department. The governance department supply information on request;

• Three reports for annual appraisal documentation relating to any serious events in which the doctor has been named in the appraisal review period. Ongoing claims are reported and any complaints which remain unresolved. Reflection on each area is expected in appraisal documentation and should be covered in appraisal discussion.

• Reports to inform the Revalidation Panels in supporting revalidation recommendations, which contain all serious incidents and ongoing claims

• Ad-hoc reports to inform governance requests on individual doctors.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

The Maintaining High Professional Standards Procedures for Medical & Dental Staff covers this process. It was updated in 2019, and will be further reviewed in 2022

When a concern arises the first consideration is whether the alleged matter is of general misconduct rather than professional misconduct. If the former is considered to be the case, as determined by the Medical Director, the matter will be dealt with under the Trust's Disciplinary procedure. However,

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should professional concerns emerge during any investigation the case will transfer back to the Maintaining High Professional Standards procedures. At his discretion the Medical Director may convene a Decision-Making Group prior to reaching a conclusion in relation to which procedure to continue the matter under.

If the case is one of a professional nature it will continue to be managed under Maintaining High Professional Standards procedures as follows:

The management of performance is a continuous process which is intended to identify problems. Numerous ways exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which need not necessarily require formal investigation or the resort to disciplinary procedures.

Concerns about a doctor or dentist's conduct or capability can arise via concerns expressed by NHS professionals, health care managers, students and non-clinical staff, review of performance against job plans, annual appraisal, revalidation, monitoring of data on performance and quality of care, clinical governance, clinical audit and other quality improvement activities, complaints about care by patients or relatives of patients, information from regulatory bodies, litigation following allegations of negligence, information from the police or coroner, or court judgements.

All allegations, including those made by relatives of patients, or concerns raised by colleagues, are properly investigated to verify the facts. All serious concerns are registered with the Chief Executive who will ensure that a case manager is appointed. The Chairman of the Board designates a non-executive member to oversee the case.

All concerns are investigated quickly and appropriately. A clear audit route is established for initiating and tracking progress, the investigation’s costs and resulting action. The Medical Director works with the Director/Head of Human Resources to decide the appropriate course of action in each case and is responsible for appointing a case investigator.

When serious concerns are raised about a practitioner, the Trust will consider whether it is necessary to place temporary restrictions on their practice. If the case manager considers a practitioner to be a serious potential danger to patients or staff, that practitioner is referred to the GMC/GDC, whether or not the case has been referred to the National Clinical Assessment Service (NHS Resolution).

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

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outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

To help monitor case management across the organisation the Trust has the following in place:

- Regular triangulation meetings attended by the Medical Director, senior representatives of Human Resources, and the Associate Medical Director for Appraisal and Revalidation. No decisions about case management are made at these meetings. They are used to discuss progress on investigations and open or emerging cases or issues. No notes of these meetings are kept but the tracker (referred to below) is updated with the current position.
- A tracker in the form of an excel spread sheet which gives brief details of 'live' matters being considered and their current status. This is used to keep track of progress and for reporting at Revalidation Decision Making panels. Access to the tracker is on a restricted basis.
- Regular reporting on an anonymous basis to the Strategic People Committee progress on all Employee Relations cases and progress relating to exclusions.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

In cases where there is concern that a doctor may be a danger to patients, the Trust has an obligation to inform such other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons for it. Details of other employers (NHS and non-NHS) may be readily available from job plans, but where it is not the practitioner is asked to supply them.

Where an NHS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Information is shared in keeping with NHSE published Guidance "Information flows to support medical governance and responsible officer statutory function"

Action for next year:

1. Develop a robust SOP relating to information transfer

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

All actions taken in accordance with these procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability, age, sexual orientation, religion or any other protected characteristics.

Case managers and case investigators involved in these procedures will be appropriately experienced or have received appropriate training which may be delivered by an external provider or arranged in-house.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

The system for ensuring pre-employment checks including qualifications are undertaken for fixed term/permanent doctors is completed via the Trust employment services team.

In order for professional/clinical staff to fulfil their role, the vast majority are required to be registered with their regulatory body before they can practice. This is a contractual requirement for these staff and it is an explicit term in the contract of employment.

It is the responsibility of the Employment Services team prior to commencement to check the Alert Letter File which identifies professional staff who may have action pending against them and with the relevant regulatory body, usually via their website, that they are appropriately registered. Prior to commencement, the Employment Services team will check that the individual is included on the relevant professional register of

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the regulatory body using their unique on-line service. Details of the confirmation are entered onto the ESR system.

The trust has a separate Professional Clinical Registration Policy which contains further details.

Locum, bank and agency staff require the same employment checks as those undertaken for permanent staff.

Warrington and Halton Hospitals NHS Foundation Trust use approved agencies established under the 'Buying Solutions Framework Agreement'. Pre-employment checks form part of the Agreement and all agencies on the framework undertake all pre-employment checks for temporary staff they employ and only supply staff who comply with the terms of the Agreement. Buying Solutions regularly audit, via a rolling programme, these agencies and this evidence is provided to the Supplies Department as part of the Agreement.

This information is maintained and available for reference via the Trust Recruitment and Selection Policy

Action for next Year:
1. To continue to review policy annually and work in line with requirements documented.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report :**
  - Since the 2020 report, we introduced 'Appraisal 2020' with emphasis on reflection and wellbeing, and informed our appraisers by an on-line forum, published guidance, e-mails and personal discussion.
  - Trust supplied information for appraisal has been reviewed to remove any which is no longer relevant, thereby reducing the administrative burden of preparing and uploading reports.

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- A full review of appraiser allocations has taken place after several years unchanged. The template developed facilitates easy forward planning to change appraiser after three appraisals, in keeping with best practice
- 8 new appraisers were trained and have taken up an allocation of appraisees.
- Quality assurance of appraisal summaries (PROGRESS tool) has commenced.
- Revalidation panels have resumed after a pause by the GMC
- The appointment of a new Medical Education Operations Manager has brought stability after a stressful period for doctors and Appraisal & Revalidation staff
- Trust inclusion of coaching and senior leadership courses which support the infrastructure now in place.

- **Actions still outstanding & Current Issues :**
  - Continue the review and development of Trust policies relating to appraisal and revalidation, in keeping with nationally accepted guidance.
  - Improve contact with Human Resources to refine information flows between our departments, and work together in identifying the assignment of doctors, including locums. We aim to offer each doctor the most appropriate management of their appraisal and revalidation situation.
  - Identify the pathway for exchange of information relating to doctors starting and leaving the Trust and develop a robust SOP around this.

- **New Actions:**

  - Staffing : Appointment of a Deputy to the Associate Medical Director, and extra clerical support post currently out for recruitment. This should facilitate succession planning, allow more cross-cover and avert single points of failure in the working practices.
  - Review and explore systems options to support appraisal and revalidation, seeking a more up to date, more user friendly and more efficient on-line system.

Overall conclusion: In spite of new challenges from the Covid-19 pandemic affecting both doctors and members of the Appraisal & Revalidation team, we have been able to maintain business as usual, but also to develop using the positive ideas from pandemic working. We have supported doctors to achieve a less onerous but more useful appraisal and those due to revalidate have been recommended on time, except for one short deferral.

Staffing of the team is improved, after a prolonged period without a manager, and we are better placed to work efficiently, share information, and build good relations with the departments of governance and human resources which are fundamental to the smooth running of our work.

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Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/165**			
SUBJECT:	**Quality Assurance Committee and Finance & Sustainability Committee – amended Terms of Reference 2021-22**			
DATE OF MEETING:	24 November 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	Proposed changes to the **Quality Assurance Committe**e Terms of Reference (V5) include: • Amendments to section 4 – Core Attendees • Amendments to section 6 - Reporting Proposed amendments to the ToR are detailed in the Revision Tracker. The **Finance and Sustainability Committee** will be the lead Board Assurance Committee for oversight of Digital Services. In order to reflect the amendment to the reporting arrangements, proposed changes to the Finance and Sustainability Committee Terms of Reference include: **<u>Amendment to section 6- Core Attendees:</u>** • 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			
PURPOSE: *(please select as appropriate)*	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review to and approve the amended Terms of Reference for F&SC and QAC.			
PREVIOUSLY CONSIDERED BY:	Quality Assurance Committee Date: 05.11.2021 Agenda Ref: QAC/21/10/241 Approved	Finance & Sustainability Committee Date: 22.09.2021 Agenda Ref: SPC/21/09/157 Approved		

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

TERMS OF REFERENCE

QUALITY ASSURANCE COMMITTEE

1. PURPOSE

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

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly

3. QUORUM

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

4. MEMBERSHIP

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

Core Members

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

- Associate Chief Nurse Planned Care
- AHP Lead

Attendees

- Obstetrics/Obstetrics Safety Champion Lead & Governance Lead

Observers

- **Public Governor**

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

5. AUTHORITY

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

6. REPORTING

The Committee will have the following reporting responsibilities:

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

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

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

- Medicines Governance Group
- Moving to Outstanding Group
- Strategy and a Greener WHH Sub-Committee (by exception)
- ~~Equality Diversity & Inclusion Sub-Committee~~

7. DUTIES & RESPONSIBILITIES

The Committee will undertake the following duties:

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

- Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery;
- Ensure all external accreditations are monitored within the Trust, so that the Board of Directors has assurance that the Trust is meeting external quality requirements, and where there is variance or risk, actions are put in place appropriately;
- Obtain assurance of the Trust's on-going compliance with the Care Quality Commission registration through appropriate systems of control.
- Ensure that the Trust has effective communication channels in place for ward to Board monitoring and that the Clinical Business Unit, directorate, speciality, ward and department governance and quality assurance structures are robust;
- Monitor the process for the production of the Trust's year end quality (Quality Accounts) and risk management (Annual Governance Statement) reports before they are presented to the Trust Audit Committee and Board for formal approval;
- Ensure all reporting Sub Committees have effective reporting structures in place and that planned assurance reports are scrutinised through a business and assurance cycle;
- To inform the Board where it has significant concerns about:
  - Standards of care in the Trust
  - Or where it considers any service (or part of) to be unsafe

8. ATTENDANCE

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

9. ADMINISTRATIVE ARRANGEMENTS

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

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

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

Papers are to be submitted in the following format:

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

10. REVIEW / EFFECTIVENESS

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

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Quality Assurance Committee
Version:	V5 DRAFT
Implementation Date:	November 2021
Review Date:	November 2021
Approved by:	Quality Assurance Committee
Approval Date:	QAC 05.10.2021 Board 24.11.2021

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

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

		Equality Diversity & Inclusion and change in titles CFO, Chief Nurse and CPO	
V5 Draft 05.10.2021	4 - Membership Core Members	**Amendments to titles**: Director of Strategy & Partnerships. Deputy ~~Assistant~~ Chief Nurse - Patient Safety & Clinical Education Director of Midwifery & Associate Chief Nurse ~~Head of Midwifery~~/Midwifery Safety Champion Lead & Governance Lead ~~Chief Information Officer~~ Senior Information Risk Owner **Delete:** ~~Assistant Chief Nurse – Clinical Effectiveness~~	
V5 Draft 05.10.2021	6 - Reporting	**Amendments**: Health & Safety ~~& Risk~~ Sub-Committee Quality Academy Committee ~~Research and Development Sub Committee~~ Palliative Care and End of Life Steering Group. **ADD** Patient Equality, Diversity and Inclusion Sub Committee, Medicines Governance Group, Moving to Outstanding Group, Strategy and a Greener WHH Sub-Committee (by exception) **REMOVE** Equality Diversity & Inclusion Sub Committee	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
07.01.2020	**V3 – replaced with Version 4**	QAC 07.01.2020 Board 29.01.2020
24.11.2021	**V4 – replaced with Version 5**	QAC 05.10.2021 Board 24.11.2021

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

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:	September 2022
Approved by:	Finance & Sustainability Committee
Approval Date:	FSC 22 September 2021, Trust Board 24 November 2021

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

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/166**	
SUBJECT:	**Constitution Amendments – Governor Responsibilities**	
DATE OF MEETING:	24 November 2021	
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)***	**#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. **#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. **#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. **#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 an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case. **#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. **#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. **#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. **#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. **#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. **#1290** Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* The Paper sets out a proposal to allow, by the way of amendment to the Trust's Constitution, amendments to the current description of Governors roles and responsibilities to encourage engagement, attendance and cohesive working amongst Governors. The key changes to be made are: • Governors must attend at least two Governors constituency meetings in any financial year. • Governors must attend at least two Constituency meetings in any financial year. • Governors must attend at least one observation visit in any financial year. • Addition of the expectation for Governors to use social media responsibly to reflect Trust Values. These amendments have been proposed and discussed at the Governors Working Party on 26.10.2021 and approved at the Council of Governors on 11.11.2021.

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

RECOMMENDATION:	The Board is asked to consider the proposed amendments to the Constitution and to approve. These amendments will be entered to create v3.12.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	COG/21/11/66
	Date of meeting	11 November 2021
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Constitution Amendments – Governor Responsibilities	AGENDA REF:	BM/21/11/166

1. BACKGROUND/CONTEXT

The Trust's Constitution states:

45. Amendment of the constitution

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

To support attendance and engagement from Governors it is proposed that the current description of the role and responsibilities of Governors is updated, by way of amendment to the Constitution, as described in section 2.

Furthermore, in order to safeguard the Trust and its members in an increasingly online society, it is proposed to add the expectation of appropriate use of social media by Governors, as described in section 2, to the Constitution.

2. PROPOSALS

It is proposed that all highlighted sections are added to the Constitution.

Page 16 of the Constitution

14. Council of Governors – duties of governors

14.1 The general duties of the Council of Governors are:

14.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

14.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

14.1.3 To undertake the Roles and Responsibilities required of Governors as set out in Annex 5.

Annex 5 – page 63 of the Constitution

Eligibility to be a Governor

A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

1. They area Director of the Trust or any other NHS Body as defined in this constitution;

2. They are a Governor of another NHS Foundation Trust, unless:

    a. They are a Local Authority Governor appointed by one of the local authorities specified in Annex 3; or

    b. They are a Partnership Governor appointed by an NHS Body specified as a partnership organisation in Annex 3;

3. They are the spouse, partner, parent or child of a member of the Council of Governors or Board of Directors of the Trust;

4. They are under sixteen years of age at the time are nominated for election or appointment;

5. They are a member of a local authority's scrutiny committee covering health matters;

6. Being a member of the public constituency, they fail to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;

7. They fail to agree to comply with the Trust's Code of Conduct for Governors.

8. They fail to demonstrate compliance with the Trust's Code of Conduct for Governors.

9. Their use of social media does not reflect Trust values or The Nolan principles.

10. They have or have been subject to a Sexual Offences Prevention Order, a Foreign Travel Order or a Risk of Sexual Harm Order made under the provisions of the Sexual Offences Act 2003;

11. On the basis of disclosures obtained through an application to the Disclosure and Barring Service (including any application to the Criminal Records Bureau made prior to the establishment of the Disclosure and Barring Service), they are not considered suitable by the Trust's Executive Director responsible for Human Resources;

12. They are incapable by reason of mental disorder, illness or injury of managing or administering their property and affairs;

13. They have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

14. They are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that his/her appointment is not in the

interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

15. They have had their name removed from any list maintained pursuant to Parts 4, 5, 6 or 7 of the NHS Act 2006 and/or Regulations made under those Parts, and has not subsequently had their name included on such a list, and, due to the reason(s) for such removal, they are not considered suitable by the Trust's Executive Director responsible for Human Resources;

14. They have previously been removed from office as a Governor of any Trust in accordance with the provisions of paragraph 8 below under the section titled 'Termination of office and removal of Governors'.

Annex 5 – Page 64 of the Constitution

Termination of office and removal of Governors

A person holding office as a Governor shall immediately cease to do so if:

1. They resign by notice in writing to the Trust Secretary;

2. It otherwise comes to the notice of the Trust Secretary at the time the Governor takes office or later that the Governor is disqualified;

3. They fail to meet the expected responsibilities laid out in Annex 5 – Page 66.

4. If a Governor fails to adhere to the provisions laid out in paragraph 3, this will result in termination of office unless the other Governors are satisfied by a 75% majority that:

   4.1 The absences were due to reasonable causes; and

   4.2 The Governor will resume attendance at meetings of the Council of Governors again within such a period as it considers reasonable;

   4.3 If a Governor has been subject to a decision in their favour under paragraph 4 above and subsequently fails to meet the attendance standards set out in paragraph 3, that Governor's tenure of office is to be terminated immediately.

4. In the case of an elected Governor, they cease to be a member of the Trust;

5. In the case of an appointed Governor, the appointing organisation terminates the appointment;

6. They have refused without reasonable cause to undertake any training, which the Council of Governors requires all Governors to undertake;

7. they have failed to sign and deliver to the Trust Secretary a statement in the form required by the Council of Governors confirming acceptance of the Trust's Code of Conduct for Governors;

8. They are removed from the Council of Governors by a resolution approved by a majority of the remaining Governors present and voting at a general meeting on the grounds that:

a) They have committed a serious breach of the Trust's Code of Conduct; or

b) They have failed to declare a relevant and material interest in accordance with the Council of Governors Standing Orders; or

c) They have acted in a manner detrimental to the interests of the Trust; or

d) The Council of Governors consider that it is not in the best interests of the Trust for him/her to continue as a Governor.

Annex 5 – Page 66 of the Constitution – Addition of Responsibilities of a Governor

Responsibilities

The responsibilities of Governors shall include to:

1. Ensure that they do not miss two consecutive Council of Governors meetings in any financial year.

2. Attend at least two Governor's constituency meetings in any financial year.

3. Attend at least two Constituency meetings in any financial year.

4. Attend at least one Governor's observation visit in any financial year.

5. Use social media responsibly upholding Trust values in line with the Nolan Principles.

Code of Conduct – page 74 of the Constitution – amendment to Paragraph 16.

1. Ensure that when acting in my official capacity, or any other circumstances, I conduct myself in a way that will not bring the office of Governor, the Council of Governors or the Trust into disrepute. This includes the use of social media as described in paragraph 9 of 'Eligibility to be a Governor' laid out in Annex 5.

3. ACTIONS AND RECOMMENDATIONS

The Board is asked to consider the proposed amendments to the Constitution and to approve. These amendments will be entered to create v3.12.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/167**			
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**			
DATE OF MEETING:	24 November 2021			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#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 **#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.			
EXECUTIVE SUMMARY	To provide the Trust Board with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.			
PURPOSE: (please select as appropriate)	Information	Approval	To note ✓	Decision
RECOMMENDATIONS:	The Trust Board is asked to receive the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/11/274		
	Date of meeting	02/11/2021		
	Summary of Outcome	Submit to Trust Board		

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

Infection Control Sub-Committee

SUBJECT	IPC BAF	AGENDA REF:	BM/21/10/167

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 guidance has been advised as new variants of the virus have emerged.

This assessment against the framework provides internal assurance on actions in place to meet legislative requirements relating to: -

- *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

In the context of COVID-19, there is an inherent level of risk for NHS staff that are treating and caring for patients. Within the healthcare setting, transmission risks can arise from: patient to staff, staff to staff, staff to patient and patients to patient. Robust risk assessment processes are central to ensuring that these risks are identified, managed and mitigated effectively.

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 monthly by the Infection Prevention and Control Team and submitted to Infection Control Sub-Committee and Quality Assurance Committee bimonthly, with an action plan to address any areas of concern identified.

This assessment has been made against version 1.6 of the Infection Prevention and Control Board Assurance Framework published on 30 June 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 Clinically Extremely Vulnerable (CEV) 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 receive the report.

Appendix 1 IPC BAF Compliance Assessment 10 2021

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;	• Overarching Environmental action plan which includes risk assessments for all clinical and corporate services • Risk assessments completed and include: - Access to PPE - Adherence to PPE guidance - Access to Hand Gel - Signage - Distancing on chairs in Outpatients departments/ staff restrooms inpatient beds and use of clear curtains - Ventilation – in all areas - Environmental hygiene - Cleaning of frequently touched items - Social distancing in all areas - Spacing of chairs in Outpatient departments - Social distancing in rest rooms • 8 week rolling inspection programme completed by the		• Following inspections, Action Plans are sent to the area manager and quarterly compliance reports are presented and the Health & Safety Sub-Committee • All Risk Assessment templates were revised in January 2021 and again in July 2021 • The situations continue to be monitored and the risk assessment templates will be further revised considering any newly published national guidance	

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	Health and Safety Team of clinical areas to review the hierarchy of controls on the risk assessment and ensure implemented • Quarterly rolling inspection plan completed by the Health and Safety Team of Corporate Service areas to review the hierarchy of controls on the risk assessment and ensure implemented			
• the documented risk assessment includes: - a review of the effectiveness of the ventilation in the area; - operational capacity; - prevalence of infection/variants of concern in the local area	• Risk assessment includes opening windows to support ventilation where there is no mechanical air change system	• Ventilation Policy required • The risk assessments do not include prevalence of infection/variants of concern	• Trust-wide site survey in progress • Ventilation Group established including the Trust appointed Authorising Engineer for Ventilation • Prevalence of infection/variants of concern in the local area are discussed at Tactical Board meetings • Health and Safety and Infection Leads meet monthly to review Covid risks	
• triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;	• Triage tool and ABBOTT ID Now Point of Care testing is in use in ED. 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			

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• POCT testing is confirmed with a repeat PCR test on all patients			
• when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be given;	• SOP for Personal Protective Equipment in place which includes RPE guidance • PPE SOP includes guidance on consideration of wearing an FFP3 mask and eye shield when caring for green pathway patients and community SARS CoV2 prevalence is high • Programme of Fit Testing continues with an ambition to ensure staff are Fit Tested against 2 types of FFP3 respirators. Data on 01/10/21 - Total Number on Database: 3827 - Total Number passed on at least 1 current supported mask: 2302 - Total Number passed on at least 2 current supported masks: 532			
• there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status and clinical specialty need	• Change in placement requirements identified – specialist care	• SOP for patient placement in place which is in line with PHE national guidance • Operational Manager/Silver Command oversight of patient placement at Bed Meetings (4 times per day and frequency	

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• The Trust is following PHE national guidance with admission screening and repeat swabbing undertaken 3 days and 5 days post admission or sooner if initial test was negative and if patient exhibits symptoms. Further repeat screening if symptoms develop • Weekly screening if all prior results negative • Screening data • Safe transfer systems in place, including a transfer team and security escort with corridor clearance to limit exposure risks		increased at times of increased activity/demand) • Patient Flow Oversight Group establish 12/04/2021 to review operational processes • Covid screening undertaken if a patient is moved to another ward • Covid-19 screening audit	
• that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance	• Covid-19 PPE audits (for aerosol and non-aerosol generating procedures) are in place for all clinical areas • Cleaning standards monitoring reports • PPE Champion/Matron daily check of compliance with standards • Vacated areas are decontaminated using Hydrogen Peroxide Vapour (HPV). In the event HPV is unavailable areas are decontaminated using a			

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	1,000ppm chlorine-based solution			
• resources are in place to enable compliance and monitoring of IPC practice including: - Staff adherence to hand hygiene - patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; - Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: - a) clinical - b) non-clinical settings	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 • Infection Prevention and Control Team visibility on wards	• Auditing of non-clinical areas	• Non-clinical area Action Card to be developed • Escalation of concerns from any staff group to the Infection Prevention and Control Team	
• monitoring of staff compliance with wearing appropriate PPE within the clinical setting	• PPE (AGP/non-AGP) audit programme in place • Refresh PPE Champions role in February 2021 • DIPC communications on the importance of IPC compliance • Sharing good practice Trust-wide via Patient Safety huddle			

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Challenge to staff where non-compliance is observed			
• that the role of PPE guardians/safety champions to embed and encourage best practice has been considered	• PPE Champions implemented with role defined • Refresh PPE Champions role in February 2021		• Plan to provide refresher training for PPE champions in October 2021	
• that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace;	• Staff screening by PCR in place for: symptomatic staff and asymptomatic staff in outbreaks • Occupational Health Service monitor staff cases and areas where clusters of cases are identified are reported to the IPC team • Self-testing – lateral flow implemented November 2020 with electronic test result reporting system including guidance on action to take according to results. Compliance monitored at Tactical meetings • LAMP testing weekly implemented in August 2021 • Staff absence monitoring including staff absent following contact by Test and Trace • Staff self-isolation Sop introduced to support return to	• Compliance with staff reporting and using LAMP	Communication strategy to improve uptake including CEO led team brief June 2021	

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	work for non-household Covid-19 contacts			
• additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health Team	• Additional staff testing as part of nosocomial outbreak investigation			
• training in IPC standard infection control and transmission-based precautions is provided to all staff	• Local induction and mandatory IPC training includes standard infection control and transmission-based precautions • Practical demonstrations of donning and doffing have been provided to PPE Champions for cascade training • Level 2 clinical training is 83% at the end of September		• 4 training sessions per week are being provided in addition to induction and mandatory training • Compliance with IPC training is monitored at Infection Control Sub-Committee and areas with lower compliance set recovery targets	
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	• Induction and mandatory IPC training updated include guidance on COVID -19 • Copies of training presentations • Training session have been recorded and information on Covid-19 added to face to face mandatory training session E-learning session is being updated • Department specific training provided to ICU; ED and theatres		• 3 training sessions per week are being provided in addition to induction and mandatory training • Compliance with IPC training is monitored at Infection Control Sub-Committee and areas with lower compliance set recovery targets	

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Bespoke training sessions available			
• all staff (clinical and non-clinical) are trained in - putting on and removing PPE; - what PPE they should wear for each setting and context as per national guidance - all staff clinical and non-clinical have access to the PPE that protects them for the appropriate setting and context as per national guidance	• PPE guidance included in the Covid 19 Policy is line with PHE national Guidance • PPE Trust Board paper • Trust wide risk assessment • Local risk assessments in place for the use of PPE • Infection Prevention and Control Team support staff education for PPE • PPE training records • Face Masks distributed to all Non-clinical areas on Friday 12th June 2020 ahead of the change in guidance for PPE to be worn in non-clinical areas • Risk assessments include details on Covid-19 secure and when face masks are required • PPE training for visitors where compassionate visiting requirements are indicated • PPE champions (58) support staff education/face to face training • PPE audit tool developed for aerosol/non-aerosol generating procedures – weekly audit			

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• PPE Audit records • Covid-19 PPE staff information booklet (x2) • PHE PPE training video website links shared and compliance monitored • Supplies including PPE is a standing agenda item at the Tactical Meetings and estimated usage rates were added to all Recovery Plans • A protocol is in place for both in and out of hours access to PPE • Further PPE training with PPE champions in July and August 2020 and February 2021			
• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	• PPE booklet (version 2) distributed in Dec 20 • Sharing of learning from incidents including social distancing in break areas and car sharing • PPE posters in all clinical areas • Desk top messages • Daily (weekdays) Covid-19 Safety huddle • PPE posters revised 02/2021 • Use of electronic desk top messages on hands, face, space, clean workplace	• Updated NHSE/I communications package	• Plan in development with Communications team to revise signage as per Every Action Counts campaign	

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Safety briefings • Daily Covid-19 safety huddle • Signage at all entrances			
• IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7) shared at Trust Wide Safety Briefing (TWSB) and via Covid daily Bulletin • Control Room with dedicated email address (single point of contact) receives national updates which are distributed as and when received for timely action • Compliance framework tracking compliance with national guidance under clearly defined work streams with nominated leads • Coronavirus Assessment Pod decontamination SOP • Coronavirus Policy version 7. Updates shown in different coloured font to support staff more easily identify latest changes/ updates • SOP for patient placement during Covid-19 pandemic • Quantitative Fit Testing SOP			

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Qualitative Fit Testing SOP • Reusable PPE Decontamination SOP • Covid-19 Screening SOP • Hospital onset Covid 19 and Outbreak Management SOP • Staff screening SOP • Review of compliance against national guidance – Survey report • Policies, guidelines and SOPs and updates are distributed by Trust Wide Safety Brief			
• changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Covid-19 Tactical Group Meetings and Recovery Board Meetings in place with clear escalation route to Trust Board • Tactical meetings (initially daily (weekdays) from 18/03/20 and stepped down to 3 times per week 01/05/20 and then to twice weekly from 06/07/20, timescale revised according to local prevalence • Recovery Board Meetings were twice per week starting on 05/05/20 feed into Strategic Executive Oversight Group (SEOG) meeting and this feeds into Board. The Associate Director of IPC attends Tactical			

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	and Recovery meetings as do the DIPC and Deputy DIPC/Consultant Microbiologist Infection Control Doctor. Recovery meetings stepped down for wave 3 • COVID Non-Executive Director Assurance Committee (COVNED)			
• risks are reflected in risk registers and the Board Assurance Framework (BAF) where appropriate	• A Covid-19 specific Risk Register has been created with risks escalated to the corporate Risk Register and Trust BAF as appropriate. Updates are discussed at the Quality Assurance Committee • Corporate Risks include impact on activity • Local risk assessments in place for the use of PPE • 2 risks on the BAF linked to: - national shortage of PPE - oxygen supply • PPE is a standing agenda item for monitoring levels at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • Oxygen daily SitRep continued beyond national reporting			

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	requirements to provide local assurance • HSIB interim bulletin on oxygen January 2021 is under review			
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Existing IPC policies in place: - Chickenpox - Clostridium difficile - Scabies - Shingles - Meningitis - MRSA - Multi-drug resistant organisms - Influenza - TB/ MDR TB - Viral Gastroenteritis - Viral haemorrhagic fevers - Isolation of immunosuppressed patients • SOPs for rapid testing for CPE/ MRSA and enteric and respiratory pathogens • Isolation for other infections and pathogens is prioritised based on transmission route • Clostridium difficile Guidelines (2018) in place and all patients with a C. difficile toxin positive			

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	or PCR positive result are isolated • Ribotyping of all community onset healthcare associated and hospital onset healthcare associated cases • Root Cause Analysis investigation for all hospital apportioned cases • Compliance with Mandatory HCAI reporting requirements • Distribution of HCAI surveillance data weekly • Re-establishing the C. difficile Cohort Ward is included in Recovery Plans • GNBSI Prevention Action Plan has been revised and work stream has been reinstated working with the Quality Academy			
• the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep	• 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			

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Covid-19 data is reviewed at Tactical meetings and Silver IPC Cell meetings • The IPC Board Assurance Framework is reviewed at QAC and Trust Board of Directors meeting bimonthly			
• this Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	• QAC submission papers bimonthly • Board Submission papers • 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			
• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Matron and IPC Walkarounds • Senior nursing team checks that action cards are being completed			

1. Systems are in place 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 posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Executive Team walkabouts • Ward Accreditation with IPC reviewer membership • Challenge occurs at the following meetings: - Tactical - Silver IPC Cell - Quality Assurance Committee - Infection Control Sub-Committee - Senior Executive Oversight Group - Covid NED Group - Increased Microbiology support/ briefings delivered to medical cabinet			

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:				
• designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• SOP for patient placement (agreed wards and critical care locations). Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status. Respiratory Step-down Unit SOP • Bespoke simulation training for patient transfer		• Increased IPC support to wards/departments caring for patients with Covid-19 • Increased staffing in IPC team to support training requirements, skilling up of senior staff to disseminate training • Increased Microbiology support/ briefings delivered to medical cabinet	

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:				
	• Availability of rapid SARS-CoV2 testing • Ongoing discussion at Nursing and Midwifery Forum, Medical Cabinet and Allied Health Professionals Forum as mitigation • Discussed at the Care Group Meetings and action agreed to update guidance • Matrons provide oversight of staffing levels to ensure all areas are appropriately and safely staffed • IPC team regularly review and have visible presence in all areas			
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	• Task Team and Domestic Assistant training for Covid-19 cohort ward areas has been carried out • Fit Testing for FFP3 masks undertaken for Domestic Assistants in areas where aerosol generating procedures are performed • Task Team support areas where there are Domestic Assistant shortfalls • Four additional HPV decontamination machines purchased and training on use provided			

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:				
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• 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 • Terminal Cleaning Guidelines 2018 • Decontamination Policy 2019 • Novel Coronavirus Policy (version 7) • 4 additional HPV machines purchased • CEO meeting and Chief Nurse/Deputy CEO and ADIPC meeting with domestic staff • Associate Director of Estates is a member of Silver IPC cell			
• assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk;	• Sign off checklist in place for terminal cleans			
• cleaning is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available	• Combined detergent/chlorine-based solution in use • 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	

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:				
chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance:	• Combined detergent/chlorine-based disinfectant diluted to 1,000ppm available chlorine is used for cleaning in patient areas • Hydrogen Peroxide Vapour is used • Information on contact time is included in the decontamination policy		products to ensure effective against coronaviruses	
• a minimum of twice daily cleaning of: - areas that have higher environmental contamination rates as set out in the PHE and other national guidance - 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails; - electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards - rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff;	• Twice daily cleaning in place • Ring the bell it's time for Clinnell campaign • Domestic staff record when they have cleaned areas • Enhanced cleaning – all areas, including non-clinical, supplied with desk wipes • Increased cleaning frequency in all public areas including toilets, communal spaces, lifts • Cleaning of workstations is included in the Environmental Action Plan • Domestic staff time cleaning activity when areas are vacant			

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:				
	• Increased cleaning included in ICU Bioquell pod SOP			
• 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 before inspection, servicing or repair equipment;	• Included in Decontamination Policy • Cleaning monitoring audits • Decontamination audits • Policy and certification process to confirm cleaning prior to service inspection or repair			
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Process for managing linen is included in the COVID-19 policy • All linen from COVID-19 possible and confirmed positive patients is treated as infectious and placed in alginate bags which are tied and then placed in a white plastic bag • Laundry policy revised May 20 • Scrub suits made available to all staff with a central collection point • Scrub suits laundered by the Trust's laundry contractor • Uniform and workwear policy is under review			
• single use items are used where possible and according to single use policy	• Decontamination Policy in place which includes single use/single patient use guidance used in			

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:				
	conjunction with any updates provided by national guidance in response to COVID-19			
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk;	• Decontamination Policy in place used in conjunction with any updates provided by National Guidance in response to COVID-19	• Decontamination Meetings suspended in wave 1	• Meetings reconvened from 17/08/20 • A SOP for decontamination of reusable PPE is in place	
• cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Cleaning monitoring programme in place • Monitoring result are circulated to managers for corrective action where standards are not met at time of auditing • Housekeepers accompany monitoring officers when on duty and corrective action is taken at time of auditing or as soon as possible • Revised National Cleanliness Standards (April 2021) are being implemented			
• where possible ventilation is maximised by opening windows where possible to assist the dilution of air	• Windows within the waiting space are opened to ventilate the area and any space having forced ventilation is adequate to keep the area ventilated so windows can be kept closed • Signage on social distancing, hand hygiene and face coverings are displayed in ED waiting areas	• Old Estate with limited mechanical ventilation/ air conditioning units • Not all areas will be provided with ventilation or can open windows • Ventilation Policy	• These areas are ventilated by keeping doors and windows open where possible/ patient comfort allows • Review of ventilation across the whole Trust estate in progress (June 2021) with recommendations being finalised • Ventilation Policy being drafted 10/2021	

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:				
	• Ventilation Group meetings with terms of Reference			

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 around antimicrobial stewardship are maintained	• Consultant Medical Microbiology daily Ward Round in Critical Care • Ward based Pharmacist support • Prescribing advice available by telephone (in and out of hours) • Infection Control Doctor presentations to Medical Cabinet • Formulary review as evidence/guidelines are updated • Antibiotic prescribing guidelines for COVID suspected patients have been published • Antimicrobial Management Steering Group Meetings were reconvened from September 2020 • C difficile outliers ward rounds recommenced in July 2020 • 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			

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:				
• 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 Infection Control Sub-Committee Dashboards • DIPC reports HCAI data at Trust Board • Information on Data Capture System • Distribution of HCAI surveillance data weekly • HCAI review meetings being reconvened from August 2021 • Annual PHE HCAI reports and monthly dashboards			

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:				
• National guidance on visiting patients in a care setting is implemented	• Restricted visiting implemented 17 March 2020; Visiting fully suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020. Paper on visiting arrangements taken to SEOG • Visiting the dying guideline in place with training provided by the Palliative Care Team		• Guidance regularly updated in-line with national guidance • Visitor risk assessments • Pre-visit symptom screening checklist • Visitor information leaflet • Family Liaison Officer team • Virtual visiting/ ipads	

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:				

	• 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 numbers and visiting time period of 1 hour			

• areas where suspected or confirmed COVID-19 patients are being treated	• Coronavirus posters with details on Red, Amber or Green			

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:				
have appropriate signage and have restricted access	pathway, displayed outside areas where patients with suspected or confirmed COVID-19 are cared for • Family Liaison service in place to keep relatives (virtually) updated on care of loved ones • Refresh of Infection Control communications campaign using national Every Action Counts toolkit in progress			
• Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information on COVID-19 is available on the Trust Web Site and at all Trust entrances			
• Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab (to date **>3828** alerts added – 09/06/2021) • 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			
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	• Information on the Trust website (updated 16/10/2020) • Signage at all entrances	Lack of concordance by visitors as national restrictions are lifted	Address as i	

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:				
	• Hand gel and face masks provided at hospital entry points • Entrances are manned (part time) to support visitor compliance – visiting restrictions are currently in place			
• Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered	• The toolkit has been reviewed and poster production plan in place with the Trust's Communications Team – roll out date to be confirmed once signed off by DIPC			

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:				
• Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Triage tool in ED includes questions on recent travel • Triage in ED includes questions on Covid-19 symptoms/ pre-admission testing results where available • Information provided prior to attending Outpatient Departments and further symptom screening in place on arrival • Molecular Point of Care Testing in place in ED	• Screening of inpatients who develop respiratory symptoms e.g. hospital acquired pneumonia (HAP)	• Requirement to test for Covid-19, any patient who develops respiratory symptoms / HAP added to the Antibiotic Formulary	

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:				
	• Lateral Flow testing in Maternity • Pre-admission screening as per NICE Guideline 179 • Additional weekly screening (after day 5) included in the Trust SOP			
• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• Patients conveyed to hospital by Ambulance are pre-assessed to determine where they are taken to in ED • ED reorganised to have Hot and Cold respiratory assessment zones to segregate patients presenting with suspected Covid-19 • Triage tool in ED and segregated areas for patients suspected to have COVID-19 • Environmental Safety Action Plan with proposal to lockdown 25% of entrances • Manned mask stations at main entrance Warrington site (part time) and mask available at other entrances with access to hand sanitisers • ED and IPC meetings established • Testing in Maternity services	• Asymptomatic patients subsequently identified as COVID-19 positive • False negative test results • Old estate, limited number of side rooms	• Process in place to isolate and close the bay to admissions when exposure incidents occur • IPCN and Patient Flow joined up working to identify side room facilities • Plan for a new ED plaza	
• Staff are aware of agreed template for triage questions to ask	• Triage tool in ED includes questions on recent travel –			

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:				
	revised tool discussed at Tactical Meeting on 11 June 2021 • Staff trained in triage questions			
• Triage 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 ED staff are rostered to carryout Triage • Point of Care Testing using (Abbot ID Now) testing in place in ED			
• face coverings are used by all outpatients and visitors;	• Observational checks carried out in Departments • Safety teams at entrances • Trust-wide communications to advise face coverings still required to coincide with the lifting of restrictions on 19th July 21	• Patient lack of concordance or inability to wear a face covering due to an underlying condition	• Social distancing maintained where patients and anyone accompanying them cannot wear a face mask • SOP to support staff decision making in relation to continuing with procedure with reasonable adjustments to ensure staff safety where patients are exempt	
• individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation;	• Patient records on Lorenzo are flagged to highlight clinically extremely vulnerable from COVID-19 patients	• Limited side room capacity	• Discussion with Patient Flow Team and review to assess: - absolute neutrophil count - vaccination status - social distancing - face masks - hand hygiene - environmental hygiene	
• clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs	• Site-wide signage • Compliance recorded on care and comfort round forms and documented in Lorenzo EPR			

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:				
• monitoring of inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	• Compliance recorded on care and comfort round forms and documented in Lorenzo EPR	• Feedback on compliance with inpatient facemask use	• IPCN observation whilst on ward walkabouts • Assurance included on Lead Nurse reporting template for Infection Prevention and Control Sub-Committee	
• patients, visitors and staff are able to maintain 2 metre 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.	• 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	
• isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative;	• Liaison takes place with Patient Flow to identify side room facilities • Rapid testing available 7 days per week • From September 21 – onsite Covid-19 testing will be available 24/7 for a period of 6 months			
• 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;	• Where a patient tests positive and has been in a bay – contacts are identified and letters regarding the Covid-19 exposure are provided to contacts • Patients testing positive are transferred to Covid-19 care areas			

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:				
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document;	• All patients admitted via emergency route are tested at admission • Daily monitoring of admission, day 3 and day 5 testing • SOP for pre-discharge to care home testing in place • Elective patients are tested 72 hours/3 days prior to admission and are asked to self-isolate • Review of draft recommendation to use Lateral Flow Testing on the day of admission for planned procedures is underway	• Patient compliance with self-isolation guidance for 72 hours prior to admission	• Review of pre-admission information to support compliance with self-isolation guidance	
• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Routine appointments have been stepped down. Social distancing measures are in place in Outpatient Departments • Recovery plan for Outpatients (28/05/2020) includes providing information not to attend if unwell with Covid-19 symptoms • Risk rated appointment schedule based on clinical priority • Virtual 'attend anywhere' clinics • Rooms identified for shielding patients	Public lack of concordance with social distancing measures	• Social distancing measures are in place in Outpatient Departments • Signage in place to keep left on corridors, walk in single file and socially distance • Seating arranged in Outpatient waiting areas to support social distancing	

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:				
• Patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas;	• Environmental Action plan in place • Keep left signage in place for internal walkways • Restricted key codes/controlled entry in place • Green pathway for surgical patients at CSTM building and Ward A5 elective • Wards identified for care of patients with Covid-19 as per Trust escalation plan • Signage at ward entrances denotes red, amber or green pathway area • Refresh of the communications IC Strategy			
• All staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe	• PPE Champions (58), roving training on donning and doffing of PPE • Links to PHE videos have been distributed. Individual booklets on COVID-19 and PPE produced and distributed • Training records from all CBUs that staff have read the Covid-19 policy, receive the PPE booklet, watched the PHE videos, received face to face training, read the Covid-19 swabbing SOP	• Staff returning to work, including after pregnancy, long term sick leave or due to extremely vulnerable status may not be fully informed with the latest guidance	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where there are shortfalls in staff training • IPC Team provide ongoing training to PPE champions on donning and doffing of PPE • Links to PHE videos are available and distributed and included in IPC mandatory training sessions	

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:				
	• PPE training videos included in mandatory training programme • Record of staff training to carrying Fit testing • Fit testing for FFP3 respirators records			
• 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;	• Links to PHE videos have been distributed. Posters are displayed in clinical areas on donning and doffing • Information recirculated to Planned and Unplanned Care Groups • Bespoke training • Information circulated on Trust Wide Safety Brief • PPE training included in mandatory training programme	• Posters not displayed in all areas • Staff returning from absence may not be fully informed/ updated with latest guidance	• Additional posters ordered and site survey to be completed by IPCNs with PPE champions for each area • IPC team provide ongoing training on donning and doffing of PPE • Links to PHE videos are available and distributed	
• A record of staff training is maintained;	• Record of training is held and maintained • Induction and Mandatory training records are held in ESR • Level 2 IPC Mandatory training is 83% in September 2021	• Some areas are below 85% compliance with level 2 training	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with Care Groups/CBUs where staff training is required or bespoke training	
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• Observational audits completed and feedback received from PPE Champions • Electronic Audit Tool developed and launched 15/05/20			

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:				
	• Audits are carried out weekly and repeated in a shorter timescale where issues are identified • Datix reporting of compliance issues • Discussion on the importance of compliance takes place where PPE risks are identified			
• Hygiene facilities (IPC measures) and messaging are available for all patients/ individuals, staff and visitors to minimise COVID-19 transmission such as: - hand hygiene facilities including instructional posters - good respiratory hygiene measures - staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care; - staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace;	• Hand hygiene audits • Hand washing signage – wash hands more frequently & for 20 seconds • Catch it Bin It Kill Posters displayed throughout the Trust • Social distancing signage in place Trust-wide • Information provided in staff Covid-19 booklet on safe travel arrangements			

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:				
- frequent decontamination of equipment and environment in both clinical and non-clinical areas - clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	• Ring the bell cleaning initiative implemented • Office risk assessments in place including use of masks if not in a single person office			
• Staff regularly undertake hand hygiene and observe standard infection control precautions	• Programme of hand hygiene audits in place – carried out weekly in clinical areas. Overall compliance • April – December 2020 =98% - 99%; • January – Jun 2021=98% - 99% • Jul – Sep 2021 = 98%			
• 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 • 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			
• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• Signage on hand washing technique is displayed on all soap dispensers. • HM Government signage has been displayed detailing 20 second handwashing			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Staff understand the requirements for uniform laundering where this is not provided for on site	• Guidance on home laundering is included in the COVID-19 PPE information leaflets • Scrub Suits have been offered as an alternative to uniforms and are laundered centrally • Trust wide emails with guidance on laundering			
• All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	• Screening for COVID-19 is undertaken in line with national guidance • Monitored by the Occupational Health and Wellbeing Team and overseen by the Workforce and Organisational Development Team			
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/ organisation onset cases (staff and patients/ individuals)	• Local statistics included in Tactical meetings agendas • Surveillance on hospital onset patient cases included on the Integrated Performance Report • Information on staff cases/outbreaks reported at Senior Executive Oversight Group by the DIPC • Briefings by Consultant Microbiologist/Infection Control Doctor to Medical Cabinet/ Nursing and Midwifery Forum • CEO trust-wide briefings			

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:				
• Positive cases identified after admission that 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	• Root Cause analysis investigation requested for all cases ≥ day 8 of admission • Outbreak reporting protocol in place including to: - Trust board - NW.ICC; PHE; CCG; CQC - NHSE/I via web-based reporting system • Process in place for RCA review with IPCT and Governance Department and terms of reference agreed • Learning themes from RCA findings are shared with CBUs • Outbreak Meeting Terms of Reference and Microbiology DIPC or Deputy presence etc • IIMARCH completed and submitted via web-based reporting system for each outbreak			
• Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings	• 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			

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:				
	• Outbreak meeting agendas, minutes and action plans • Outbreak reporting reference numbers from NHSE/I via web-based reporting system • Emails to PHE; CCG; CQC			

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:				
• Restricted access between pathways if possible, (depending on size of the facility, prevalence/ incidence rate low/high) by other patients/ individuals, visitors or staff	• Green pathway for Surgical cases at CSTM building and A5 elective ward • ICU expansion into theatre for non-Covid ICU cases in theatre pods and use of recovery for patients with Covid-19 • Restricted access to green pathway areas • Relocation of respiratory ward to B18 (adjacent to ICU)			
• Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	• Signage in place stating Covid-19 cases on wards • Signage displayed at ward/department entrances advising Red, Amber or Green Covid Pathway • Keep left signage on corridors • Distancing in waiting areas			

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:				
	• Signage clearly states areas are Red, Amber or Green and written information to state what this means			
• Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status	• Limited number of single rooms for isolation (65)	• Cohorting in place as advised by the Infection Prevention and Control Team • Operational Manager/Silver Command oversight at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand) • Abbot ID now testing in ED provides rapid results to support patient placement	
• Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Additional hand washing facilities in anterooms on ward A7 • Side rooms in use for non-clinical activity converted back for clinical inpatient use • 2 single rooms on A2 • 1 single room on A7 • 4 additional single rooms: - 2 between A5 and A6; - 2 between A8 and A9 • 3 single room pods built in AMU • 1 outside ACCU • ED 1 Bioquell Pod • Critical Care - 5 Bioquell Pods • Ward B18 – 4 Bioquell Pods	• Old Estate with limited side room capacity	• Daily review of side room utilization at bed meetings • 4 additional Bioquell pods installed on ward B18	

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Isolation Policy and Alert organism policies in place • Datix completed when it has not been possible to isolate patients	• Limited number of side rooms • Potential non-compliance of patients with shielding pre-operatively	• Isolation priority protocol in place related to transmission-based precautions • Daily liaison with Patient Flow Team to support risk prioritisation	

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
There are systems and processes in place to ensure:				
• Testing is undertaken by competent and trained individuals	• Training on swabbing technique provided verbally and by video	• Small number of samples rejected due to insufficient cellular material or incorrectly labelled	• Swabbing SOP and training provided • Competency assessment tool launched	
• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other 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 • LAMP testing in place for staff	• RCAs identified some routine samples are being missed • Low uptake of staff LAMP testing	• Daily senior nurse oversight to ensure compliance • Electronic systems support identification of patients who have not be 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	
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• Testing turn around times are monitored at Silver IPC cell			
• regular monitoring and reporting that identified cases have been tested and	• LION BIS used to monitor testing in line with guidance and follow-			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
reported in line with the testing protocols (correctly recorded data)	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 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			
• that those inpatients who go on to develop symptoms of 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 those emergency admissions who test negative on admission are retested 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	• 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	

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
	• Weekly screening implemented		not be 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 negative patients daily	• Community prevalence increasing >300 per 100k 7-day rate from beginning of Sep 2021 and above 400 per 100k 7 day rate from Oct 2021 • Reduced nosocomial case numbers • Increased testing in outbreak areas as advised be the Infection Control Doctor • Daily testing has been implemented on wards during Covid-19 outbreaks			
• that those being discharged to a care home are being 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			
• that those being discharged to a care facility within their 14 days isolation period should be discharged to a	• Named community facility for care of patients who require continued isolation for Covid-19			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
designated care setting, where they should complete their remaining isolation				
• that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	• Elective admission screening in place with results reviewed prior to admission • Where result is positive procedures are deferred • Draft recommendations for planned care areas to introduce lateral flow testing on the day of admission is under review	• Patient compliance with self-isolation guidance for 72 hours prior to admission	• Review of pre-admission information to support compliance with self-isolation guidance	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
• Staff are supported in adhering to all IPC policies, including those for other alert organisms	• PPE Champions in place • 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			
• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7).	Update required to include pathway guidance in line with latest guidance	• Subscription and daily review of Gov. UK email updates • Control Room inbox is monitored 7 days per week and guidance issued	

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 that:				
	TWSB and Covid daily Bulletin used to communicate updates • Additional SOPs written		over the weekend- out or of hours is escalated for action • Additional posters ordered Links to PHE videos are available on the Trust Hub and distributed • Meeting held with Critical Care to review PPE levels (April 21/ June 21) • Meeting held with Theatre teams (July 21)	
• All clinical waste and linen/laundry related to confirmed or suspected COVID-19 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			
• 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**	
Appropriate systems and processes are in place to ensure:				
• Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	• 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			

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**	
Appropriate 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			
• That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	• Process in place for electronic self-assessment followed by manager assessment if risks are identified – compliance with completion of risk assessments is monitored by the HR Department			
• Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	• 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			

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**	
Appropriate 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 FFP 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			

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**	
Appropriate systems and processes are in place to ensure:				
	- Total Number passed on at least 2 current supported masks: 554			
• 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	
• For those who fail a fit test, there is a record given to and held by trainee 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	
• For 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	

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**	
Appropriate systems and processes are in place to ensure:				
• Following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• 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 in February 2021 • 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 is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned/elective care pathways and urgent/ emergency care pathways, as per national guidance	• Staffing reviews undertaken for all COVID areas • Staff movements managed by the senior nursing team at daily meetings • Senior Nurse presence 7 days per week 8am-8pm to support staffing management • Planned elective areas have designated teams, who are not moved to any other area in the Trust • Where it is necessary to move staff between different areas to support patient safety, this is			

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**	
Appropriate systems and processes are in place to ensure:				
	discussed with the Infection Control Team. This cross over has not occurred between Elective and Emergency Care pathways			
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Signage in place along corridors to socially distance, keep left and walk in single file • Risk assessments of all areas to achieve Covid-19 secure spaces • IPC Team and/or Health and Safety Team review where concerns have been raised	• Compliance in office spaces	• Non-clinical area daily action card in development • Health and Safety Team reviews	
• 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			
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas	• Guidance on PPE distributed by email, PPE booklet, posters			
• 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 risk assessed criteria from non-household Covid-19 contact			

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**	
Appropriate systems and processes are in place to ensure:				
• Staff that 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	• Test and Trace Service hours of operation	• National guidance for 16 hour per day service (cover in place for 11.5 hours per day) • 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 10 2021

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	Develop ventilation policy	Nov 21			ECR	IPCT	Draft Policy received 30/09/2021	
2	Revise risk assessment templates to include prevalence of infection/variants of concern	Nov 21						
3	Improve compliance with LAMP testing	Nov 21		Revise introduction plan Communication strategy to improve uptake including CEO led team brief June 2021	CPO	CBU Triumvirate Leads		
4	Audit non-clinical area compliance with mitigation identified in risk assessments. Develop daily action card for non-clinical areas	Nov 21			ADIPC	IPCNs		
5	Improve compliance with LAMP testing currently 433 staff participating	Nov 21						
6	Improve compliance with level 2 IPC training to ≥ 85%	Dec 21		Four training sessions per week are being provided	A C Ns Unplanned and Planned Care	ADIPC CBU Triumvirates	Sep 2021 = 83% compliance increased from 73% compliant in March 2021	
Criterion 2 Provide and maintain a clean and appropriate environment – Nil actions identified								
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes – Nil actions identified								
Criterion 4 Provide suitable and 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								

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
7	Update Signage aligned to Every Action Count resources	Oct 21		Agreement for roll out with DIPC and Communications Team	DIPC Interim Communications Lead	ADIPC	Posters designed and roll out plan being devised Draft emailed to DIPC 07/10/2021	
Criterion 5 Ensure prompt identification of people who have or are at risk of developing an infection								
8	Test inpatients that develop Covid-19 symptoms	Nov 21		Update guidance in the Antibiotic Formulary to test for Covid-19, any patient who develops respiratory symptoms e.g. hospital acquired pneumonia	LPAMS	CMMs		
9	Monitoring of compliance with face mask use by inpatients	Mar 22		Add information on compliance with patient face mask use to Lead Nurse HLBP for ICSC Circulate revised template to Lead Nurses	ADIPC		Revised HLBP in use	
10	Compliance with 10 key actions guidance on testing	Nov 21		Review of pre-admission guidance on self-isolation for elective admission Review of recommendations for on the day of admission lateral flow testing	A C N Planned Care	IPCNs	Copy of information	
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								
11	Install additional Bioquell pods	Aug 21	Oct 21	Plan developed to install 4 Bioquell pods in ward B18	MC CBU Manager	ADE	Bioquell pods installed	

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 8 Secure adequate access to laboratory support as appropriate								
12	Daily swabbing compliance review to ensure compliance with Day of admission, Day 3 and Day 5 and weekly Covid screening	Sep 21	Oct 21		ADIPC	IPC Admin	Email confirmation of swabbing calculation dates	
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								
14	Centralised records of FFP3 Fit Testing	Nov 21		Add records to ESR	DCN Patient Safety	DCPO	Spreadsheet includes all staff records	
15	Documented (centrally held records) process for supporting staff who fail fit testing including redeployment options. Records should be held centrally of discussions with employees	Nov 21			DCPO		Alternative respiratory protection (powered hoods). Redeployment Hub established for vulnerable staff	

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**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/168**
SUBJECT:	**Infection Prevention and Control**
DATE OF MEETING:	24 November 2021
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will.. Work in partnership to design and provide high quality, financially sustainable services.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#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 **#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.
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection prevention and control activity for Quarter 2 (Q2) 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 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 Q2 Trust apportioned HCAIs included: - • 14 E. coli bacteraemia cases • 6 Klebsiella spp. bacteraemia cases • 0 P. aeruginosa bacteraemia case • 9 Clostridium difficile cases • Nil MRSA bacteraemia cases • 6 MSSA bacteraemia cases Covid-19 cases were detected: - • 326 (0-2 days)

	• 23 (3-7 days) • 5 (8-14 days – probable healthcare associated) • 4 (15+ days – definite healthcare associated) • 1 Covid-19 outbreak			
PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**		Quality Assurance Committee	
	Agenda Ref.		QAC/21/11/278	
	Date of meeting		02/11/2021	
	Summary of Outcome		Submit to Board	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

SUBJECT	Infection Prevention and Control Q2 report 2021/22	Agenda Ref:	BM/21/11/168

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 2 (Q2) 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 Clostridium (nomenclature changed to Clostridioides) 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). In July 2020, apportionment of bacteraemia cases (Gram-positive and Gram-negative) 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, with 2019 calendar year data used as a baseline. WHH HCAI thresholds are shown in table 1.

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:

- 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	Target	Position	A	M	J	J	A	S	Total
C. difficile	≤44	Over trajectory	4	6	4	6	1	2	23
MRSA bacteraemia	Zero tolerance	On trajectory	0	0	0	0	0	0	0
MSSA bacteraemia	No target	No target	4	4	2	1	4	1	16
E. coli bacteraemia	≤81	Under trajectory	9	6	8	4	6	4	37
Klebsiella spp. bacteraemia	≤23	Under trajectory	1	2	1	2	3	1	10
P. aeruginosa bacteraemia	≤4	Under trajectory	0	1	0	0	0	0	1

Clostridium difficile

All Trust apportioned cases undergo post infection review. Following internal review of 10 cases, 5 were submitted to the CCG for review and 3 cases were considered unavoidable by the CCG panel. Ribotyping of all hospital onset/healthcare associated and community onset/ healthcare associated cases has not identified any links between Trust apportioned toxin positive cases.

Gram positive bacteraemia

Nil cases of MRSA bacteraemia reported in Q1 or Q2. The Trust has been MRSA Bacteraemia free for a rolling 12-month period and the Trust is on target at the mid-year point.

Year to date (YTD) 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)

Year to date (YTD) figures for GNBSI cases are shown in the table above. The Trust is below threshold for all GNBSIs at the mid-year point. 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, A8, B14, B19) and the Quality Academy. Areas of focus include: - hydration, continence management, reducing usage of urinary catheters and improving care where required, hand hygiene (including patients) and urinary tract infection detection/management. The urinary catheter passport has been launched at a series of meetings across the Trust.

Comparative data for HCAI rates for the 2020/21 FY with other Northwest (NW) Trusts, is included in appendix 2. For C. difficile the Trust is above the England and northwest rates. Work is in progress to increase resources dedicated to antimicrobial stewardship. Environmental hygiene has been enhanced with increased use of hydrogen peroxide vapour and a programme of hand hygiene education continues.

For E. coli the Trust is just above the NW rate but below the England rate. For Klebsiella species; P. aeruginosa, MRSA and MRA bacteraemia cases the Trust is below both NW and England rates.

Outbreaks/Incidents

Covid-19 Exposure

There have been 4 Covid-19 exposure incidents which have been jointly managed by the Infection Prevention and Control Team and Occupational Health. Staff in contact were followed up for a 10-day period following exposure with none developing symptoms or testing positive.

Covid-19

Covid-19 cases detected in Q2 were identified as detailed below: -

- 326 cases (0-2 days)
- 23 cases (3-7 days)
- 5 cases (8-14 days – hospital onset probable healthcare associated)
- 4 cases (15+ days – hospital onset definite healthcare associated)

Q2 saw an increase in patient admissions with Covid-19. This mirrors a rise in community prevalence data. 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 ensuring 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. Restoration of visiting remains on hold due to high local prevalence with exceptions made on compassionate grounds.

The Trust compliance with the NHSE/I Board Assurance Framework (version 1.6) linked to the Code of Practice on prevention of Healthcare Associated Infections is assessed bimonthly and detailed papers are submitted to the Quality Assurance Committee and Trust Board. An action plan has been developed to support minor gaps in assurance.

One Covid-19 patient outbreak was reported at the end of September affecting patients. This is an active outbreak and is IPC standards are being closely monitored.

Next steps include: -

- Increase uptake of LAMP testing for staff
- Continue to provide and reinforce updates on Covid-19 IPC precautions
- Continue to review RCA findings from nosocomial cases
- Staff vaccination programme completion and establishing booster programme
- Refresher training for PPE Champions

Infection Prevention and Control Training

Training compliance by month is shown in Table 3. Overall compliance with Mandatory training was 86% at the end of August.

Table 3 Infection Control Training compliance

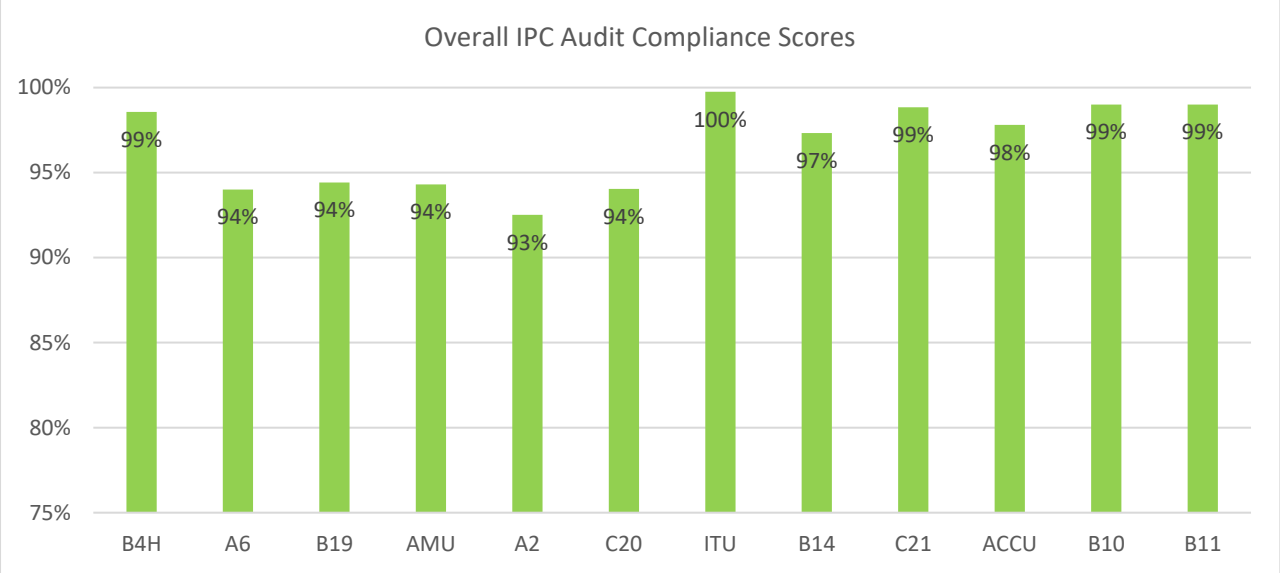
Infection Control Training	A	M	J	J	A	S
Level 1 – Non-Clinical	92%	91%	90%	89%	89%	Data awaited
Level 2 - Clinical	82%	83%	83%	82%	83%	
Overall % of staff trained	**87%**	**87%**	**87%**	**86%**	**86%**	

The Infection Prevention and Control Nurses (IPCNs) have provided 4 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.

Infection Prevention and Control Audits

Twelve audits were completed with overall compliance ranging between 94 – 99%.

Table 4 Infection Control Audits



A detailed breakdown of each audit is shown in appendix 4. Low environmental audit scores related to clutter/general untidiness and low/high level dust. Estate issues requiring attention includes damage to flooring and dusty extraction vents.

Low urinary catheter care scores relate to knowledge on correct catheter sampling technique and documentation of ongoing need for the catheter to remain in situ. Work is in progress with the Quality Academy to avoid use of unnecessary catheters and improve standards where these devices are required.

Environmental Hygiene

Good progress is being made by the task and finish group to implement the revised National Standards of Healthcare Cleanliness (April 2021). Areas have been reassigned for cleaning category and wording of the Commitment to cleanliness charter is being reviewed to make it more patient/visitor focussed.

Antimicrobial Stewardship

Awareness raising events

The Infection Prevention and Control Team carried out focussed awareness raising activity on antimicrobial stewardship using desk top messages on IV to oral switch in July.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. IMPACT ON QPS

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

5. MEASUREMENTS/EVALUATIONS

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

6. TRAJECTORIES/OBJECTIVES AGREED

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 is to reduce healthcare associated E. coli bacteraemia by 25% by March 2022 – this will be revised in line with the NHSE/I published thresholds
- The zero tolerance to avoidable MRSA bacteraemia cases remains in place

Work streams will continue to:-

- Progress GNBSI prevention
- Reduce the incidence of Clostridium difficile infection and implement learning from incidents
- Promote Antimicrobial Stewardship and challenge inappropriate prescribing
- Partnership working with Urgent and Emergency Care CBU to support timely blood culture sampling
- 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 and the 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 and 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

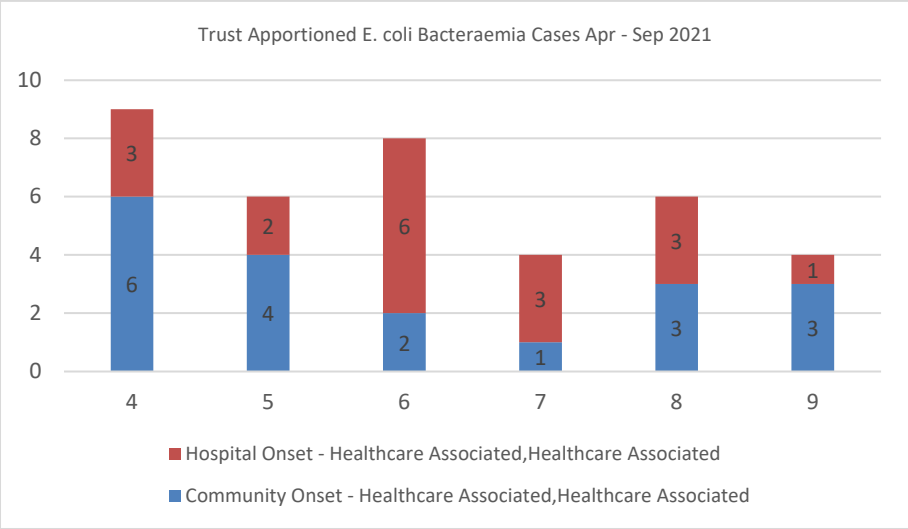
10. RECOMMENDATIONS

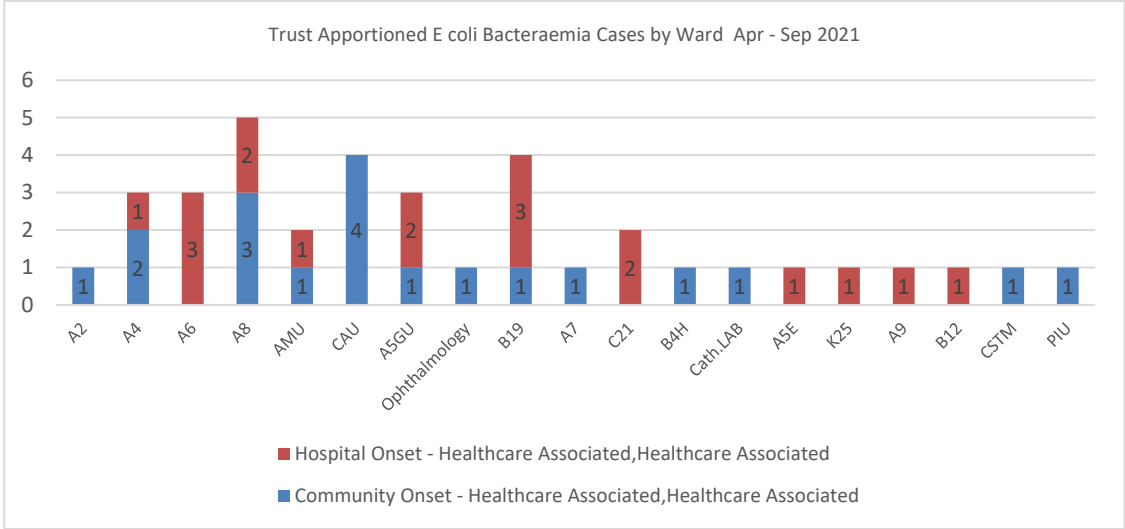
The Trust Board is asked to receive the report and note the exceptions reported and progress made.

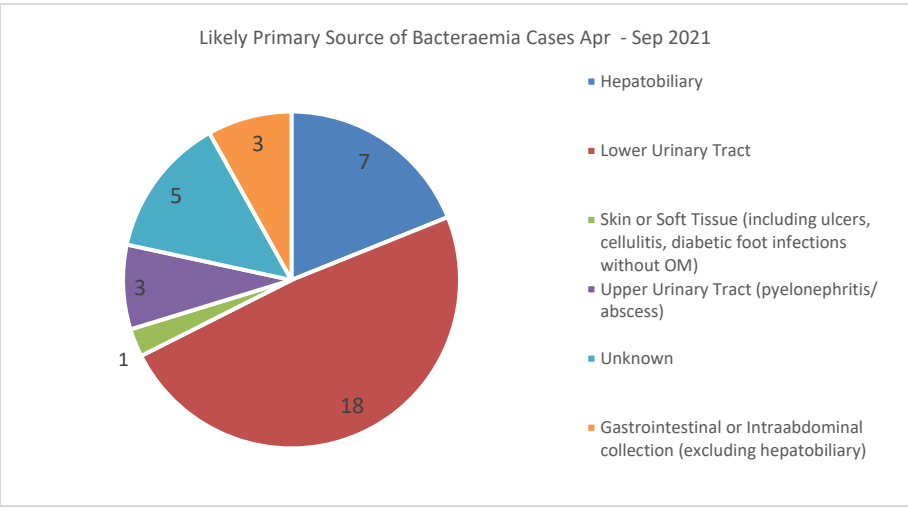
Appendix 1 Healthcare Associated Infection Data Apr – Sep 2021

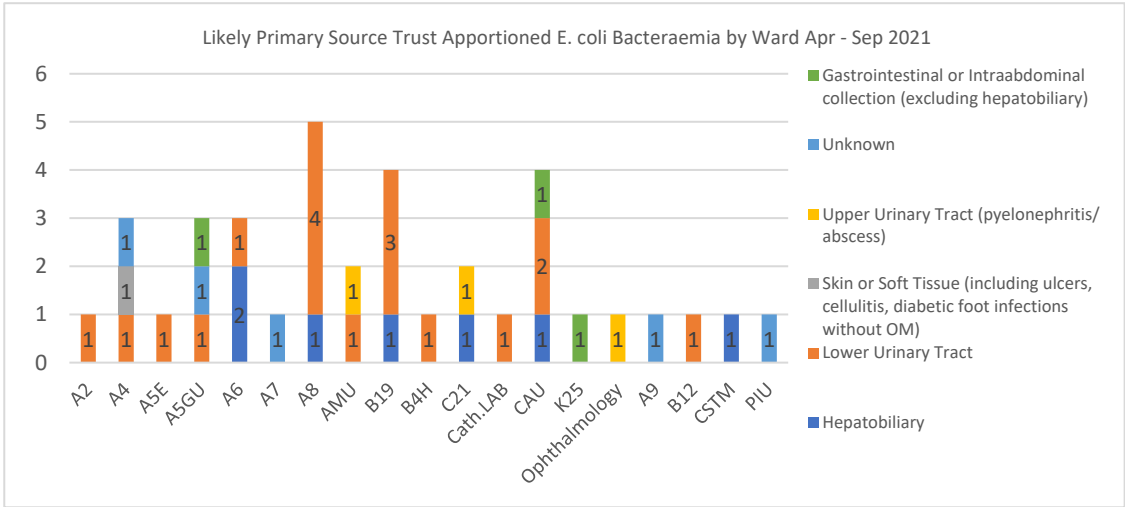
Threshold = 81 cases
YTD Total = 37

Gram Negative Bloodstream Infection: E. coli



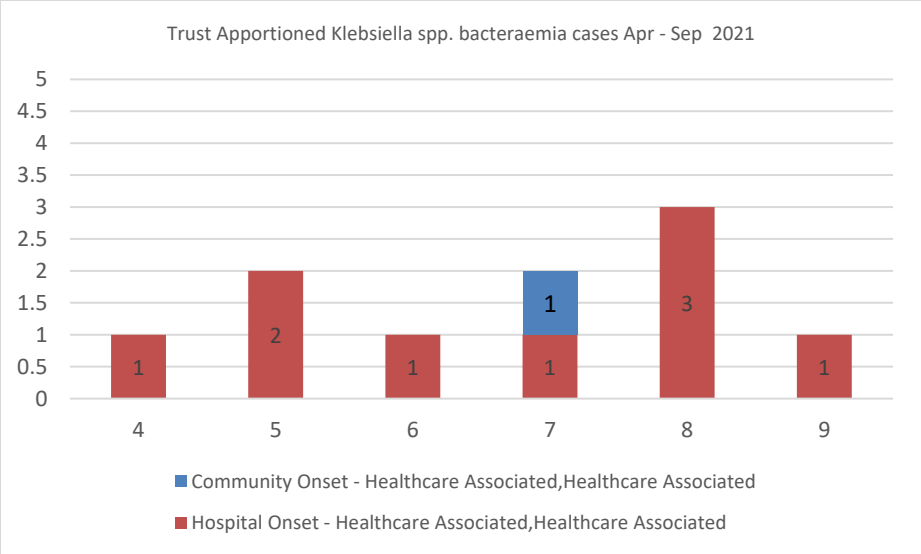


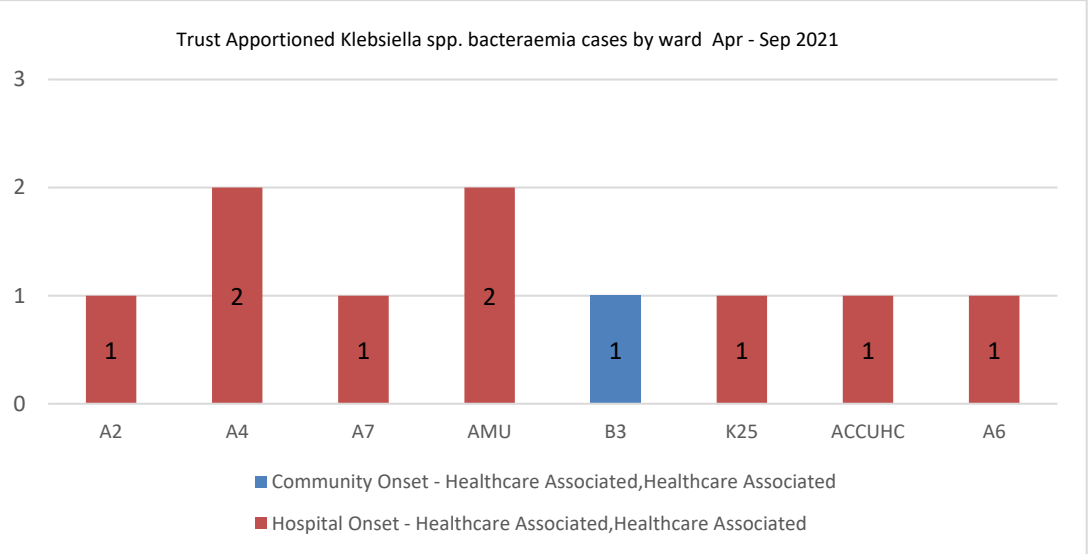


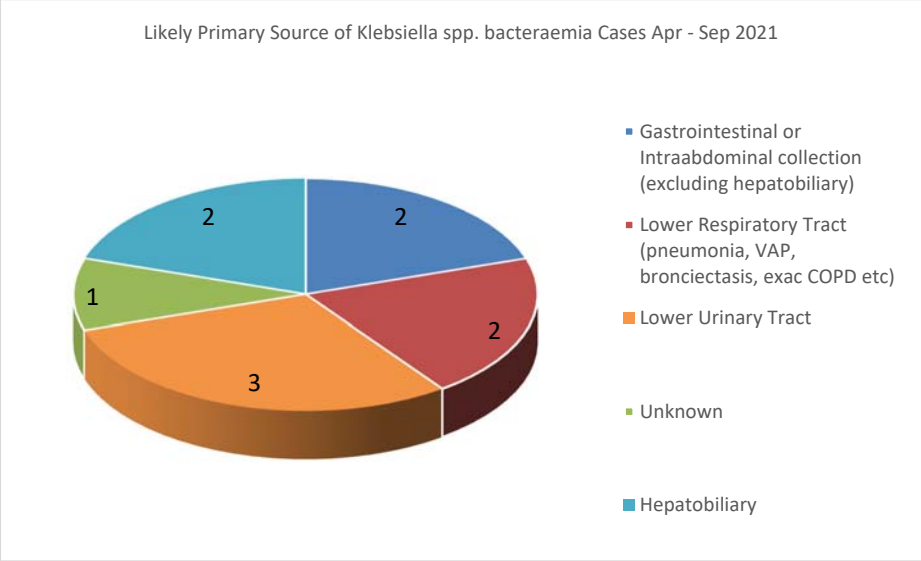


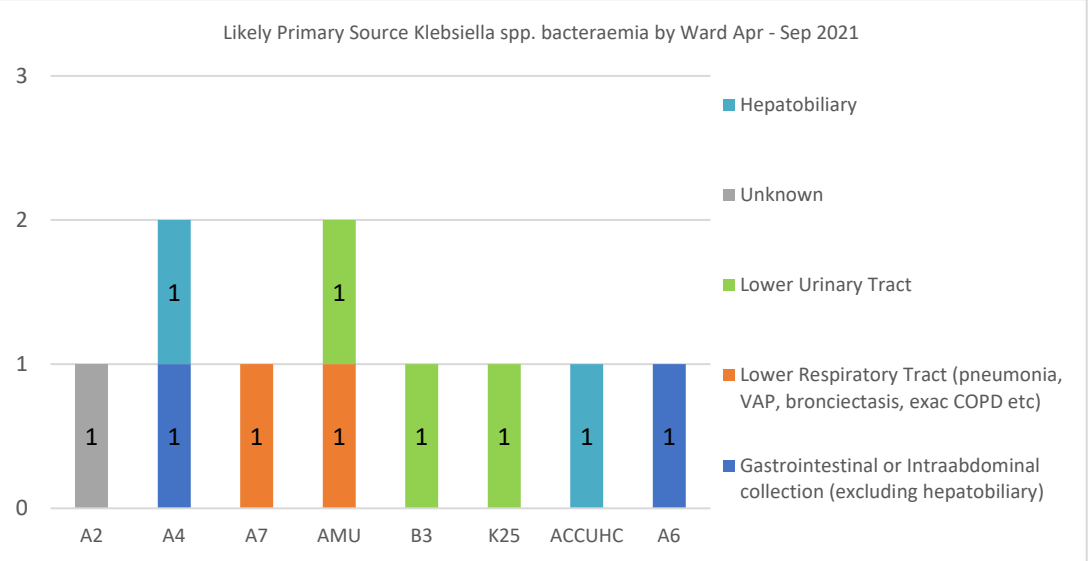
Gram Negative Bloodstream Infection: Klebsiella spp.

Threshold = 23 cases
YTD Total = 10 cases



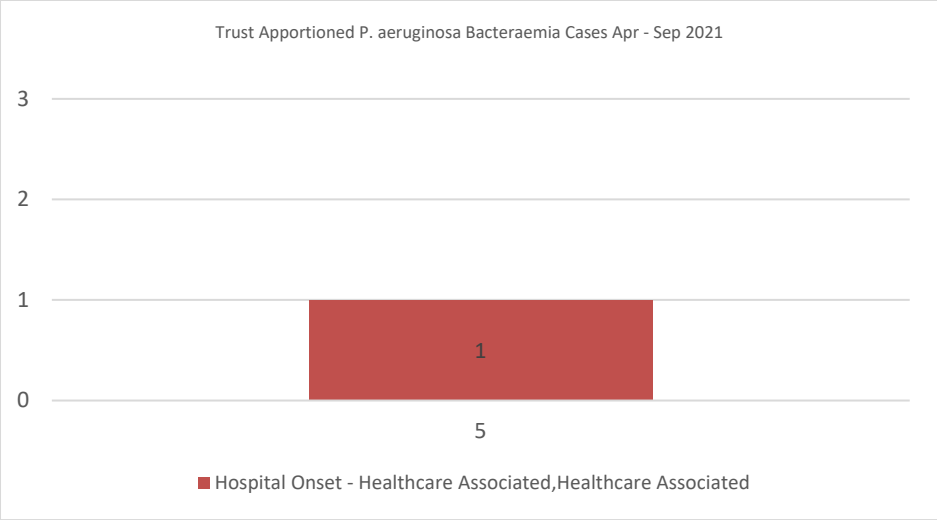


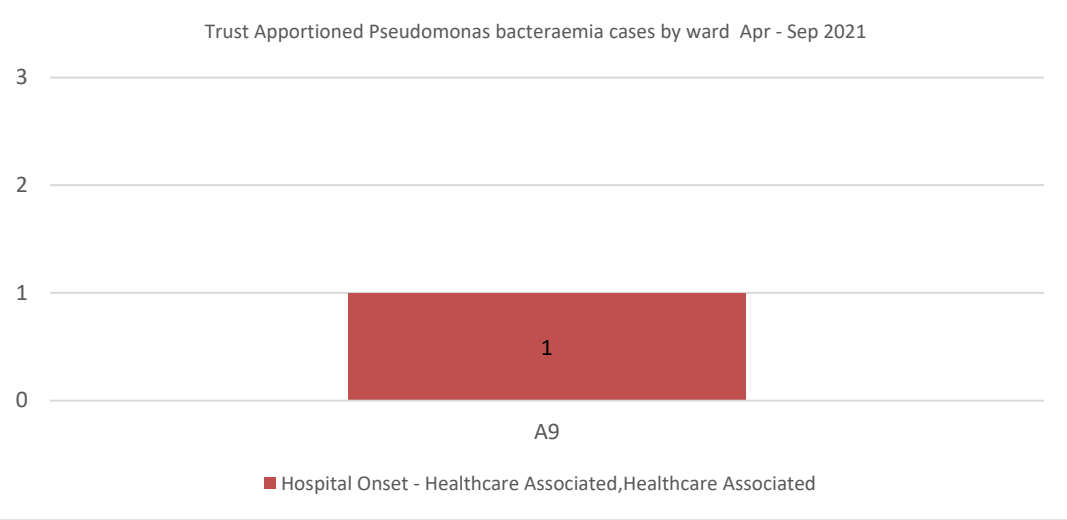


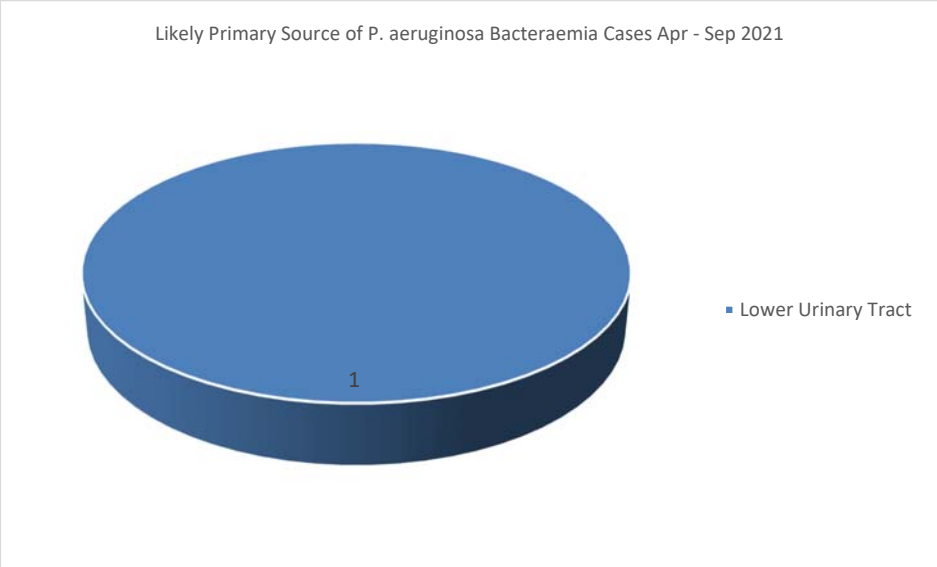


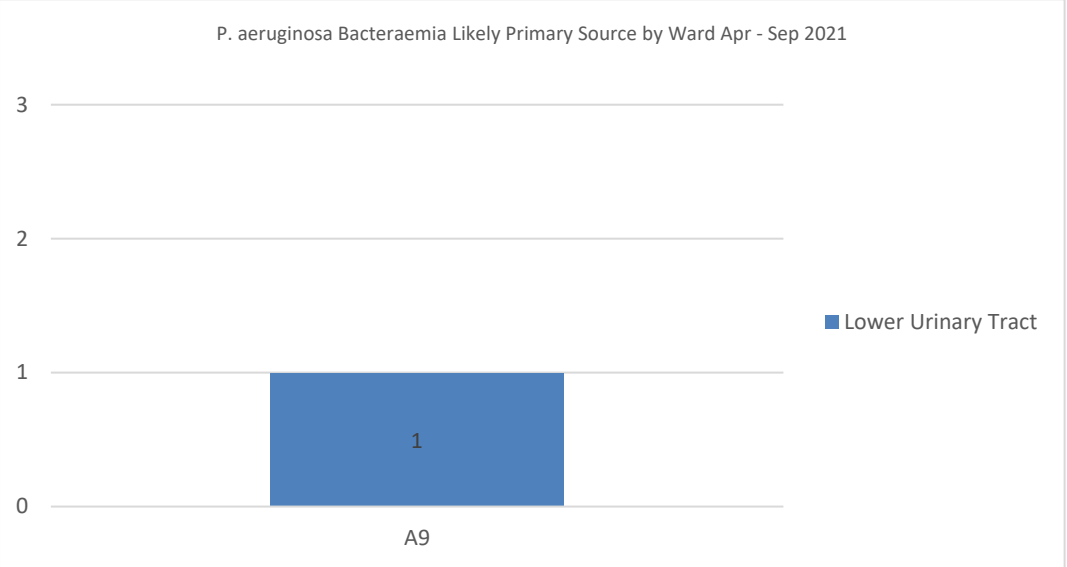
Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa)

Threshold = 4 cases
YTD Total = 1



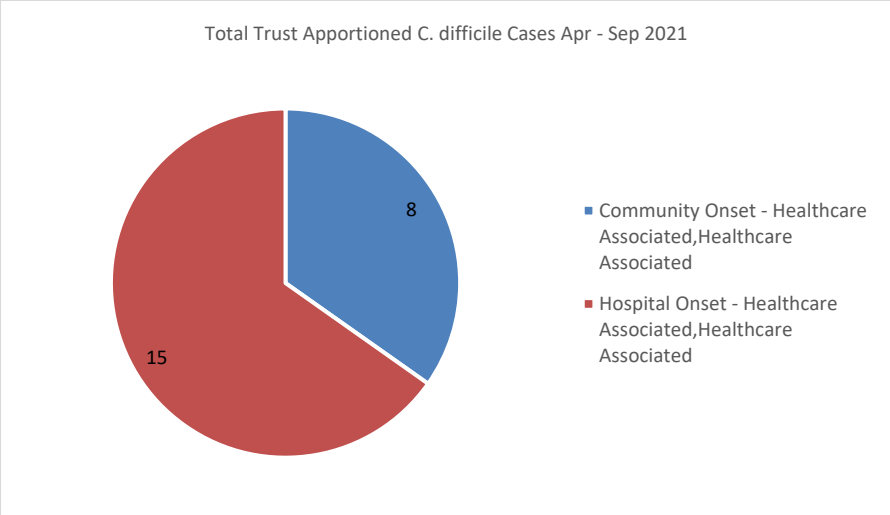


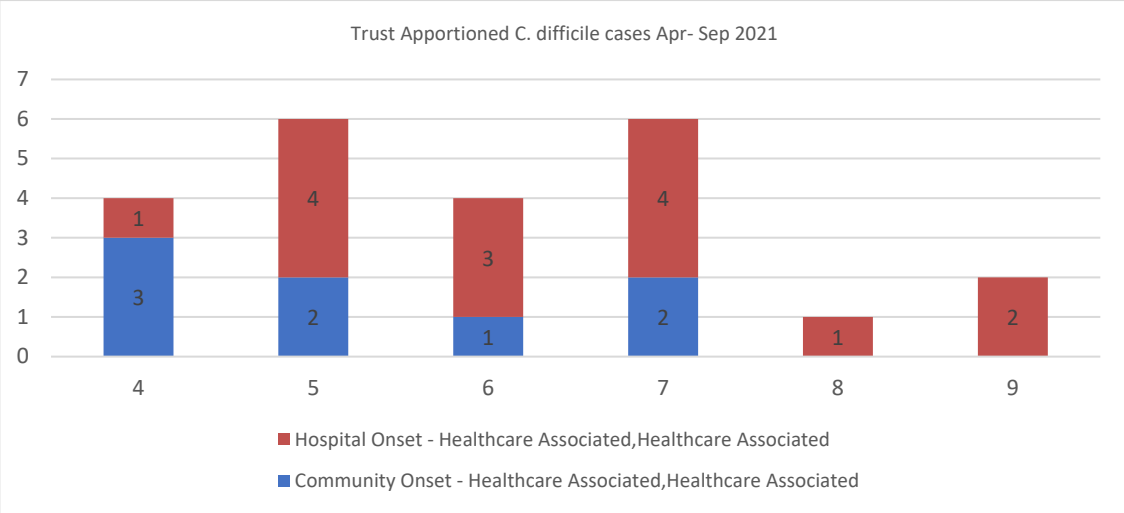


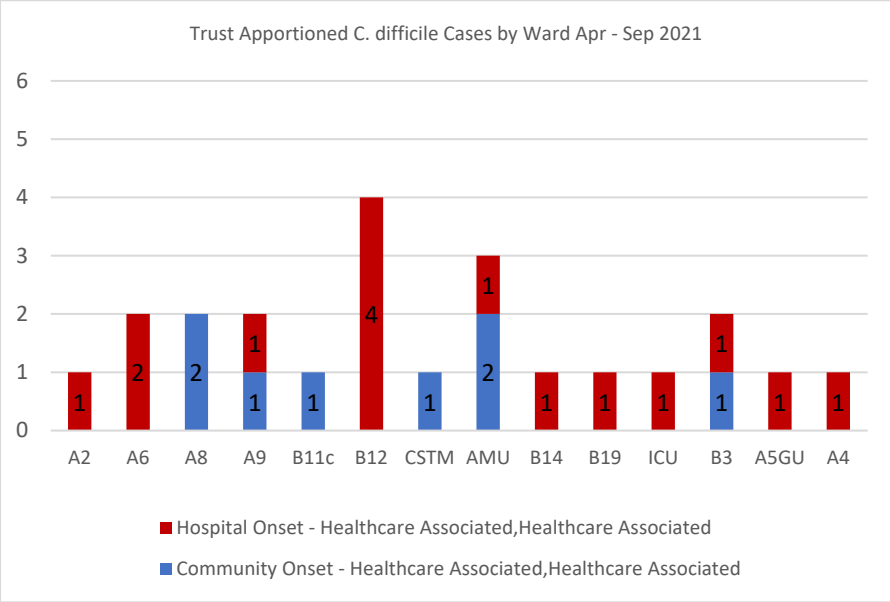


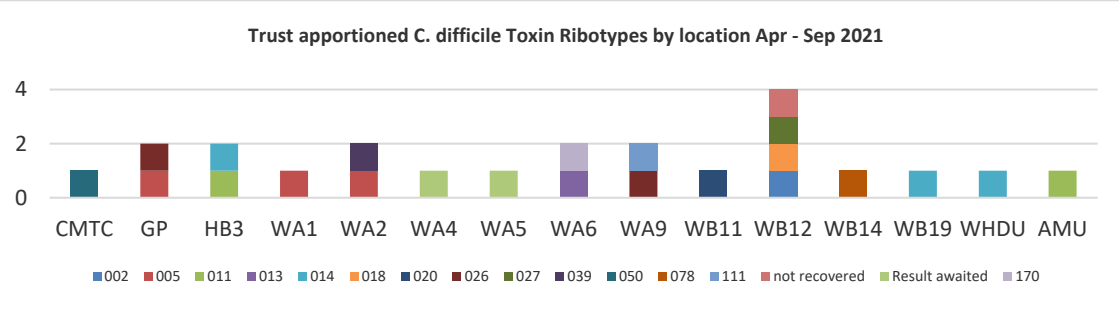
Threshold = 44 cases
YTD Total = 23

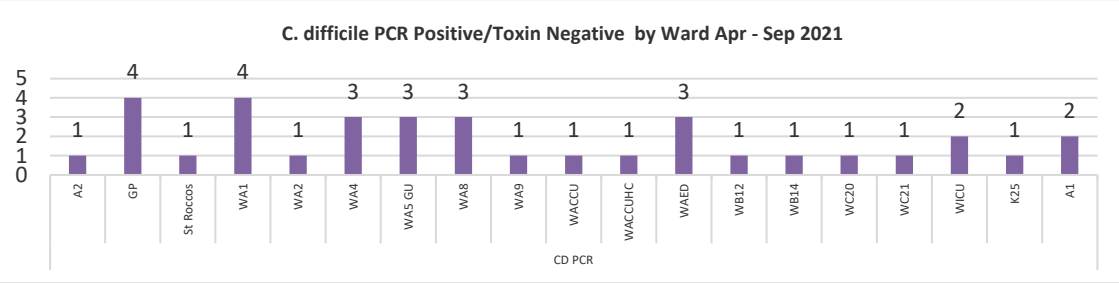
Clostridioides difficile (C. difficile)





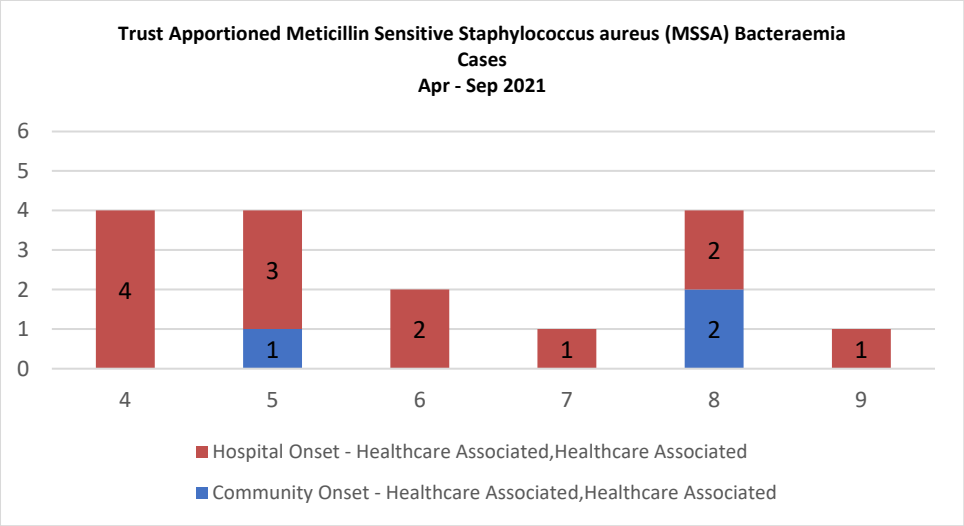


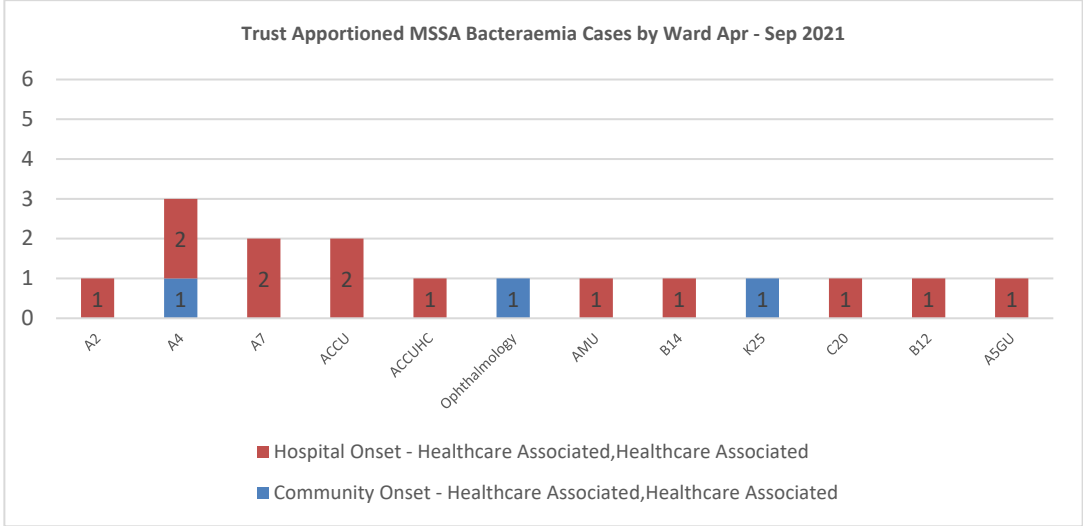


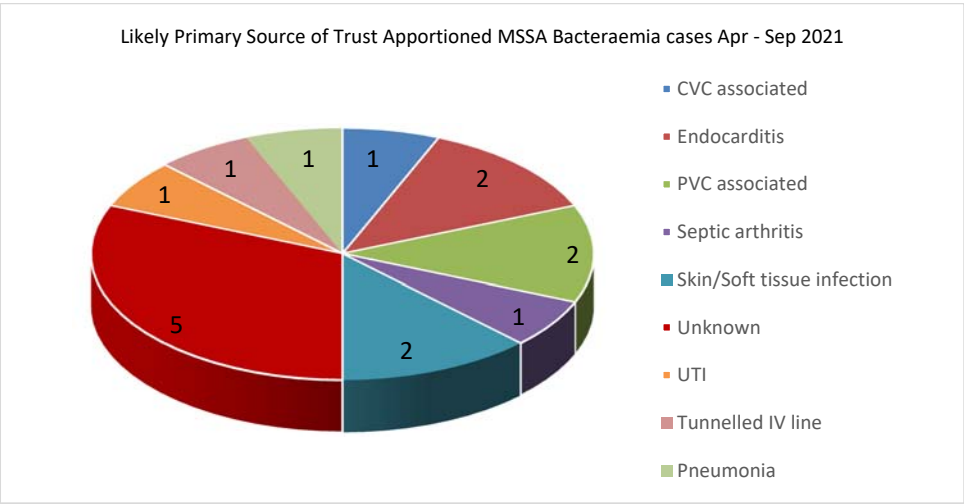


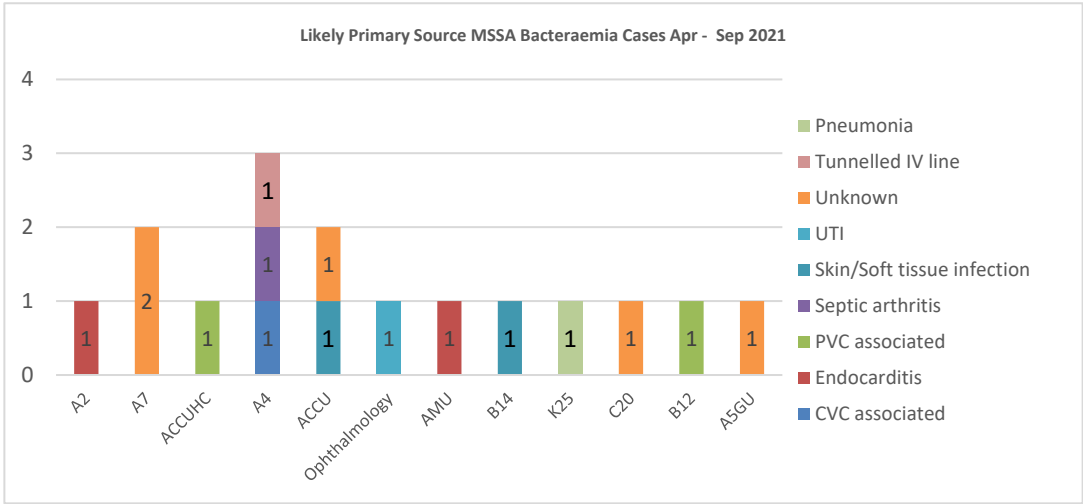
Gram Positive Bloodstream Infection: Staphylococcus aureus

No Threshold set





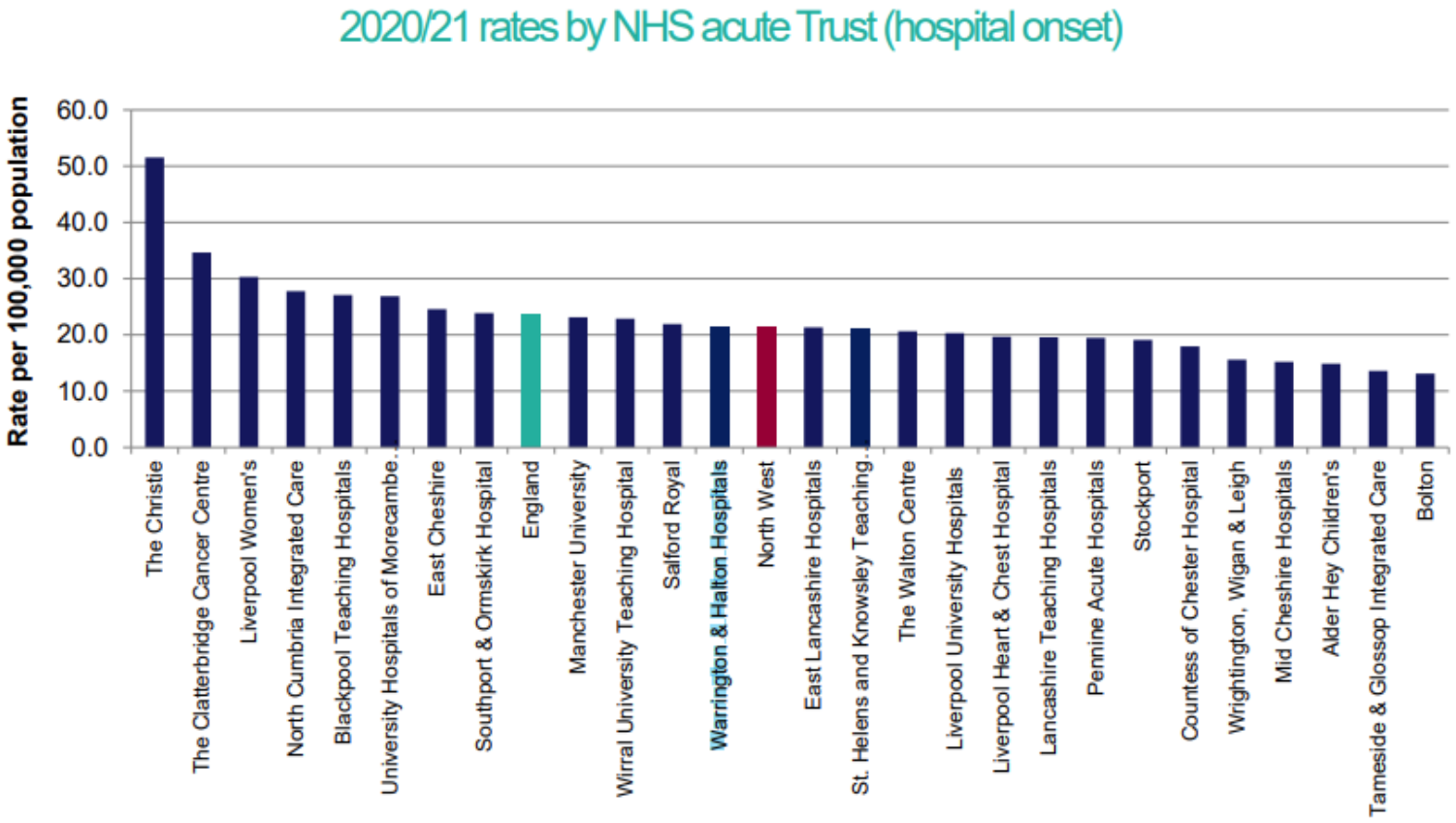




Appendix 2 Comparison of Healthcare Associated Infection Data Across the Northwest

Public Health England

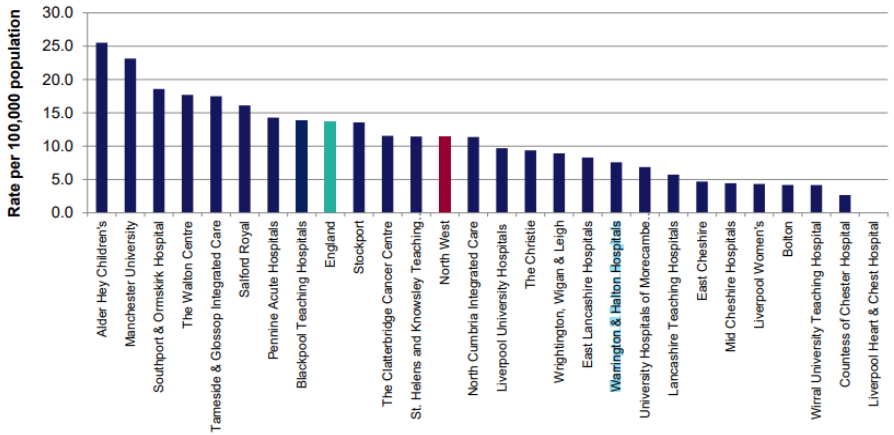
E. coli bacteraemia



Public Health England

Klebsiella spp bacteraemia

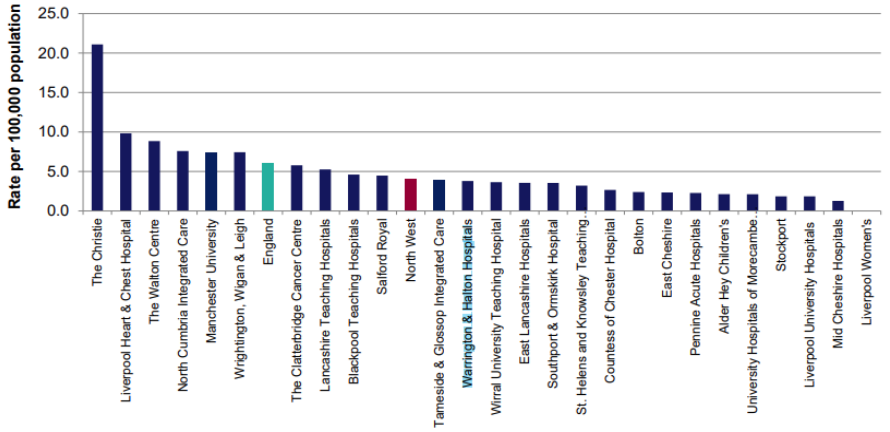
2020/21 rates by NHS acute Trust (hospital onset)



Public Health England

Pseudomonas aeruginosa bacteraemia

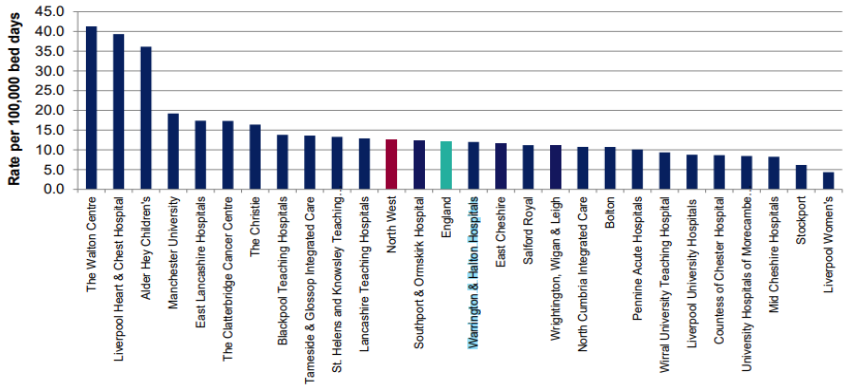
2020/21 rates by NHS acute Trust (hospital onset)



Public Health England

MSSA bacteraemia

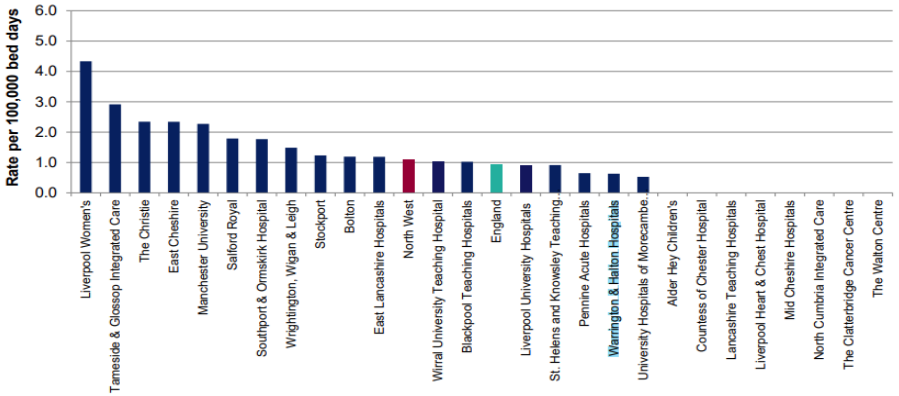
2020/21 rates by NHS acute Trust (hospital onset)



Public Health England

MRSA bacteraemia

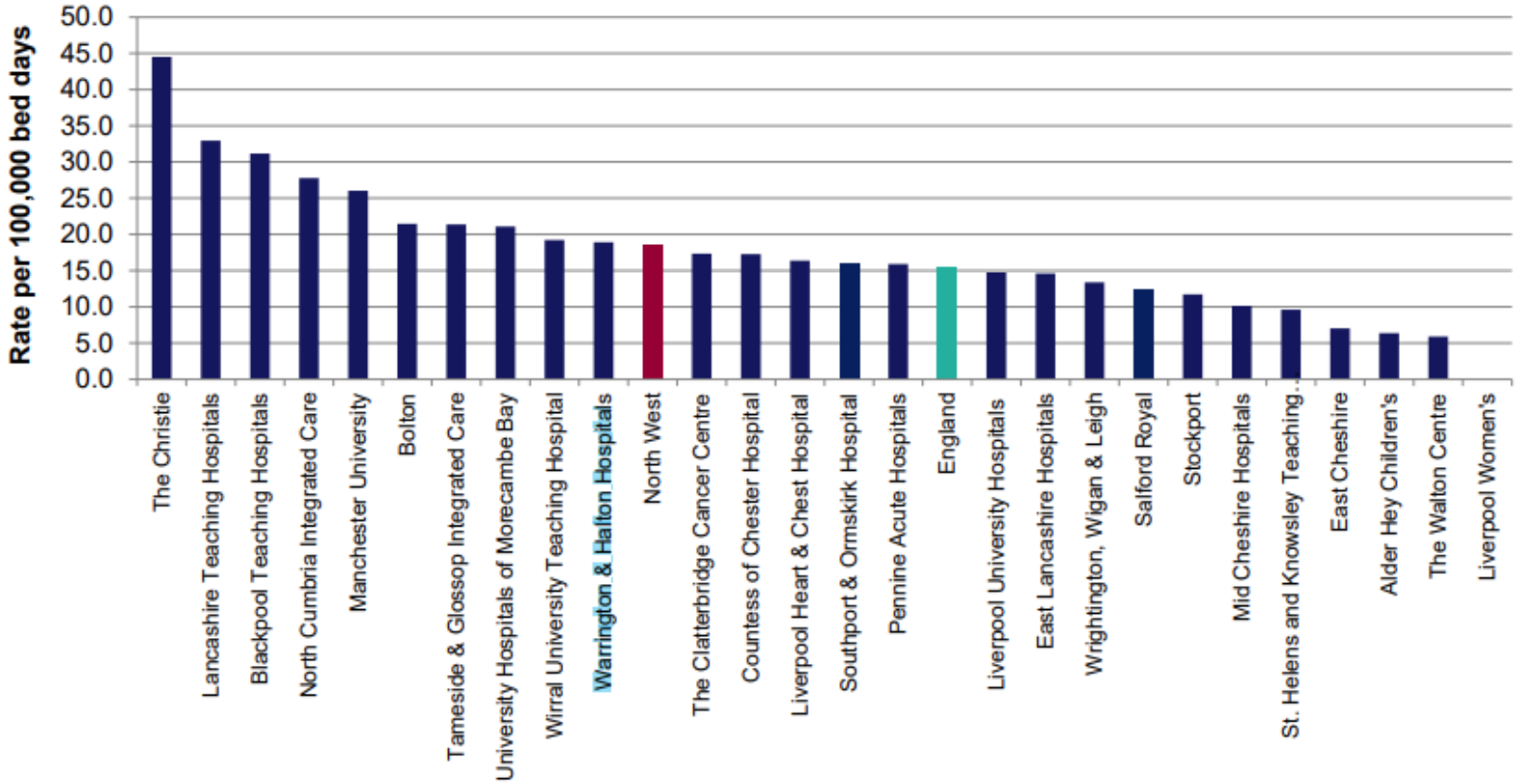
2020/21 rates by NHS acute Trust (hospital onset)



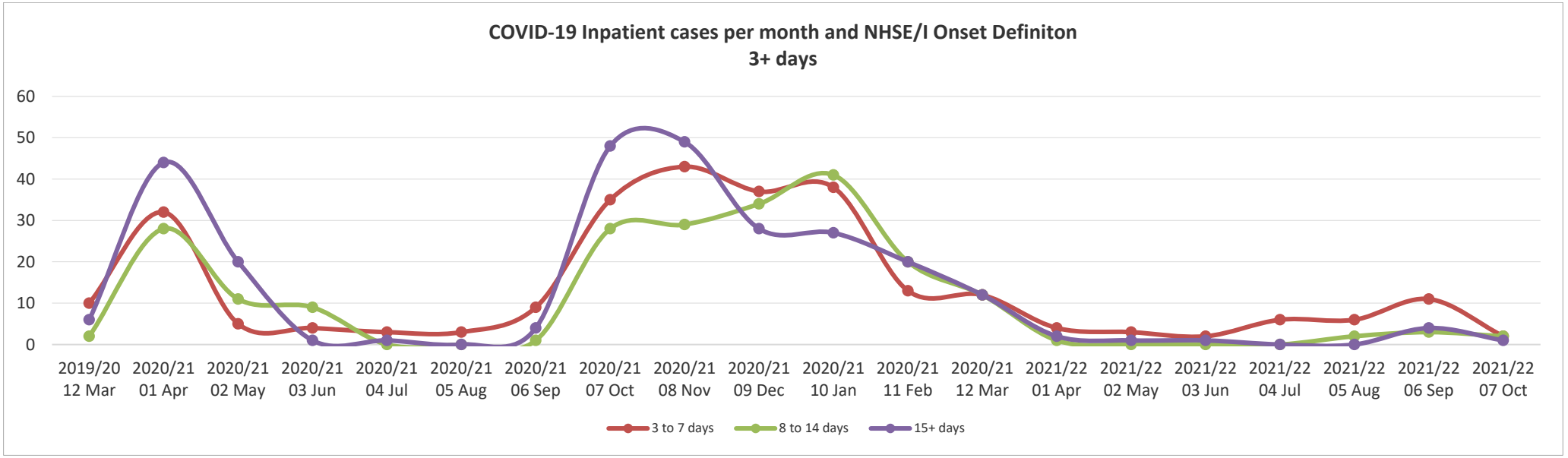
Public Health England

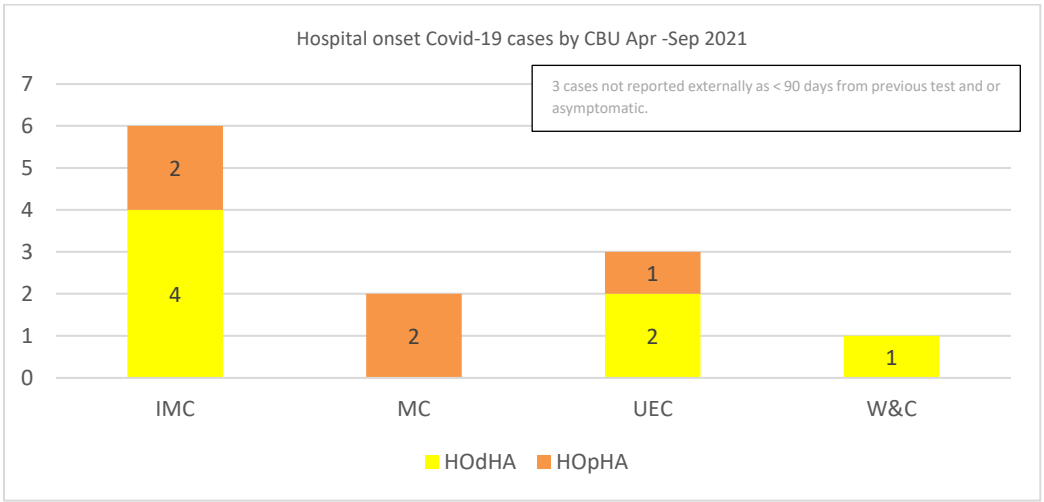
Clostridium difficile infection

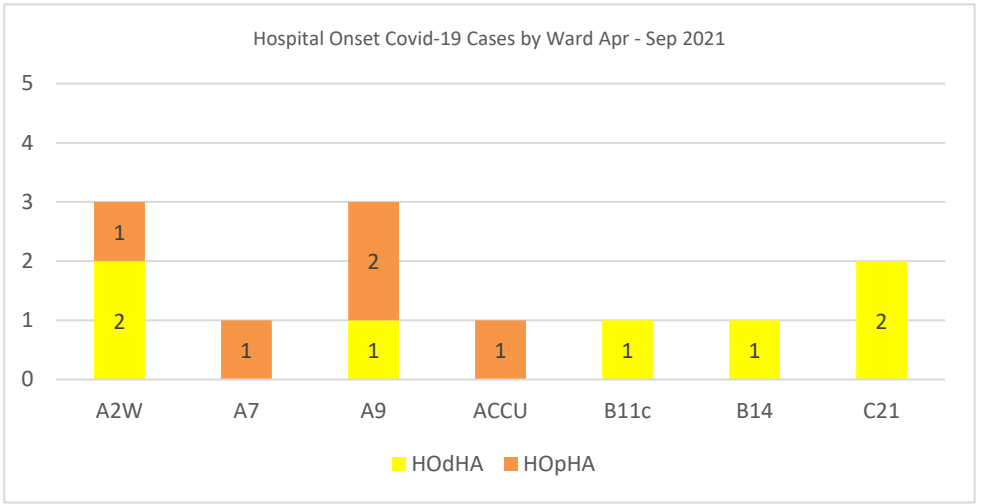
2020/21 rates by NHS acute Trust (hospital onset)



Appendix 3 Covid-19 Cases







Appendix 4 Infection Control Audit Scores

Ward	B4H	A6	B19	AMU	A2	C20	ITU	B14	C21	ACCU	B10	B11
Environment	94%	79%	89%	90%	75%	85%	97%	90%	97%	94%	92%	93%
Ward Kitchens	100%	93%	90%	76%	80%	93%	100%	90%	97%	97%	97%	93%
Handling/Disposal of Linen	100%	100%	94%	100%	100%	100%	100%	94%	100%	100%	100%	100%
Departmental Waste	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe Handling Disposal of Sharps	100%	100%	96%	100%	96%	100%	100%	96%	96%	100%	100%	100%
Patient Equipment (General)	100%	97%	90%	95%	90%	94%	100%	98%	98%	93%	98%	98%
Patient Equipment (Specialist)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Personal Protective Equipment	100%	93%	100%	79%	92%	93%	100%	100%	100%	92%	100%	100%
Short Term Catheter Management	N/A	89%	94%	100%	100%	81%	100%	100%	100%	100%	100%	100%
Enteral Feeding	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	N/A	N/A	N/A	N/A
Care of Peripheral Intravenous Lines	100%	100%	91%	100%	100%	91%	100%	100%	100%	100%	100%	100%
Non-Tunnelled Central Venous Catheters	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A
Isolation Precautions	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	10000%
Hand Hygiene	91%	92%	94%	97%	85%	97%	100%	100%	100%	100%	100%	100%
Overall Compliance	**99%**	**94%**	**94%**	**94%**	**93%**	**94%**	**100%**	**97%**	**99%**	**98%**	**99%**	**99%**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/169**	
SUBJECT:	**Learning from Deaths Report Q2 2021-22**	
DATE OF MEETING:	24 November 2021	
AUTHOR(S):	Eshita Hasan, Associate Medical Director, Patient Safety and Trust-wide Lead for Mortality, Alison Talbot, Associate Director of Governance.	
EXECUTIVE DIRECTOR SPONSOR:	Anne Robinson, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate*)**	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X
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 **#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. **#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.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper summarises 'Learning from Deaths' for Q2 2021/2022, for noting and scrutiny, in compliance with National Guidance requirements on Learning from Deaths. **Key points to note are:** • During Q2 2021/22, 265 deaths occurred within the Trust. • Of these, 74 met the criteria to be subject to a Structured Judgement Review (SJR). • SJRs have been completed on 33 out of 74 assigned. • 0 cases were escalated to a Serious Incident investigation following an SJR. • HSMR (Hospital Standardised Mortality Ratio) based on 12 months data up to and including 30-Jun-2021 is 86.67. This result is not an outlier. • HES SHMI (Summary Hospital-level Mortality Indicator based on Hospital Episode Statistics) for the 12-month period up to and including 30-April-2021 is 98.36. This result is not an outlier. • Attached as appendices are the MRG theme of the month **(Appendix A) and** Serious Incident Newsletter **(Appendix B)** for learning.	
PURPOSE: *(please select as appropriate)*	Information | Approval | To note X | Decision	
RECOMMENDATION:	To note the contents of the paper.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/21/11/282

	Date of meeting	02/11/21
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Deaths Report Q2 2021-22	AGENDA REF:	BM/21/11/169

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 occurred 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 asses 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. ACTIONS REQUIRED/RESPONSIBLE OFFICER

n/a

4. IMPACT ON QPS?

n/a

5. MEASUREMENTS/EVALUATIONS

Total number of deaths and investigation levels.

Month	Number of Deaths	Number of deaths which met SI (Serious Incident) criteria
July 2021	87	0
August 2021	91	0
Sept 2021	87	0

Total number of learning disability deaths reviewed via LeDer (Learning Disability Mortality Review), perinatal deaths reviewed by PMRT (Perinatal Mortality Review Tool) process and deaths in children reviewed by the Child Death Review process;

- Deaths in patients with a learning disability are reported to the LeDeR portal for review by the LeDeR process. The number of LD deaths reviewed by this process will be collated and information provided in the next quarterly report. This information has been requested from the LD lead nurse.
- No child deaths and perinatal deaths were reported in this quarter to MRG.

SJR reviewed

- During Quarter 2 21-22, 74 deaths met the criteria to be subject to a Structured Judgement Review (SJR).
- SJRs have been completed on 33 out of 74 assigned.

Table 1 below denotes the number of SJR completed with overall assessment of care rating.

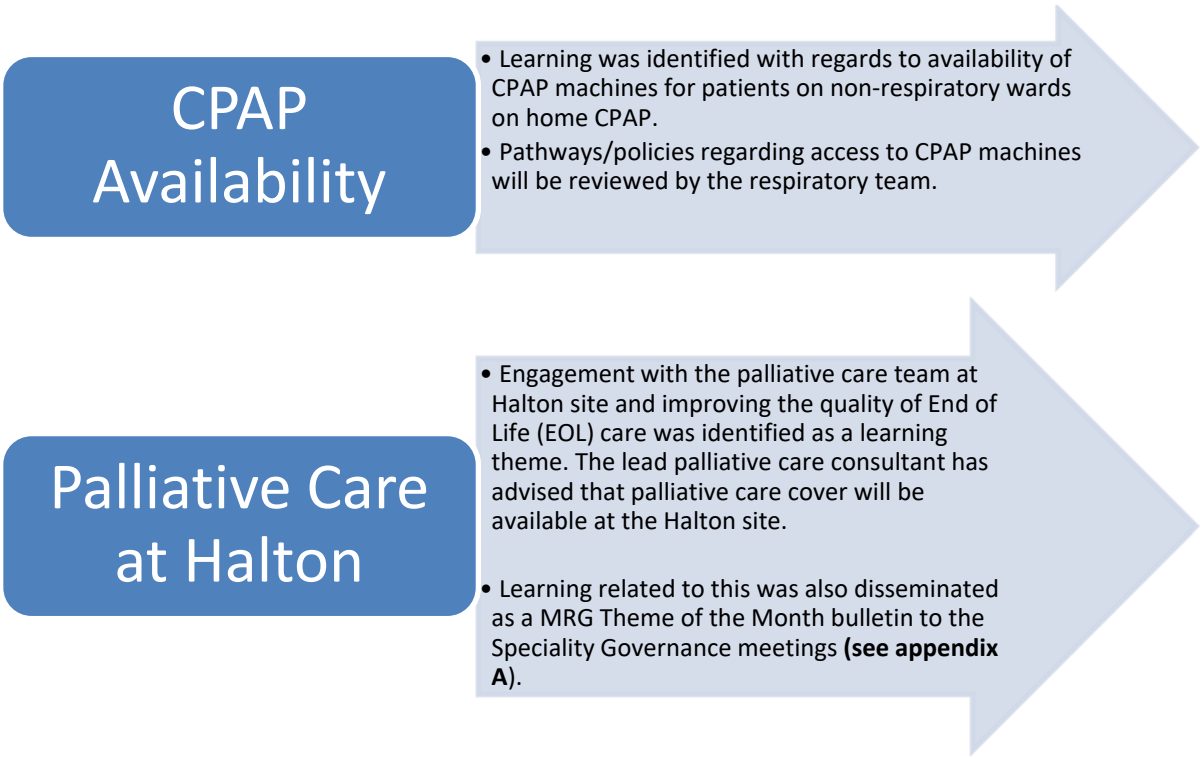
	Overall Assessment Care Rating Following SJR					Total
	1: Very Poor	2: Poor	3: Adequate	4: Good	5: Excellent	
Q2	**0**	**0**	4	28	1	33

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

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

Cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Specialty Governance meetings.

Snapshot of learning identified in MRG:



Learning is disseminated to the Clinical Business Unit Governance Meetings by a MRG Theme of the Month learning bulletin and a Serious incident newsletter. The Chief Registrar attends MRG and this facilitates dissemination of learning to junior doctors.

Opportunities for Quality Improvement (QI) projects identified from learning points are supported by QI team membership at MRG.

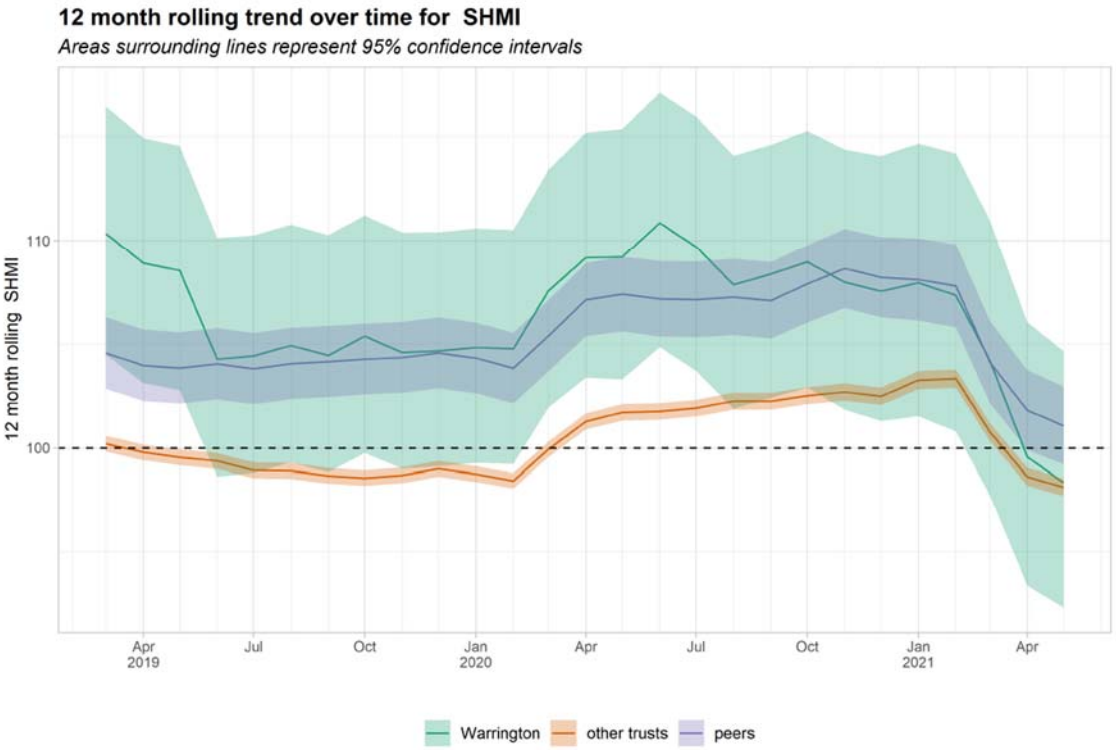
Serious Incident investigations:

Serious incident investigations have been completed in 2 hospital deaths in Q1 (ID 152576 and ID 152575); investigation was prompted following governance review of an incident report and Medical Examiner review. The learning from these investigations is attached in Appendix B.

6. TRAJECTORIES/OBJECTIVES AGREED

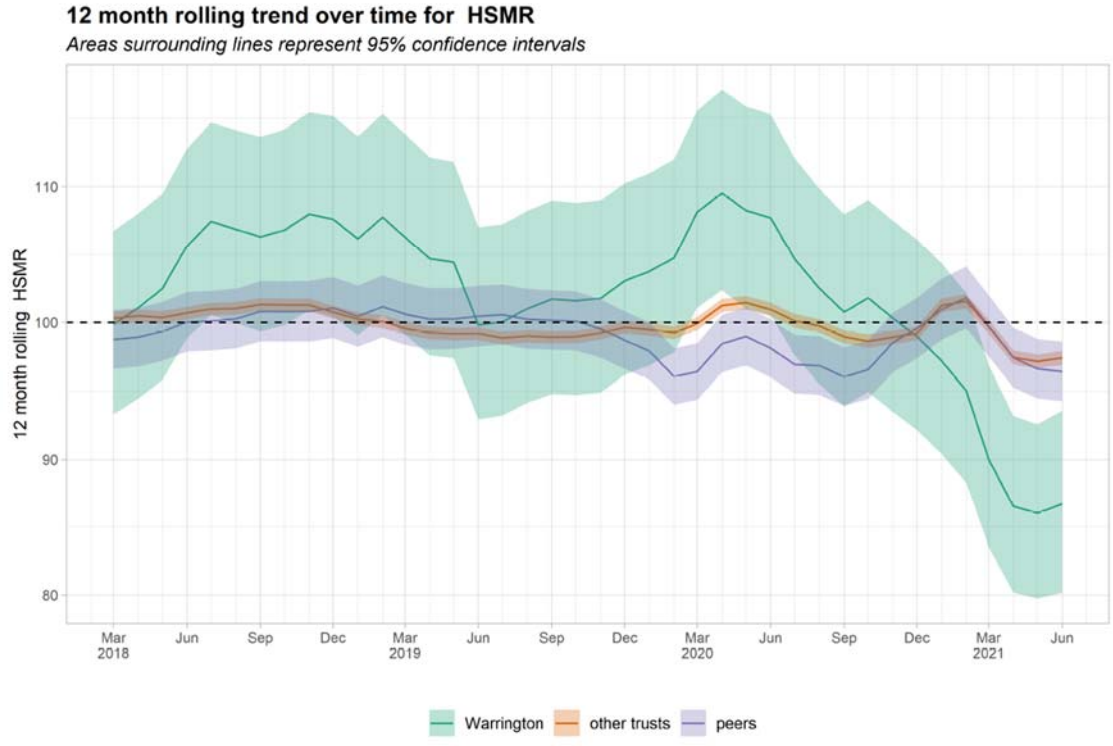
SHMI (Summary Hospital-level Mortality Indicator)

All observed deaths in hospital and within 30 days of discharge. SHMI for the 12-month period up to 30-April-2021 is 98.36. This result is not an outlier. (Graph 1 below denotes the rolling trend over 12 months compared to peers).



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

- HSMR for the 12-month period up to 30-Jun-2021 is 86.67. This result is not an outlier. (Graph 2 below denotes the rolling trend over 12 months compared to peers)



The key diagnosis groups showing as outliers for HSMR and SHMI on the HED report have been reviewed at MRG:

- SHMI outlier for “other endocrine” disorders.
- SHMI outlier for acute post-haemorrhagic anaemia, deficiency and other anaemia
- HSMR alert for UTI in March ‘21. (UTI in-hospital mortality has also featured as a red flag in the CQC Insight Report published in March ’21.)

These alerts will be investigated by undertaking the following:

- Extracting the patient-level data
- Coding review
- Case reviews to assess quality of care if indicated after review of coding and contextual indicators.

The focussed review on anaemia deaths is due for presentation and discussion at the October MRG. Learning from this review will be summarised in the next Learning from Deaths report.

The coding review of UTI mortality has been completed; case reviews will be commenced on the identified and eligible cases with completion planned for end of December 2021.

Extraction of patient-level data for endocrine mortality outlier cases has been requested and coding review is expected to be completed by end December 2021 which will inform the need for case reviews if indicated.

Other mortality improvement workstreams:

WHH performance for in hospital mortality following fractured neck of femur is a CQC Insight Red flag indicator. Performance for 2019-2020 was worse than the national average.

The Hip Fracture Focus Group has developed an improvement action plan that is being monitored by the Orthogeriatric Group and reported to the M2O meeting.

7. MONITORING/REPORTING ROUTES

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

8. TIMELINES

Ongoing; the Mortality Review Group meets monthly to review deaths that have been subject to a Structured Judgement Review.
The focussed work on UTI mortality is due to be completed at the end of the year.

9. ASSURANCE COMMITTEE

Quality Assurance committee

10. RECOMMENDATIONS

The Board are asked to note this report.

Appendix A

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

We are WHH

MRG Theme of the Month | September – 2021

CASE STUDY – PALLIATIVE/END OF LIFE CARE

Background

76-year-old patient was originally admitted to Warrington Hospital from the community on 04/06/21 with a fall, preceded by a few months of deteriorating mobility and a background history of advanced dementia, hypertension, PAF, postural hypotension, gout and anxiety with depression. Spouse was the patient's main carer and was struggling to give the care required. Patient was transferred to Halton Hospital on 11/06/21 for 'rehabilitation' but was transferred back to Warrington Hospital on 30/06/21 after general deterioration and increased O2 requirements (another reason given for transfer was lack of availability of Taz/Pip and 0.45% saline) with a diagnosis of aspiration pneumonia. Patient sadly passed 04/07/2021.

Points Identified

- The transfer of very sick patients from Halton to Warrington is a regular occurrence especially in care of the elderly.
- The patient was deemed to be "super stranded" and futile scope for active management at Warrington. The reviewers were of the opinion that the patient could have been more proactively managed at the Halton site, similar to patients on rehab wards.
- Lack of availability of Taz/Pip and 0.45% saline was an issue during admittance at Halton. Syringe driver also suggested/queried for site.

Learning

- Clarify whether Halton have any palliative care team support, consultants or specialist nurses that can cross cover both sites.
- Support discussions within palliative care and make sure consultants in Halton have adequate support in terms of EOL.
- Establish chain of command at Halton regarding decision making when it comes to palliative care. Review criteria for inter site patient transfer.
- Review availability of drugs (Taz/pip, 0.45% saline) and syringe driver influencing transfer.

theHub

Please ensure you are familiar with COVID 19 policies, all of which can be find under 'Policies & Procedures - 'COVID 19' on the HUB, or you can find the policies by using the 'Induction App' on your phone. For more information on this please contact emily.barnett@nhs.net (Policy Officer)

Appendix B

Background

Patient was a 52-year-old with a PMH asthma, was not taking any medications and was noted to be fit and well.
On the 18th April 2021 patient attended ED having injured their ankle/foot at work that day. Patient was assessed by a clinician in ED and sent home with advice and analgesia.
On the 28th April 2021 the patient was reviewed by general practitioner (GP) who requested another x-ray and prescribed amitriptyline to aid with sleep.
Patient attended ED again on the 10th May 2021 as although the ankle pain was improving, patient now had groin pain which they felt was worsening. The working diagnosis was felt to be that the patient had a hip sprain from altered gait due to the ankle injury. Patient was given analgesia to take home and advice for exercises and discharged at 22:10.
At 00:10 patient was brought back in by ambulance post cardiac arrest witnessed by family. A review took place in ED and patient was transferred to ITU for intubation but sadly passed away on the 16th May 2021. The cause of death was noted to be bilateral pulmonary embolisms.

Issues Identified	Action	Outcome
Potential for risk factors and signs of VTE not identified.	Share the investigations and findings with all ED staff for learning.	Awareness of the incident and the missed opportunities as an opportunity for learning.
COVID-19 status (and potential VTE risk) not considered at clinical assessment prior to cardiac arrest. It is unknown from the information available if VTE had been considered. Additionally, it is unknown if had reported a history of COVID-19 symptoms; there is no evidence of immunisation status.	Share the investigations and findings with all primary care/ED staff for learning.	This was another issue found which did not contribute to the incident but can provide opportunities for additional learning.
A missed opportunity by both primary care and Warrington hospital to consider DVT as a potential diagnosis despite a normal clinical examination with no signs of DVT in view of the history.	Share the investigation with primary care for their learning.	Awareness of the incident and the missed opportunities as an opportunity for learning.

Background

Patient was 81 years old with a past medical history of CKD stage 4, Hypertension, vascular dementia, AF on warfarin, type 2 diabetes and asthma. The patient was admitted on the 12th May 2021 due to severe back pain which was causing him decreased mobility. Patient was admitted for further investigations. Sadly, on the 13th May 2021 the patient suddenly deteriorated and sadly passed away. Following this death, the patient's care was reviewed by the medical examiner on 02/06/2021 who found that the likely cause of death was an intracerebral bleed which may have been prevented if the hypertension had been controlled more aggressively on admission. The medical examiner completed an incident form which then prompted a further review of care and an investigation was commenced.

Issues Identified	Action	Outcome
Antihypertensives were not given as prescribed as they were unavailable in the department.	Review of medications available as stock in A&E.	This will ensure the appropriate, most used medications are available as stock in A&E
Limited number of medications available as stock in ED.	Review of medications available as stock in A&E.	This will ensure the appropriate, most used medications are available as stock in A&E
Delay in the delivery of non-critical medications ordered from pharmacy in ED	Review of the process of ordering noncritical medications in ED to see if the process can be expedited.	This will ensure patients should be able to receive their regular medications in a timely manner.
Delays in non-critical medications ordered from A&E arriving in the department (several hours)	Review of the process of ordering noncritical medications in ED to see if the process can be expedited.	This will ensure patients should be able to receive their regular medications in a timely manner.
No comment on what Mrs Currans blood pressure was during the post take ward round. Only comment was "obs stable".	Good practice to state the observations if previous concerns raised regarding them.	Awareness of the incident and the missed opportunities as an opportunity for learning.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/170**	
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined Report for Q2 2021-22**	
DATE OF MEETING:	24 November 2021	
AUTHOR(S):	Mrs Fran Oldfield, Guardian of Safe Working Hours	
EXECUTIVE DIRECTOR SPONSOR:	Anne Robinson, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#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 **#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 **#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. **#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. **#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.	
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 2 (July – Sept) 2021-22, 57 Exception Reports (ERs) were submitted – this represents an 8% reduction compared to Q1 (which had a particularly high number of reports) reflecting that junior doctors' workloads may be returning slowly to pre pandemic levels. The vast majority (73%) of ERs relate to excessive hours worked. Three ERs were submitted because of missed educational opportunities. Five Immediate Safety Concerns (ISC) were reported by medical trainees due to gaps in the rota and perceived inability to maintain patient safety. One additional ISC was reported but the issue was not felt to be an ISC by GSW. The T&O F1 rota has been identified as being non-compliant. A temporary solution has now been implemented with the definitive solution to be implemented early in 2022.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision None Required
RECOMMENDATION:	The Committee are requested to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/21/11/102		
	Date of meeting	17 November 2021		
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Guardian of Safe Working for Junior Doctors Combined Report for Q2 2021-22	AGENDA REF:	BM/21/11/170

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.

It is important to remember that most of the 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 relate 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.

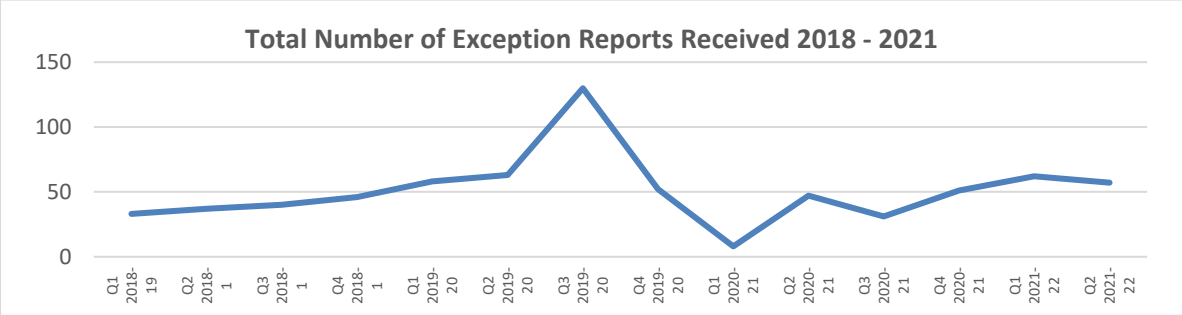
The Trust appointed a new GSW in September 2021 and this is the first report since handover of the role.

2. KEY ELEMENTS

Exception Reporting (July – October 2021-22)

During Quarter 2 2021-22, 57 Exception Reports were submitted, which is lower than the last quarter but within normal variation and in line with pre-pandemic levels as demonstrated in Chart 1 below:

Chart 1: Total Number of Exception Reports received by quarter since 2018



The majority of ERs raised relate to junior doctors working past their allocated time (>70%), usually on an ad-hoc basis. There were more in medical specialties (63%) than surgery. Three ERs related to missed educational opportunities, in two separate surgical specialities. Correspondence has been received by the juniors involved that these issues have now been addressed and educational opportunities are now being attended. There were 6 immediate safety concerns, (ISC) submitted in this quarter, 5 relating to gaps in the medical rota. These were highlighted to the medical rota manager and lead consultants and have now been addressed. An additional ISC was logged and was deemed not to be an ISC by the GSW.

Exception Reporting – Q2

Quarter	Reporting Period	Deadline for Data Provided by the Host
Q2 Report	**1st July 2021**	**30th Sept 2021**

Exception Reports (ER) over past quarter	
Reference period of report	01/07/21 - 30/09/21
Total number of exception reports received	57
Number relating to immediate patient safety issues	6
Number relating to hours of working	42
Number relating to pattern of work	1
Number relating to educational opportunities	3
Number relating to service support available to the doctor	11

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

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	11
Total number of overtime payments	19
Total number of work schedule reviews	4
Total number of reports resulting in no action	2
Total number of organisation changes	0
Compensation	0
Unresolved	44
Total number of resolutions	**36**
Total resolved exceptions	**38**

***Note**:*
** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*

** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*

** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

Reasons for ER over last quarter by specialty & grade						
ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate patient safety issues	Acute Medicine	CT1	0	2	1	1
	General medicine	CT1	0	1	0	1
	General medicine	FY1	0	3	0	3
Total			**0**	**6**	**1**	**5**
No. relating to hours/pattern	Acute Medicine	FY1	0	6	5	2
	Cardiology	ST3	0	1	1	0
	Gastroenterology	FY1	0	1	1	2
	General medicine	CT1	0	7	0	7
	General medicine	FY1	0	9	4	5
	General surgery	FY1	10	5	10	7
	General surgery	FY2	0	1	0	1
	Geriatric medicine	FY1	3	1	0	1
	Paediatrics	FY1	0	1	1	0
	Paediatrics	ST1	1	0	0	0
	Respiratory Medicine	FY1	0	0	0	1
	Trauma & Orthopaedic Surgery	FY1	0	7	14	1
	Trauma & Orthopaedic Surgery	FY2	0	1	1	0
	Urology	FY1	0	3	0	3
Total			**14**	**43**	**37**	**30**
No. relating to educational opportunities	General surgery	FY1	0	0	0	1
	Otolaryngology (ENT)	FY2	0	1	0	1
	Trauma & Orthopaedic Surgery	FY2	0	2	0	2
Total			**0**	**3**	**0**	**4**
No. relating to service support available	Acute Medicine	CT1	0	2	1	1
	General medicine	CT1	0	1	0	1
	General medicine	FY1	0	7	0	7
	Respiratory Medicine	CT1	0	1	0	1
Total			**0**	**11**	**1**	**10**

Summary

- number of exception reports raised = 57
- number of work schedule reviews that have taken place = 2
- immediate safety concerns = 6
- fines that were levied by the Guardian = NIL
- The majority of ERs have been submitted by FY1 doctors (73%) reflecting the busy workload of medical trainees on the wards. Highest numbers of ERs have been reported from medicine (63%) reflecting the general workload in medicine is undoubtedly higher.

73% of ERs relate to excess hours worked. 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 need to be done out of hours generally.

Three ERs were submitted due to missed educational opportunity. These issues have now been rectified.

Five Immediate Safety Concern (ISC) were reported from medical juniors due to gaps on the medical rota. This has been addressed and will be monitored at Junior Doctors Forum.

Review of Exception Report Themes

Further work has been undertaken to review themes of Exception Reports which are raised.

Out of Hours Orthopaedic On-Call rota

The out of hours orthopaedic on-call was identified as being non-compliant for F1 doctors following the revisions to the contract which were agreed in 2019 which stated the following:
The rota had a 1:2 weekend frequency and has therefore been non-compliant since 2019.

At the time the issue was highlighted to the GSW, Clinical Director, CBU manager and Director of Medical Education but no corrective action taken. A temporary solution has recently been agreed with rota managers. The FY1 rota has been reorganised and the rota will temporarily become a 1:3 weekend rota with FY2s providing cover for gaps up until December. Further work needs to be undertaken to find a more permanent solution going forward.

Foundation Doctors Self Development Time

Another issue has been related to Foundation doctors not being able to take self-development time (SDT) at allocated times. This is a new provision for Foundation Doctors and therefore understandably have been some initial issues with implementation. The Foundation Programme Team have clarified provision requirements and improves should therefore be seen next quarter.

Assurance can be provided that all Foundation Programme Doctors employed during this period were on track to progress through their current year of training.

Junior Doctors Forum and Improving ES / Medical Trainee Engagement

Historically, there has been under-reporting from an Exception Reporting perspective and in order to raise awareness and increase ER uptake, one of the medical trainees has undertaken a project to review ER and this was presented at the Junior Doctors Forum in September. This may explain the increase in ER this month.

Weekend frequency allowance

The weekend frequency allowance rates for those working 1 in 2, 1 in 3, and 1 in 6 weekends will be uplifted in order to ensure these trainees are not paid less per hour for working more intense frequencies. The rate for those working 1 in 2 weekends will be 15% of their basic salary; for those working 1 in 3 weekends it will be 10% of their basic salary, and for those working 1 in 6 it will be 5% of their basic salary. This change will come into effect in December 2019.

Maximum 1 in 2 weekend frequency

All reasonable steps should be taken to avoid rostering trainees at a frequency of greater than 1 in 3 weekends. Authorisation for a rota using a pattern greater than 1 in 3 should require a clearly identified clinical reason agreed by the clinical director and be deemed appropriate by the guardian of safe working. Such rotas should be co-produced with junior doctors, agreed via the JDF and reviewed annually. Trainees that wish to work in excess of 1:3 weekends by undertaking additional work, for example as a locum, are able to agree to do so but must not work at a frequency of greater than the maximum 1 in 2 weekend limit

In addition, historically, there have been delays in the review meetings between the ES and Junior Doctor, once an ER has been submitted. At the end of Q2, there were 44 unresolved ERs (up from 29 in the last quarter).

The GSW and Medical Trainee Workforce Administrator are working on a new system to prompt junior doctors to complete the ERs, so it is hoped this will improve significantly in the next quarter. Junior Doctors are now receiving an email reminder to have their ER signed off within 2 weeks, if they want to receive compensatory payment or time off in lieu (TOIL). Any difficulties with the sign-off process are be escalated to the Medical Education Service and / or the Guardian of Safe Working.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Previous GSW reports have fed back that all WHH are compliant; however, the Trauma & Orthopaedic F1 on-call rota has been non-compliance since 2019. A temporary adjusted has been made to the rota to ensure compliance and further work to ensure ongoing compliance is required for future rotations. Escalation to the DME will be undertaken and to the Medical Director if unresolved. It is within the GSW jurisdiction to issue a fine for repeated non-compliance, however it is recognised that this is unhelpful in resolving this issue. An update will be provided next time.

Junior doctors have reported problems with the volume of work attributed to medical outlier ward rounds on the surgical wards. Ward rounds are happening late in the day and juniors are having to work overtime to complete jobs identified on the ward rounds. The Trust has recently agreed to fund a business case that will significantly increase the number of substantive consultants in Integrated Medicine and Community and over time, this will address the ward cover relating to medical outliers. This will be fed back at the next Junior Doctors Forum.

Longstanding issues with the delay in sign-off of Exception Reports has been highlighted and with the new GSW and email prompting we hope to see this improve over the next 6 months.

The issue of Foundation Doctors having adequate time off SDT time has been highlighted and Foundation School have clarified how this should be taken. This will again be reviewed at the next JDF and taken forwards if there are ongoing issues.

4. IMPACT ON QPS?

The role of the GSW specifically addresses issues highlighted using the exception reporting system enabling doctors to experience high quality training which in turn will enable high quality care to be delivered to patients.

5. MEASUREMENTS/EVALUATIONS

Exception Report submitted by Lead Employer doctors – Q2 2020-21

11 ERs were submitted by trainees with central contracts from the Lead Employer 2019/20. No significant events or issues related to these ERs

6. 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 Exception Report submitted, ether for payment or TOIL, it is the Educational Supervisor who is required to respond to the Exception Report 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 Exception Report 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.

7. 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.

8. TIMELINES

Guardian of Safe Working - Quarterly Reports, Safe Working Hours Junior Doctors in Training:-

- Q3 - (end of Dec 2020) – submitted January 2021
- Q4 – (end of March 2021) – submitted May 2021
- Q1 – (end of June 2021) - submitted July 2021
- Q2 – (end of Sept 2021) – submitted Nov 2021
- Q3 – (end of December 2021) – to be submitted February 2022

9. ASSURANCE COMMITTEE

N/A

10. RECOMMENDATIONS

The Committee are 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.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/11/171**	
SUBJECT:	**Implementation of NHS Patient Safety Strategy**	
DATE OF MEETING:	24 November 2021	
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 X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** Failure to provide adequate staffing levels in some specialities and wards. 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):*	This paper describes the National Patient Safety Strategy (*Safer culture, safer systems, safer patients*) launched in July 2019. There are a number of initiatives within the National Patient Safety Strategy including: • The framework for involving patients in safety • Patient Safety Syllabus • Patient Safety Incident Management System (PSIMS) • Patient Safety Specialist (PSS) • Patient Safety Partners (PSP) • Patient Safety Incident Response Framework (PSIRF) Each point is detailed within this paper with the key updates and next steps in preparation for implementation of the Patient Safety Strategy.	

PURPOSE: *(please select as appropriate)*	Information	Approval	**To note** **x**	Decision
RECOMMENDATION:	The Board of Directors are asked to note the report			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	
	Date of meeting	02 November 2021
	Summary of Outcome	To be noted at Trust Board
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	

FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

REPORT TO BOARD OF DIRECTORS

SUBJECT	Implementation of NHS Patient Safety Strategy	AGENDA REF:	BM/21/11/171

1. BACKGROUND/CONTEXT

The National Patient Safety Strategy was originally launched in July 2019 and describes two main foundations as key to continuously improving patient safety:

- 'a patient safety culture'
- 'a patient safety system'

The strategy recognises the advancements made in patient safety and that NHS staff have the desire, drive and commitment to do more to improve patient safety across our hospitals.

Three strategic aims will support the development of both foundations:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information **(Insight)**
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement)**
- designing and supporting programmes that deliver effective and sustainable change in the most important areas **(Improvement)**

In April 2021, an NHS update paper "Short-medium term priorities for Patient Safety Specialists" was published. This describes how Patient Safety Specialists (the PSS role is described in the Key Elements section of this paper) can support implementation of the NHS Patient Safety strategy and identified key work programmes as outlined below:

- Just culture
- National Patient Safety Alerts
- Improving quality of incident reporting
- Transition from NRLS (National Reporting and Learning System) and StEIS **(**Strategic Executive Information System) to PSIMS (Patient Safety Incident Management System)
- Implementation of the new Patient Safety Incident Response Framework (PSIRF)
- Implementation of the Framework for Involving Patients in Patient Safety
- Patient safety education and training
- National patient safety improvement programmes

2. KEY ELEMENTS

This paper will describe the key points to note on each of the areas which underpin the overarching strategy:

2.1 Just Culture

It is a requirement of the NHS Patient Safety Strategy that all providers should set out how they will embed the principles of a safety culture on an ongoing basis. This should include monitoring and response to NHS staff survey results and any other safety culture assessments; and adoption of the NHS England and NHS Improvement 'A Just Culture Guide' or equivalent.

2.2 National Patient Safety Alerts

A key feature of National Patient Safety Alerts (NatPSAs) is the need for leaders in each organisation to manage the implementation of all relevant actions for each alert, ensure alert implementation is centrally managed, the required actions are embedded into practice and compliance sign off has executive oversight.

The local system for managing alerts must ensure the board is notified as new NatPSAs are issued; and the appropriate people who are involved in implementation are contacted to ensure they understand their responsibilities, allowing actions to be completed in the identified timescale. NatPSAs are only recorded as 'action completed' on Central Alerting System (CAS) with executive authorisation and assurance that all actions are complete. The board should be aware that a record of noncompliance with alerts by their designated deadline is publicly available on the CAS website,

2.3 Improving quality of incident reporting

The objective of incident reporting is to highlight opportunities for patient safety to be improved both locally and nationally and to enable that information to be shared with those who need to see it. It is then critical for that information to be acted upon effectively and sustainably. Organisations should use (NRLS) explorer reports to effectively capture and describe incidents to Board.

2.4 Transition from NRLS and STEIS to PSIMS and LFPSE (Learn from Patient Safety Events)

A new national (LFPSE) service is in the final stages of development as a central service for the recording and analysis of patient safety events that occur in healthcare. This system was called PSIMS during its development stage. LFPSE will replace the current NRLS and STEIS systems for reporting patient safety events.

LFPSE is currently in its public beta stage which is an extended piloting stage where organisations with a Local Risk Management System (LRMS) with a LFPSE compliant system can start uploading patient safety events. Local organisations should continue to use NRLS in the meantime but commence conversations with the local LRMS vendor about timescales for upgrading LRMS to a LFPSE compliant system.

2.5 Implementation of PSIRF

The new PSIRF will replace the current Serious Incident framework. It outlines a new approach to responding to patient safety incidents and how and when a patient safety investigation should be undertaken. National Standards for Patient Safety Investigation were published in March 2020 to support the implementation of PSIRF.

2.6 The key changes noted are:

- A broader scope – moving away from identifying Serious Incidents and looking at Patient Safety Incidents as a whole.

- Transparency – supporting staff, supporting families and setting out clear and defined expectations to ensure all are informed.
- Purpose – reinforcing the purpose of the incident investigation - avoiding looking at preventability and liability.
- Terminology – removing root cause.
- Timeframes – no longer working towards 60 days – working with families to agree timeframes where possible.
- Investigators – having dedicated time and expertise to complete investigations.

A PSIRF implementation lead needs to be identified and a gap analysis undertaken to understand the skills, capability and capacity to undertake a patient safety incident investigation or other types of responses following a patient safety incident as per PSIRF. This needs to be undertaken prior to a further publication, anticipated in Spring 2022, when Trusts will be expected to transition over a period of time to PSIRF.

2.7 Implementation of the Framework for Involving Patients in Patient Safety

The framework is split into two parts:

- Part A: Involving patients in their own safety;
- Part B: Patient safety partner (PSP) involvement in organisational safety.

Part A: Involving patients in their own safety

A key priority is empowering patients to get involved in their own safety by:

- Asking directly if they understand the care or have any questions
- Providing leaflets, videos and apps which encourage patients to ask questions to health care professionals
- Addressing inequalities in healthcare by treating patients as an individual not by their diagnosis (e.g. for those with learning disabilities).

Part B: PSP

Part B of the framework 'PSP involvement in organisational safety' relates to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety. PSPs can act as

'knowledge brokers' as they often have the insight of a user of services across different parts of the NHS or may have experience of avoidable harm and can therefore help inform the development of safety solutions that cross organisational boundaries. They provide a different perspective on patient safety, one that is not influenced by organisational bias or historical systems. PSPs perform a very different role from that of a governor in a foundation trust or a traditional NHS volunteer; however, individuals working in these roles can also be a PSP.

The role for a PSP can be:

- Membership of safety and quality committees whose responsibilities include the review and analysis of safety data;

- Involvement in patient safety improvement projects;
- Working with organisation boards to consider how to improve safety;
- involvement in staff patient safety training;
- Participation in investigation oversight groups.

A job description for this renumerated role is available in the strategy document.

It is a requirement that by June 2022 two PSPs will be employed at each Trust and will have received training by June 2023. An operational lead for implementation of this strategy (same as PSIRF implementation lead) is required.

2.8 Patient Safety Education and Training

A national patient safety syllabus was published in May 2021. The syllabus will underpin the development of patient safety curricula for all NHS staff. It is anticipated that training will be rolled out by Q1 2023/24. Further guidance on its implementation is awaited.

2.9 Patient Safety Improvement Programmes

There are currently five National Patient Safety Improvement Programmes:

- Managing deterioration
- Maternity and neonatal
- Adoption and spread
- Medicines safety
- Mental health

These programmes are supported by the Patient Safety Collaboratives (PSCs), who develop Local Improvement Plans collaboratively with relevant local stakeholders. Currently, WHH participates in the “Managing deterioration” and “Maternity and neonatal” programmes.

2.10 Role of Patient Safety Specialist

All NHS organisations must have at least one person as their designated Patient Safety Specialist who is considered a key part of the strategy. Patient safety specialists will be the lead patient safety experts in healthcare organisations, working full time (although two or more people may fulfil the role by sharing the responsibility) on patient safety. They will provide dynamic, senior leadership, visibility and expert support to the patient safety work in their organisations. They will support the development of a patient safety culture and safety systems; and have sufficient seniority to engage directly with their executive team. It is anticipated that PSS will receive training in their role by Q1 2023/24.

WHH currently has 2 named Patient Safety Specialists who fulfil the role by sharing the responsibility.

2.11 Next Steps

In order to ensure a proactive approach is adopted for implementation of the Patient Safety Strategy, a project manager will be appointed by Q4 2021/22 to lead on implementation on all the elements described in this paper. It is expected that the final version of the PSIRF will be published in Spring 2022 and organisations will be expected to transition to this with guidance on timeframes for this transition.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Trust Board of Directors is asked to note the content of the report and the work that is required to deliver the key changes within the framework of the NHS Patient Safety Strategy.

4. RECOMMENDATIONS

The Board of Directors is asked to note the report.