We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 29th March 2023
10.00am-12.30pm
Trust Conference Room WHH/Via MS Teams

SUPPLEMENTARY PACK

BM/23/03/41 – Digital Strategy Group Reports (22.02.23/22.03.23) – Pg 2
BM/23/03/42 – Guardian of Safe Working for Junior Doctors Combined Q3 - Pg 21
BM/23/03/43 – Learning from Experience Report Q3 – Pg 29
BM/23/03/44 - Infection Prevention and Control Report Q3 – Pg 3
BM/23/03/45 – Safe Staffing Report; 6 Monthly Acuity Review (Nov 22) – Pg 71
BM/23/03/46 – Learning from Deaths Report Q3 2023 – Pg 95
BM/23/03/47 – Changes to Enhanced Monitoring Status (GMC) – Pg 108

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/41 - BM/23/03/47**	
SUBJECT:	**Supplementary Papers**	
DATE OF MEETING:	29 March 2023	
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.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In following best NHS corporate governance practice, and to support WHHs commitment to openness and transparency, the papers listed below are provided as supplementary papers for the Trust Board meeting 29th March 2023. No actions are required from the Trust Board – they are provided for information only. The papers provided are: • **BM/23/03/41 Digital Strategy Group Report** – presented at Finance & Sustainability Committee 22.02.23 & 22.03.23 • **BM/23/03/42 Guardian of Safe Working Q3** – presented at Strategic People Committee 22.02.23 • **BM/23/03/43 Learning from Experience Summary Report Q3** - presented at Quality Assurance Committee 22.02.23 • **BM/23/03/44 Directors of Infection Prevention and Control (DIPC) Quarterly Report Q3** – presented at Quality Assurance Committee 07.02.23 • **BM/23/03/45 Safe Nurse Staffing Report; 6 Monthly Acuity Review** – presented at Quality Assurance Committee 07.02.23 • **BM/23/03/46 Mortality Review (Learning from Deaths Quarterly Report Q3** – presented at Quality Assurance Committee 07.03.23 • **BM/23/03/47 Changes to Enhanced Monitoring Status – General Medical Council** – presented at Council of Governors 16.02.23	

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the supplementary papers provided for information.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Multiple Committees, as listed above		

	Agenda Ref.	As listed above
	Date of meeting	See above
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/23/02/35**
SUBJECT:	**Digital Strategy Group (DSG) - monthly update**
DATE OF MEETING:	22nd February 2023
AUTHOR(S):	Tom Poulter, Chief Information Officer
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVES:	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experiencece.
EXECUTIVE SUMMARY:	The Digital Strategy Group (DSG) met on 13th February 2023. This report provides a summary of the updates received from the new DSG feeder groups, providing the following assurance status for key delivery areas: • **Digital Transformation Highlight Report** Moderate Assurance • **Digital Service Delivery Highlight Report** Moderate Assurance • **Digital Care Highlight Report** Moderate Assurance • **Digital Analytics Highlight Report** Moderate Assurance • **EPCMS Procurement Highlight Report** Moderate Assurance **Items for escalation to Finance and Sustainability Committee** (for information only): • Digital Strategy refresh – next steps • National/ICS profiling of Frontline Digitisation funding for EPCMS (addressed via separate FSC item) • Regional cyber security developments (Deloitte SOC) • Badgernet MIAA report (to be reported to QAC) • Digital Diagnostics programme & ICnet development • National Digital Maturity Assessment (DMA) • Regional radiology system (CRIS) 12 hour planned outage • Digital capital plan challenges due to CISCO supply chain issues (being managed via Capital Planning Group) • Microsoft 365 national licencing renewal Minutes of the Digital Strategy Group meeting are attached as Appendix A to this report for reference.

PURPOSE: (please select as appropriate)	Information	Approval	To note	Decision
	X			
RECOMMENDATION:	The FSC is asked to note the contents of the report, including assurance levels.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests	

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Digital Strategy Group HLB	AGENDA REF	FSC/23/02/35

1. BACKGROUND/CONTEXT

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

2. KEY ELEMENTS

WHH Digital Strategy Refresh

- Feedback has been received on the working draft of the Digital Strategy, and it will be updated to reference our Commitment to Digital Inclusion (includes technology/networks and also a wide range of patients' needs and abilities while maintaining equality and access to services for those who do not/will not have access to technology), and the Digital enablement of productivity, restoration and recovery, focusing on development areas in CBUs.
- Consultancy support is due to be awarded imminently using the Seed funding for Business case/Strategy development. The strategy is due for completion in line with the Trust enabling strategies refresh Programme, approximately April/May 2023, culminating in "Digital Week".

Digital Transformation Delivery Highlight Report (Moderate Assurance)

- The team have worked on CDC forms in Lorenzo and ICE referrals to support PIFU and Frailty Virtual Wards and are working on complex optimisation for ITU, eDNAR and DASH risk assessment
- Request for Change from Pharmacy to pause testing to ePMA part 4 approved at DTDG
- Deep dive into Paper/Print review to take place and recommendation to be brought to Execs in March. EPR team to shadow areas and digitise processes, to contribute to EPCMS readiness.
- CRIS datacentre onboarding of Mid Cheshire scheduled for April 23, 12 hour outage is being challenged with the vendor at a regional level
- PACS re-procurement underway, contracts are signed and the regional team have begun planning
- Meeting with Clinisys to discuss single ICE instance to understand impact on EPCMS. Planned patch for v7 is to be agreed, and discussions ongoing around v8 upgrade (end of life software) – CPG has approved budget
- Cloud DR (Disaster Recovery) project being developed, premarket engagement has been kicked off
- Phase 2 CISCO – supply issue may impact delivery dates for switches, a plan is in place with CPG
- Patient Entertainment premarket engagement ongoing – current supplier requires 12 months' notice to terminate (28th March 2023) procurement are negotiating the terms. No funding is

secured at present. Decision to be made regarding Patient Meal Ordering – tactical solution or as part of Entertainment supplier offering.

Digital Service Delivery Highlight Report (Moderate Assurance)

- Progress being made on Power BI dashboard for Service Desk ticket overview - 70 % of tickets are service requests, 30% are incidents, aiming to develop self service
- CBU engagement ongoing to develop SLA agreement and service catalogue. Aim to complete for 1st April 2023 to launch alongside Digital Strategy and GMWHH updates
- Change Advisory Group process has been refined, overseeing all changes to systems/downtime.
- Cheshire and Merseyside Digital and Data Strategy development designing a security operations centre, with consultancy from Deloittes.
- BadgerNet Vendor management commences Feb 2023 – received notice that Clevermed have been acquired by System C, awaiting further information on impact to WHH
- Microsoft Shared tenancy is coming to an end, potential additional costs for national licensing deal – deep dive on usage to take place.

Digital Care Delivery Highlight Report (Moderate Assurance)

- ICNet - no funded business case. Options appraisal indicates preference to share StHK instance.
- Badgernet - Planned developments for phase 2 were presented to DCDG - seamless integration from Lorenzo to Badgernet in regard to ePMA discharge medication and clerking; and access to ICE for requests and results through Badgernet
- MIAA Critical Application Review was presented at DCDG, a number of high risk recommendations which are being worked on and will be presented in March.
- Local developments for improving referral, elective c-sections and induction of labour diaries, auto blood result integration.
- BMJ App, assisting in clinical decision support – to be taken to Solution Design Group for development
- eMed3 Fit Note – possibility of CDC form within Lorenzo – to be taken to Solution Design Group for development
- Regional Endoscopy - Received MoU for AI Polyps, further due diligence before Finance sign MoU
- DCDG have supported deferring ITU CDC form to Q1 to avoid winter pressure, supported deferring Specialist Palliative Care CDC form to Q4, and rejected additional colours to support RRT/red to green- further work to take place with Patient Flow team

Digital Analytics Highlight Report (Moderate Assurance)

- Deliverables completed include Interfaces with Badgernet/new dashboard, RTT 78 week report, Military Veterans dashboard, National Audit of Dementia, Clinical Notes report
- 2x band 7 posts filled internally, recruiting to back fill 2x band 6 posts
- Digital Analytics request form went live, picking up themes of work and capacity analysis
- Currently mapping external reporting outside of Digital Analytics team – verification of data provided and ensuring good data quality – good response received from CBUs and Departments
- SharePoint/Intranet and Trust Website developments ongoing

EPCMS Procurement Highlight Report (Moderate Assurance)

- OBC v3 scheduled at Trust Board 1st March with Exec support. Non-exec meetings 13/14th Feb.
- Partnership proposal is ongoing, MoU has been approved by WHH execs in January and is going through partner execs in February 2023.
- Developing joint plan to align with PBC and procurement launch plan, regular meetings are in place.
- Further information on implication of Frontline Digitisation funding cuts, restrictions on ICBs moving money around to facilitate timetabling has been highlighted, ICB letter of support is yet to be obtained

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Digital Strategy Group would like to highlight the following items the attention of FSC, but for information only :

- Digital Strategy refresh – next steps
- National/ICS profiling of Frontline Digitisation funding for EPCMS (addressed via separate FSC item)
- Regional cyber security developments (Deloitte SOC)
- Badgernet MIAA report (to be reported to QAC)
- Digital Diagnostics programme & ICnet development
- National Digital Maturity Assessment (DMA)
- Regional radiology system (CRIS) 12 hour planned outage
- Digital capital plan challenges due to CISCO supply chain issues (being managed via Capital Planning Group)
- Microsoft 365 national licencing renewal

4. RECOMMENDATIONS

The FSC is asked to note the contents of the report, including internally assessed assurance levels.

Appendix 1 – Minutes of Digital Strategy Group

DIGITAL STRATEGY GROUP
Minutes of the Meeting: Monday 13th February 2023 13:30-15:30
Microsoft Teams Meeting

Attendees:

Paul	Fitzsimmons	Executive Medical Director	PF
Tom	Poulter	Chief Information Officer	TP
Sue	Caisley	Deputy Chief Information Officer	SC
Emma	O'Brien	Head of Programmes and ePR	EOB
Sharon	Kilkenny	Associate Director – Unplanned Care	SK
Alison	Jordan	Associate Director of Information	AJ
Elaine	Czarnecki-Wilson	ITPMO Support (minutes)	ECW

Apologies:

Kelly	Jones	Head of Strategy and Partnerships	KJ
Kimberley	Salmon-Jamieson	Director of Nursing - Chief Nurse	KSJ
Lucy	Gardner	Director of Strategy & Partnerships	LG
Zoe	Harris	Director of Operations and Performance, Deputy COO	ZH
Andrea	McGee	Chief Finance Officer	AMG

Agenda items.	Action
WHHFT/DSG/1 - Introductions and Apologies Apologies noted above.	
WHHFT/DSG/2 - Notes of Previous Meeting All agreed as accurate. **Action Log:** DSG03- part of wider strategy refresh, to be discussed as part of agenda item – timetable to be scheduled for board engagement session – on track DSG17- TP to share, also item to go to QAC (SC/TP/EO to take paper) – paper went to DCDG to review management responses, action log shared - complete DSG19- TP/AJ have discussed at joint SLT. Reporting of Digital Analytics programmes has also been discussed, next month, highlight report template will be used form March onwards. Projects being supported by DA will be included in Digital Services highlight report to avoid duplication and DA report will cover anything else being covered DSG20- On track DSG21- complete DSG23- complete DSG24- complete DSG25– complete DSG26- complete DSG27- complete DSG28- complete DSG29- Staff comms will be scheduled for April 2023	
WHHFT/DSG/3 - WHH Digital Strategy update TP gave a verbal update to the group Summary was presented to FSC in January 2023, feedback was received from committee members, including: • Discussion about Digital Inclusion – the importance of reflecting this in the strategy – further reference to our Commitment to Digital Inclusion, not just access to technology or	

networks, includes a wide range of characteristics including patients' needs and abilities, will also need to maintain equality and access to services for those who do not or will not have access to technology.
- Patient representation is required, TP will link in with Patient Experience team to devise approach for this
- Discussion around importance of Digital enablement of productivity, restoration and recovery. Meeting with Dan Moore to explore in further detail for CBU priorities and specific areas for development and focus.

The updated Digital Strategy slides will feature this feedback. Consultancy support is due to be awarded imminently using the Seed funding for Business case/Strategy development. The digital portfolio and sub strategies that underpin the Strategy will be developed for the Trust and also to link into the Place and ICS strategies. The refresh process needs to align with the Trust Strategy refresh Programme, which is estimated to be around April/May 2023, culminating in the Digital Week.

WHHFT/DSG/4 – Strategic Programme Updates

No Strategy Colleagues were present at the meeting to update.

WHHFT/DSG/5 - Digital Transformation Delivery Highlight Report

SC presented the slides.

Paperless care

Clinical optimisation will be covered under the DCDG highlight report for the next meeting.
- Developed 5x CDC forms to support PIFU and Frailty Virtual Wards
- Created 3x ICE referral forms
- Upgrades to eOutcome iPad applications
- Working on complex optimisation for ITU, eDNAR, DASH risk assessment
- Request for Change from Pharmacy to pause testing to ePMA part 4 approved at DTDG
- Continuing Paper and Print review – further discovery work has taken place, a deeper review of the programme is due to be completed and a mandate/recommendation will be brought next month to Execs. Business cases are going through Finance to pay for various department's overspends to Synertec. There is support for streamlining and standardisation of the existing patient communication processes from Dan Moore and Zoe Harris. Workstream factfinding is still ongoing, the ePR team will shadow areas and gather information to be digitised, which will also contribute to the EPCMS readiness activity.

Digital Diagnostics
- Radiology
  - CRIS Datacentre moved on 4th Jan, Mid Cheshire are due to onboard in April 2023, which involves a 12 hour outage – this is being challenged and will need approval at Event Planning Group
  - PACS re-procurement – new contract signed, kick off meeting is arranged to plan the projects, being managed by regional teams
- Pathology
  - Awaiting meeting with Clinisys to discuss single ICE instance, WHH have the option to join – need to understand the commercials in regard to EPCMS
  - Planned patch to ICE v 7 is still to be agreed and v8 options are being discussed – CPG has approved budget

Digital Infrastructure
- Supported go lives of Halton Hub, Switchboard ARC upgrade, McAfee upgrade & CRIS Migration
- All projects on track for Q4. Phase 2 CISCO supply issue may impact delivery dates, plan in place with CPG.

- Continuing to develop Cloud DR project for 23/24, premarket engagement has been kicked off, this replaces the cancelled Halton SAN project.

EPCMS

- OBC v 3 is scheduled to go to Trust Board on 1st March, Execs were supportive last week. Non-exec meetings 13/14th Feb.
- Partnership proposal is ongoing, MoU has been approved by WHH execs in January and is going through partner execs in February 2023.
- Developing joint plan to align with OBC and procurement launch plan, regular meetings are in place.
- Need to investigate implication of Frontline Digitisation funding cuts, there are restrictions on ICBs moving money around to facilitate timetabling, ICB letter of support is yet to be obtained

Patient Entertainment

- Current Hospedia contract ends March 2024, premarket engagement ongoing. Draft engagement plan, digital leading on project group with attendance from Patient Experience, Procurement and Estates. 12 months' notice to terminate the contract, procurement are currently negotiating – notice would be required 28th March 2023. No funding secured at the moment. Decision to be made for Patient Meal Ordering, tactical standalone solution could be used, Morecambe Bay solution is being demoed.

Recommendation/Escalation:

- Online Forms Pilot – little information available from NHSE, WHH to make decision whether to continue with pilot – meeting in Feb 2023.
- Transitioning the Clinical Optimisation to DCDG – DSG agree
- Potential delays to CISCO, under management at CPG
- Cancellation of Halton SAN project, exploring Cloud DR
- RfC for ePMA 4 testing pause
- Share prioritisation matrix at DCDG in March
- CRIS data move 12 hour downtime
- Patient experience tactical solution
- OBC v3 scheduled for approval by WHH trust board on 1st March 2023

WHHFT/DSG/6 - Digital Service Delivery Highlight Report

TP presented the slides

Digital Services activity

- Good progress made in recent weeks developing dashboard using Power BI giving an overview of tickets raised in each monthly period. Good understanding of categorisation of incidents/service requests, summary numbers of activity are shown on the slides. 70 % of tickets are service requests, 30% are incidents. The aim is to make more service requests self-service, to reduce call waiting times and abandonment rate.

CBU level activity

- CBU representation is encouraged at the meetings, detailed themes and reporting can be provided to ensure our resources are being used to best meet their needs. Availability and Capacity are to be introduced for Business Critical systems, and the list is to be discussed and finalised at the next meeting.
- Working towards advertising SLA levels to the Trust, engagement with CBUs to develop and sign off document/service catalogue is ongoing, aiming to complete 1st April 2023 to be launched alongside the new digital Strategy – AJ recommended a week of GMWHH updates.

CAG updates

- Oversees all changes to live environment, process has been developed and refined. The IT Change policy is to be fully signed off and supported to implement changes to any systems, to provide assurance.
- Place and Regional change management is to be linked, challenges for coordinating downtime and shared systems/services

Open RCAs

- Tracking actions related to specific outages, no significant items to be raised at this meeting, a dashboard and process is being developed.

Cyber Security

- Details for various reporting metrics and scores are included on the slide.
- Cheshire and Merseyside regional development as part of the Digital and Data Strategy to design a security operations centre, which will involve consultancy activity run by Deloittes to develop a proposal and business case.

Vendor Management

- Processes are being applied to other business critical systems, including Dedalus, Clinisys and Fraxinus
- Microsoft 365 shared tenancy is coming to an end, expressions of interest in nationally agreed Licencing deal, potential for additional costs, deep dive review on Microsoft Vendor Management area is scheduled, including licence usage and allocation.
- Badgernet Vendor management commences Feb 2023 – we have also received notice that Clevermed has been acquired by System C. Implications are to be assessed when further information is available.

Recommendation/Escalation:

- Open RCAs
- ISDN Accreditation
- ORMIS fix under testing
- Information Governance Training
- 12 hour outage
- ICE upgrade
- Regional development around Cyber security

WHHFT/DSG/7 - Digital Care Delivery Highlight Report

Presented the slides

Digital Maternity update

- Planned developments for phase 2 of Badgernet were presented to DCDG - seamless integration from Lorenzo to Badgernet in regard to ePMA discharge medication and clerking; and access to ICE for requests and results through Badgernet
- MIAA Critical Application Review was presented at DCDG, a number of high risk recommendations which are being worked on and will be presented in March.
- Local developments for improving referral, elective c-sections and induction of labour diaries, auto blood result integration.

ICNet development – Lesley and Zaman to attend DCDG to update on requirement for Clinical Surveillance system, no funded business case. Options appraisal indicates preference to share StHK instance.

Items for Prioritisation, both seen by the DCDG group as worthwhile investment: • BMJ App, assisting in clinical decision support – Dr Wai took an action to understand what we have available at WHH already, the app should be available within a CDC form within Lorenzo, and is being taken to Solutions Design Group for further work • eMed3 Fit Note – possibility of CDC form within Lorenzo, and is being taken to Solutions Design Group for further work Both need clinical leads/SRO to be decided at DCDG Regional Endoscopy • Received an MoU for AI Polyps. • Further due diligence to be completed, to provide assurance before Finance sign MoU. Recommendation/Escalation: • DCDG have supported deferring ITU CDC form to Q1 to avoid winter pressure • DCDG have supported deferring Specialist Palliative Care CDC form to Q4– new form issued by ICB • Additional colours to support RRT and red to green – rejected by DCDG, information should be used that is already available – a report was suggested and further work is underway with Patient Flow Team • MIAA Critical Application Review to FSC and formal summary to QAC	
WHHFT/DSG/8 - Digital Analytics Highlight Report Deliverables completed in January 2023: • Interfaces with Badgernet – new dashboard created • RTT 78 week report has been completed • Military Veterans dashboard now completed • National Audit of Dementia • Clinical Notes report, in support of paper review Delivery plan 22/23: • 2x Senior Analysts band 7 posts have been filled by internal promotion, 2x band 6 posts being back filled • Digital works request form went live – helping to see how capacity is being used, picking up themes of work and signposting . • Used GMWHH process, lots of feedback • Currently working on mapping external reporting outside of Digital Analytics team – verification of data provided and ensuring good data quality – good response received from CBUs and Departments • Highlight reports will be used for Integration and Reporting from March 2023 • SharePoint/Intranet and Trust Website developments ongoing • AI developments – National NHS AI Lab currently piloting different technologies and specialties, ICB will have a workstream – **Chris and Alison attend C&M information leads and will query at this meeting**	
WHHFT/DSG/9 - EPCMS Delivery Highlight Report As covered in Transformation update. Lorenzo business case – 1 year extension to go through March's governance.	

WHHFT/DSG/10 – Any Other Business

NHS Mail authentication has changed, Service Desk should be aware. Issues with NHSmail on mobile phones

Action: TP to follow up and communicate self service fix.

Action: Review Bring Your Own Device (BYOD) policy - TP

Items for escalation to Finance and Sustainability Committee

- Strategy refresh – consultancy support
- National/ICS scheduling of Frontline Digitisation funding for EPCMS
- Regional cyber security developments
- Badgernet MIAA report assurances
- ICNet development
- Microsoft 365 renewal
- CRIS 12 hour outage
- Review of Digital Capital Plan and year end issues

Date and Time of Next Meeting: Monday 13th March 2023 13:30-15:30

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/23/03/55**
SUBJECT:	**Digital Strategy Group (DSG) update**
DATE OF MEETING:	22nd March 2023
AUTHOR(S):	Tom Poulter, Chief Information Officer
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVES:	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experiencece.
EXECUTIVE SUMMARY:	The Digital Strategy Group (DSG) met on 13th March 2023. This report provides a summary of the updates received from the new DSG feeder groups, providing the following assurance status for key delivery areas: • **Digital Transformation Highlight Report** Moderate Assurance • **Digital Service Delivery Highlight Report** Moderate Assurance • **Digital Care Highlight Report** Moderate Assurance • **Digital Analytics Highlight Report** Moderate Assurance **Items for escalation to Finance and Sustainability Committee** (for information only): • Patient meal ordering/Patient Entertainment approach • EPR Procurement Partnership timetable • Lorenzo extension Business Case Minutes of the Digital Strategy Group meeting are attached as Appendix A to this report for reference.

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

RECOMMENDATION:	The FSC is asked to note the contents of the report, including assurance levels.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests	

SUBJECT	Digital Strategy Group update	AGENDA REF	FSC/23/03/55

1. BACKGROUND/CONTEXT

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

2. KEY ELEMENTS

Channel 3 Consulting – Digital Strategy

- Seed fund monies were received for the Digital Strategy refresh activities that Channel 3 are assisting to develop. This will be for WHH and at Place level, with work ongoing with Strategy representatives from each area.
- Channel 3 will be carrying out the Digital Strategy refresh project in 3 stages:
    - Stage 1 - Digital Strategy
        - Review – content of existing strategy, how it sits within and aligns to Corporate, ICS and NHS strategies.
        - Engagement – carry out interactive feedback sessions with clinical audiences and 1-1 meetings with key stakeholders to understand issues/concerns.
        - Recommendations – present alterations/guidance to update current strategy, prioritised to meet the Trust obligations and long-term objectives.
        - Plan & Benefits – scope and develop the sub-strategy business cases, funding requests and Programme Plan for the delivery of the projects to support the Strategy and deliver Benefits.
    - Stage 2 - Sub-Strategies and Benefits
    - Stage 3 - Programme Plan
- Channel 3 are currently building the timeline and confirming scope of work at project initiation stage, talking to key stakeholders, developing high level milestone plan and technical baseline across all system. Non-Executive Directors and chairs of committees will also be engaged.
- The Digital Strategy will have a clear alignment with the key aims of the overall WHH Trust strategy and align to the timetable for Trust wide Strategy refresh, the Digital Clinical Safety Strategy, ICS Strategy, and Quality Strategy. The Priorities should align with the QPS Framework and Sub-strategies will be positioned to be clear and robust.

Patient Entertainment

- A meeting is scheduled to take place with the Executive team, where an options paper will be presented for review.
- Under the current rolling Hospedia contract, Bring Your Own Device is not allowed – new contract wording will allow this. The main requirement is a WiFi network which can handle multiple streaming devices without impacting on our clinical systems. Technical due diligence to take place to allow robust solution to be taken forward.
- Any funding requests will be in 24/25 capital/revenue plan. 12 months' notice to be given 31st March 2023 to start new contract 2024. Project group meets regularly with clinical representation and opportunities to lay foundations for network capacity during current works are ongoing with network upgrades in current capital year.
- Patient eMeal ordering is being taken as a separate development due to the timescales. The system will interface with Lorenzo and be procured separately.

Digital Transformation Delivery Highlight Report (Moderate Assurance)

- Prioritisation took place at Digital Care Delivery Group aligned with What Good Looks Like/HiMMS/QPS
- DrDoctor solution has been chosen by NHSE for Online Forms pilot.
- Digital Services are supporting Junior Doctor Strikes, drop ins last week and floorwalkers this week.
- Preparing a paper for Trust wide paper and print review – ePR team working to understand paper heavy areas to digitise and harmonise patient letters.
- Prioritised using the matrix during DCDG – identified 3 Must projects: deteriorating patients, outpatient prescribing and Sepsis pathway patient ward. Patient Information Ward Boards have been paused (nice to have). Patient Entertainment and meal ordering are awaiting further information before prioritisation
- Capital for 22/23 will be spent within plan, delivery slippage for Cisco project but FRG agreed vesting agreement for switches.
- 23/24 infrastructure project high level plan is being worked on for finance profiling
- Presentation from WBC Living Well Starting Well Staying Well, joint plan due end March, which will align to ICB strategy. Virtual Wards GP referrals goes live mid March.

Digital Service Delivery Highlight Report (Moderate Assurance)

- Dashboards are now available which can be drilled down at Care Group and CBU level to understand the data. Clinical Support Services places the highest demand on Digital Services, this covers Pathology, Radiology etc. which allows further investigation on issues with infrastructure or systems.
- CAG new policy and reporting process has been established, a comprehensive report is now produced to cover infrastructure and system changes. Comms are being prepared to explain that all systems should go through the IT Change Enablement policy.
- Cyber Security regional development - Deloittes are consulting on a security operations centre at Cheshire & Merseyside Regional level, an options appraisal is being prepared. An enhanced level cyber security monitoring team (pooling of resources) will oversee the regional security risks.
- Business Critical Systems list is being finalised, this is mandated as part of the DTAC framework to cover Information Governance, Security and Vendor Management.
- Vendor Management routine meetings are taking place for Service reviews and outstanding issues.

Digital Care Delivery Highlight Report (Moderate Assurance)

- Prioritisation
- Clinical Transformation/Optimisation Go lives:
  - CDC form and configurations; Pharmacy scannable patient barcodes and ED Ward round form changes to support CQUINs
  - OneResponse integration with Lorenzo to add ambulance patients to ED expected patient lists
  - Palliative care CDC form, Tissue Donation form
- Badgernet – critical application review has been reported to DSG and Audit Committee, now to be presented to QAC in preparation for CQC inspection.

Digital Analytics Highlight Report (Moderate Assurance)

- Smartsheets now reporting overhead of effort (slide 3 & 4) - development vs. reporting to NHS E/I
- Can now show granular detail of different tasks received through Digital Analytics Request to demonstrate how the team are spending their time.
- Observation that almost 50% time spent on statutory reports. Amending reporting also taking a lot of team's time – can a self-service platform assist this?
- Draft plan for 23/24 details signposting people to self-service, and also developing automation.
- Regular meetings take place between Digital Analytics and Digital Services to ensure alignment of workstreams.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Digital Strategy Group would like to highlight the following items the attention of FSC, but for information only :

- Patient meal ordering/Patient Entertainment approach
- EPCMS
- Lorenzo extension Business Case

4. RECOMMENDATIONS

The FSC is asked to note the contents of the report, including internally assessed assurance levels.

Appendix 1

DIGITAL STRATEGY GROUP
Minutes of the Meeting: Monday 13th March 2023 13:30-15:30
Microsoft Teams Meeting

Attendees:

Tom	Poulter	Chief Information Officer [Chair]	TP
Sue	Caisley	Deputy Chief Information Officer	SC
Emma	O'Brien	Head of Programmes and ePR	EOB
Alison	Jordan	Associate Director of Information	AJ
Elaine	Czarnecki-Wilson	ITPMO Support (minutes)	ECW
Kelly	Jones	Head of Strategy and Partnerships	KJ
Andrea	McGee	Chief Finance Officer	AMG
Paula	Wright	Chief Nursing Information Officer	PW

In attendance:

Steph	Morgan	Strategy Consultant [Channel 3 Consulting]	SM
Kevin	Willans	Strategy Consultant [Channel 3 Consulting]	KW
Becky	Warnes	Strategy Consultant [Channel 3 Consulting]	BW

Apologies:

Paul	Fitzsimmons	Executive Medical Director	PF
Kimberley	Salmon-Jamieson	Director of Nursing - Chief Nurse	KSJ
Lucy	Gardner	Director of Strategy & Partnerships	LG

WHHFT/DSG/4 - Patient Entertainment Options Paper (For Approval) SC meeting PF and KSJ this week. SC gave a verbal update on the current offering being provided by Hospedia that is patient funded – average length of stay costs for 1 week stay are £55. Plan to present options to execs: 1. Do nothing. 2. Continue with WifiSpark and also offer BYOD (require monitoring for inappropriate sites etc. and Wi-Fi upgrade) and negotiate £1 per day for those who cannot bring their own device – supports digital inclusion. 3. Full procurement- replace all devices £800,000 - £1,000,000. Paper will be shared for comments once meeting with execs has taken place. AMG shared a personal experience of using streaming services while visiting a relative at another hospital. Current rolling Hospedia contract states BYOD not allowed – new contract will allow this. Main requirement is WiFi network which can handle multiple streaming devices without impacting on our clinical systems. Technical due diligence to take place to allow robust solution to be taken forward. SC confirmed that the funding will be in 24/25 plan. 12 months' notice to be given 31st March 2023 to start new contract 2024. Project group meets regularly with clinical representation. TP added that opportunities to lay foundations for network capacity during current works are ongoing with network upgrades in current capital year. Patient engagement platforms and Patient Held Records are in development at ICS level. The Patient eMeal ordering is being taken as a separate development due to the timescales. The system will interface with Lorenzo and be procured separately.	
WHHFT/DSG/5 – Strategic Programme Updates Main focus is on alignment of Digital Priorities to WHH Trust Strategy refresh. **Action: KJ will share the highlight report with the group with key digital points to be highlighted.** TP/SC/KJ met to discuss objectives aligned to QPS – Digital mainly sits in Sustainability – reference to alignment and interspersed throughout rest of strategy for Digital work programmes that align to People and Quality	

objectives. Draft Trust Strategy is going to Board for comments today and will then be sent for review by Digital Services.

WHHFT/DSG/6 - Digital Transformation Delivery Highlight Report

SC presented the slides.

Paperless care

- Prioritisation took place at Digital Care Delivery Group aligned with What Good Looks Like/HiMMS and QPS
- Advised that DrDoctor solution has been chosen by NHSE for Online Forms pilot.
- Supporting Junior Doctor Strikes, drop ins last week and floorwalkers this week.
- Preparing a paper for Trust wide paper and print review, coming to April's group for approval – ePR team understanding paper heavy areas to digitise and harmonise patient letters. Scope of issues and processes is wide-ranging and links to other developments - initiation was through FRG as part of CIP programme, strategic developments as part of ongoing sustainability workstreams – need to calculate possible savings and identify budget holders. Need to specify realistic and achievable financial savings and update following the process mapping work ongoing. 5% efficiency programme without impact on quality for 23/24. TP discussed with DM and ZH to discuss support for workstreams reconfigure budgets for patient correspondence etc.
- Prioritised using the matrix during DCDG – identified 3 Must projects: deteriorating patients, outpatient prescribing and Sepsis pathway patient ward. Patient Information Ward Boards have been paused (nice to have). Patient Entertainment and meal ordering are awaiting further information before prioritsation.

Digital Infrastructure

- Completed Comms cabinet phase 3
- Capital to be spent within plan, delivery slippage but doesn't affect funding.
- Cisco phase 2, FRG agreed to vesting agreement for switches.
- 23/24 projects – high level plan will be presented to Infrastructure group and then this group to support finance profiling.

Integration

- A number of projects have been completed, connecting test systems to improve deployment. Working on:
    - Live messaging for NWAS
    - Somerset Cancer integration
    - Phlebotomy app integration
    - Phase 2 of BadgerNet – ePrescribing and ICE link

Action: Technical terms to be simplified for future reports

EPCMS

Partnership meetings ongoing with StHK and S&O, NHS E/I. WHH OBC approved 1st March to go through Fundamental Criteria review, 200+ questions expected. Received caveated ICB letter of support, working through finance queries, and business case to extend Lorenzo to November 2025.

S&O, LUHFT, STHK, and WHH met with Karen Smith and Paul Swanwick, described phasing of finances. Preferred option to ask for 1 year extension, or allowance to facilitate local capital moves within ICB – AMG highlighted unsupported system and convergence policy setting WHH procurement back. TP/SC to follow up with John Llewellyn

Warrington Together

Presentation from WBC Living Well Starting Well Staying Well, joint plan due end March, which will align to ICB strategy. Virtual Wards GP referrals goes live mid March.
Consultancy for Digital Strategy complete and awarded to Channel 3

Transformation programme updates

• Work on unplanned care – SDEC move/Fracture Clinic, Renal beds on ITU, Patient Flow collaborating with Morecambe Bay dashboards. • Updating NWAS collaboration to reduce ambulance handover. • ED ambulatory patients moving to ED locations. • Discharge improvement T&F creating information packs for wards including documentation and QRGs Escalation: • Patient Meal ordering to be procured as standalone • Note Digital work for Doctors Strike – Floorwalkers and Drop-in sessions • EPCMS Partnership OBC and governance need to be aligned with StHK and S&O • ICB letter of support provided with finance conditions for OBC	
WHHFT/DSG/7 - Digital Service Delivery Highlight Report Digital Services activity Dashboards are now available to present at the meeting which can be drilled down at Care Group and CBU level to understand the data. Clinical Support Services places the highest demand on Digital Services, this covers Pathology, Radiology etc. which allows further investigation on issues with infrastructure or systems. CAG updates A new policy and reporting process has been established, a comprehensive report is now produced to cover infrastructure and system changes. Comms are being prepared to explain that all systems should go through the IT Change Enablement policy Cyber Security Regional development that Deloittes are consulting on a security operations centre at Cheshire & Merseyside Regional level, an options appraisal is being prepared. An enhanced level cyber security monitoring team (pooling of resources) will oversee the regional security risks. Business Critical Systems The list is being finalised, this is mandated as part of the DTAC framework to cover Information Governance, Security and Vendor Management. The list will be presented at the next DSG meeting. AMG added that a recent meeting took place that highlighted the size of spends on suppliers, it was discussed that this could inform procurements and spends across the ICS. It was discussed that insurance was being looked at to cover any outgoings incurred from downtime that may not be covered by SLA payments. The Business Critical list will be presented at the next DSDG meeting and the IAO role/processes will be reviewed. Vendor Management Receiving updates from IAOs to clarify that routine meetings are taking place for Service reviews and outstanding issues. Standardisation of the process will take place and a SOP will be written.	
WHHFT/DSG/8 - Digital Care Delivery Highlight Report Prioritisation items were discussed as part of the Transformation update. Clinical Transformation/Optimisation Go lives: • CDC form and configurations; Pharmacy scannable patient barcodes and ED Ward round form changes to support CQUINs • OneResponse integration with Lorenzo to add ambulance patients to ED expected patient lists • Palliative care CDC form, Tissue Donation form Badgernet – critical application review has been reported to DSG and Audit Committee, now to be presented to QAC in preparation for CQC inspection. **Action: Deep dive review to take place ahead of QAC, cross reference with CQC prep checklist.**	
WHHFT/DSG/9 - Digital Analytics Highlight Report • 8 deliverables achieved in Feb, 6 in train for March, 5 cancelled, 1 delayed (slide 5&6) • Smartsheets reporting overhead of effort (slide 3 & 4) - development vs. reporting to NHS E/I	

• Can now show granular detail of different tasks received through Digital Analytics Request Smartsheet. Can demonstrate how the team are spending their time. • Observation that almost 50% time spent on statutory reports. Amending reporting also taking a lot of team's time – can a self-service platform assist this? • Draft plan for 23/24 details signposting people to self-service, and also developing automation • TP/AJ to discuss infrastructure support for this • Microsoft licensing has been escalated – affects PowerBI • 22/23 workplan was shown on slide 8 • 23/24 plan has reviewed 22/23 plan, team has drafted deliverables which have been presented to exec directors. Final plan to be presented to Execs 12th April and DSG April • Regular meetings take place between Digital Analytics and Digital Services to ensure alignment of workstreams	
WHHFT/DSG/10 – Any Other Business none	
Items for escalation to Finance and Sustainability Committee • Patient meal ordering/Patient Entertainment - prioritisation • EPCMS • Lorenzo business case	
Date and Time of Next Meeting: Monday 10th April 2023 13:30-15:30	

STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	**SPC/23/02/22**
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined Report for Q3, 2022/23**
DATE OF MEETING:	22nd February 2023
ACTION REQUIRED:	**None**
AUTHOR(S):	Mrs Frances Oldfield, Guardian of Safe Working Hours
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE	SO1: We will … Always put our patients first delivering safe and effective care and an excellent patient experience.
EXECUTIVE SUMMARY:	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 3 (Oct 2022 – Dec 2022) 2022-23, 114 exception reports were submitted of which 2 were highlighted as an immediate safety concern. The majority 95 (83%) of exception reports relate to hours of working. 9 exception reports relate to missed educational opportunities and 10 exception reports submitted related to service support available to the doctor. The total number of exception reports for this quarter has reduced compared to Q2 but still remains above average (see chart 1).

PURPOSE: (please select as appropriate)	Information ✓	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**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(If relevant)***	None	

STRATEGIC PEOPLE COMMITTEE

SUBJECT	Guardian of Safe Working for Junior Doctors Quarterly Report – **Quarter 3 2022-23 (1st October – 31st Dec 2022)**	**AGENDA REF:**	**SPC/23/02/22**

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 trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues, Rota Managers, and the Guardian of Safe Working (GSW).

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

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

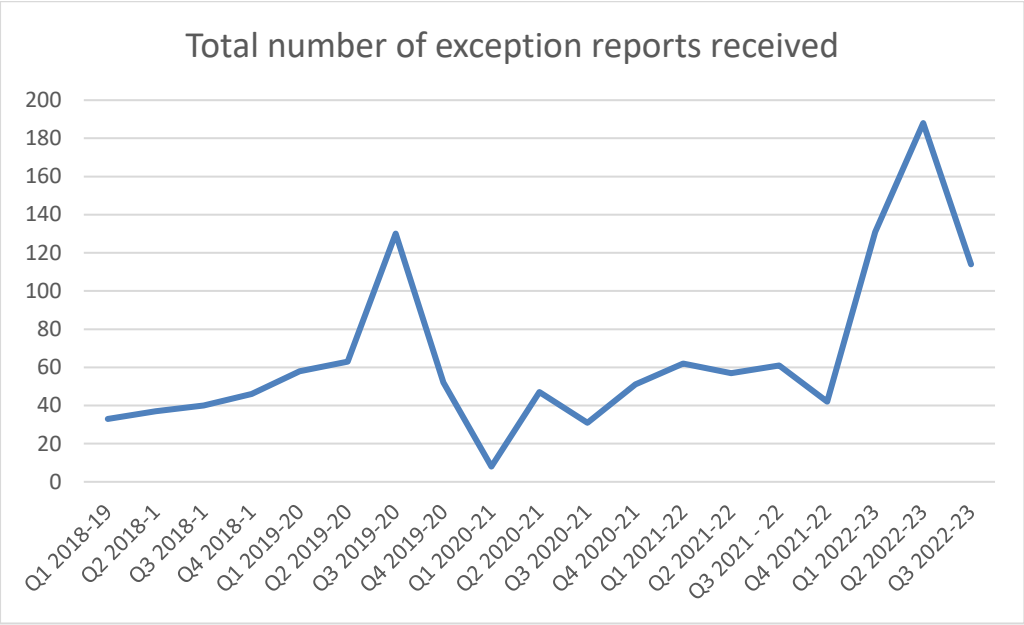
As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relating to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. KEY ELEMENTS

Exception Reporting (Oct – Dec 2022)

During Q3, 2022 - 2023, 114 exception reports (ERs) were submitted. This has reduced compared to Q2 but remains above average. As discussed in the Q2 report, it is hoped that increased junior doctor engagement and education with regards to the need for exception reporting, the number of ERs is likely to be higher than previous years.

Chart 1 below illustrates pre and post pandemic reporting trends:



Immediate Safety Concerns

Immediate safety concern ERs were submitted on 2 occasions during Q3.

The first ISC was submitted by a medical F1 doctor reporting problems faced on the first day of a new placement in medicine. The doctor felt unsupported and overwhelmed with the workload. Following further exploration by the doctor's educational supervisor it was established that there was a lack of communication regarding escalation pathways rather than there being lack of support. The GOSW met with the individual Junior Doctor to confirm that they were receiving adequate support and supervision. A follow up meeting to provide further assurance was scheduled and there are no ongoing concerns.

The second ISC was submitted by an F2 in T&O relating to a particularly difficult shift where a locum doctor was placed in the registrar post. There were problems with sickness, leaving gaps overnight and miscommunication led to the senior team appearing unavailable. This was quickly rectified, and the night registrar was called on-site but for a period of time the F2 doctor felt very unsupported. An action plan including a new SOP has been developed by the T&O department to deal with last minute absence as a result of this ISC exception report.

Themes for Q3 (Oct – Dec 2022)

For this quarter there has been no specific pattern of exception reporting. Reports have been from many specialties and grades of doctor. There are numerous rota gaps in all specialities, and this is impacting junior doctors across the board.

Fines

During Q3 the GSW identified several contractual breaches of the terms in the Junior Doctors Contract 2016. This has resulted in a fine being levied to the Clinical Business Unit responsible for Medicine on 30th Jan 2023. Two medical F1 Doctors had reported they were unable to take any contractual rest breaks during multiple night shifts. A fine applies if rest breaks are missed on 25% of occasions across a 4-week period and it was confirmed that this breach had occurred. Therefore, breaches relating to missed breaks resulted in a fine totalling ***£641.06*** which was calculated as x2 the relevant hourly rate. The GSW is responsible for the balance which must be used to benefit the education, training and working environment of trainees. The GSW should devise the allocation of funds in collaboration with the employer/host organisation junior doctors' forum, or equivalent.

At the most recent Junior Doctors Forum (JDF) the GSW highlighted the total of funds accrued as a result of GSW fines. To date none of these funds have been allocated. The GSW has therefore made it a priority action for the JDF reps to bring suggestion/plans for usage by the next forum. Money spent will be detailed in future reports.

Summary

- Number of exception reports raised = 114
- Number of work schedule reviews that have taken place = 5
- ERs flagged as immediate safety concerns = 2
- Fines that were levied by the Guardian = 1

Exception Reports (ER) over past quarter	
Reference period of report	01/10/22 - 31/12/22
Total number of exception reports received	114
Number relating to immediate patient safety issues	2
Number relating to hours of working	92
Number relating to pattern of work	3
Number relating to educational opportunities	9
Number relating to service support available to the doctor	10

***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.*

We continue to monitor any delays in signing off ERs and regular reminders are sent by the Medical Trainees Workforce Administrator. At the end of Q3 there were 55 unresolved ERs, and at the time of writing this report there were 66 unresolved ERs. The GSW and Medical Trainees Workforce Administrator will continue to monitor outstanding ERs and encourage continued engagement from both trainees and educational supervisors. To reinforce the sign off process a training session was held on the 6th of Feb 2023 for educational supervisors within the Trust. This was well attended, and feedback was extremely positive. Slides from the session were distributed for those that could not attend on the day.

The JDF meetings continue to be well attended and there is strong engagement between Junior Doctors' Representatives, the Chief Registrar, the Medical Education Manager and GSW.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

To continue to monitor fines levied by the GSW to ensure issues and concerns are addressed and any necessary remedial action is implemented.

4. MEASUREMENTS/EVALUATIONS

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	49
Total number of overtime payments	42
Total number of work schedule reviews	5
Total number of reports resulting in no action	3
Total number of organisation changes	1
Compensation	0
Unresolved	102
Total number of resolutions	**100**
Total resolved exceptions	**100**

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

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

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

5. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days. Alternatively, the ES can delegate this to the Clinical Supervisor if appropriate

4. The Junior Doctor needs to indicate their "acceptance" or "escalate" to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the MWA will review an issue an email to expedite sign-off in line with the new SOP for exception reporting.

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

6. MONITORING/REPORTING ROUTES

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

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

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

7. TIMELINES

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

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

8. ASSURANCE COMMITTEE (IF RELEVANT)

N/A

9. RECOMMENDATIONS

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

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/23/02/38**			
SUBJECT:	**Learning from Experience, Quarter 3 2022/23**			
DATE OF MEETING:	7th February 2023			
AUTHOR(S):	Layla Alani, Director Integrated Governance, Deputy Chief Nurse Nicola Edmondson, Associate Director of Governance Maresa Kelsall, Patient Safety Manager Medina Yassin, Head of Complaints, PALS & Legal Services			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EXECUTIVE SUMMARY	The Learning from Experience Report, Quarter 3, 2022/23 provides an overview of the Learning from Experience across the organisation. The information within the report is extracted from the Datix Risk Management Information System and other Clinical Governance reports in order to triangulate the data and learning from Incidents, Complaints, Claims, Health & Safety Clinical Audit, Quality Improvement and Research and Development related to Quarter 3, 2022/23.			
PURPOSE: (please select as appropriate)	Information	Approval	To note x	Decision
RECOMMENDATIONS:	The Quality Assurance Committee is asked to note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Learning from Experience, Quarter 3 2022/23	AGENDA REF:	QAC/23/02/38

1. BACKGROUND/CONTEXT

The Learning from Experience Report, Quarter 3, 2022/23 provides an overview of the Learning from Experience and relates to the period 1st October 2022 to 31st December 2022. It contains both quantitative and qualitative data analysis using information obtained from the Datix Risk Management Information System in order to triangulate the data and learning from incidents, complaints, claims, health & safety, clinical audit, Quality Improvement and Research and Development related to Quarter 2, 2022/23.

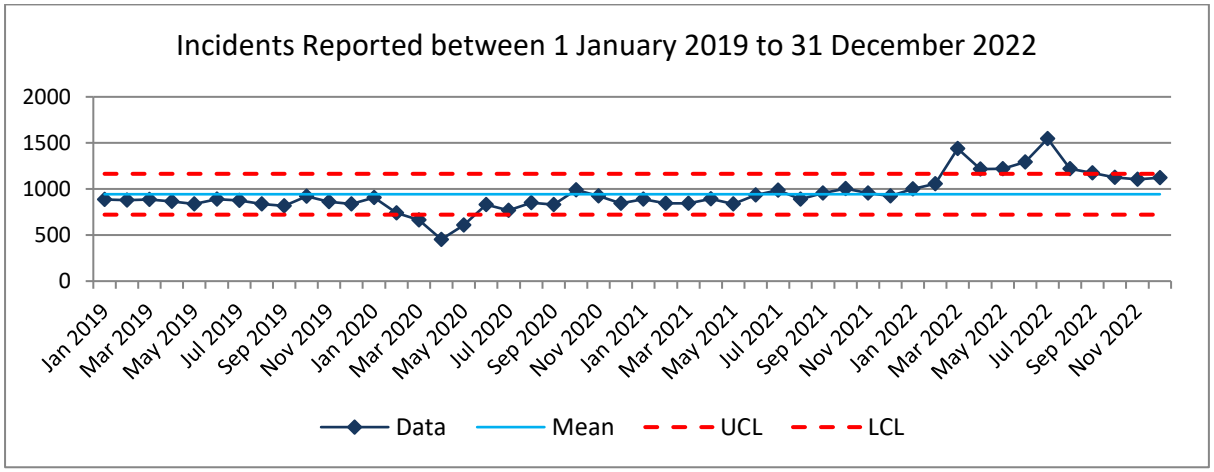
The report includes a summary of themes, trends and key findings identified in Quarter 3 with specific recommendations to support learning across the organisation.

2. KEY ELEMENTS

2.1 Incident Reporting Position across the Trust (Acute and Corporate Services)

In Quarter 3, a total of 3939 incidents were reported across the Trust. This shows that there was a 15% decrease in incident reporting (588 incidents) when compared to a total of 3351 incidents reported in Quarter 2. Urgent and Emergency Care accounts for a large proportion of the decrease in incidents reported which relates to the number of reported waits over 12 hours in the emergency department and this is elaborated on in more detail in the Incident Reporting Position per Clinical Business Unit (CBU) section. However, on calculating the variance in the total number of incidents across the Trust for Quarter 3, incident reporting remains within normal variance as shown in graph 1 below.

Graph 1



2.2 Incident Reporting Position per Clinical Business Unit (CBU)

In Quarter 3, a total of 3093 incidents were reported across the six CBUs and Clinical Support Services as shown in the graph 2 below. The incident profile relating to harm is detailed in Table 1. There is a marginal increase in the harm profile.

Graph 2

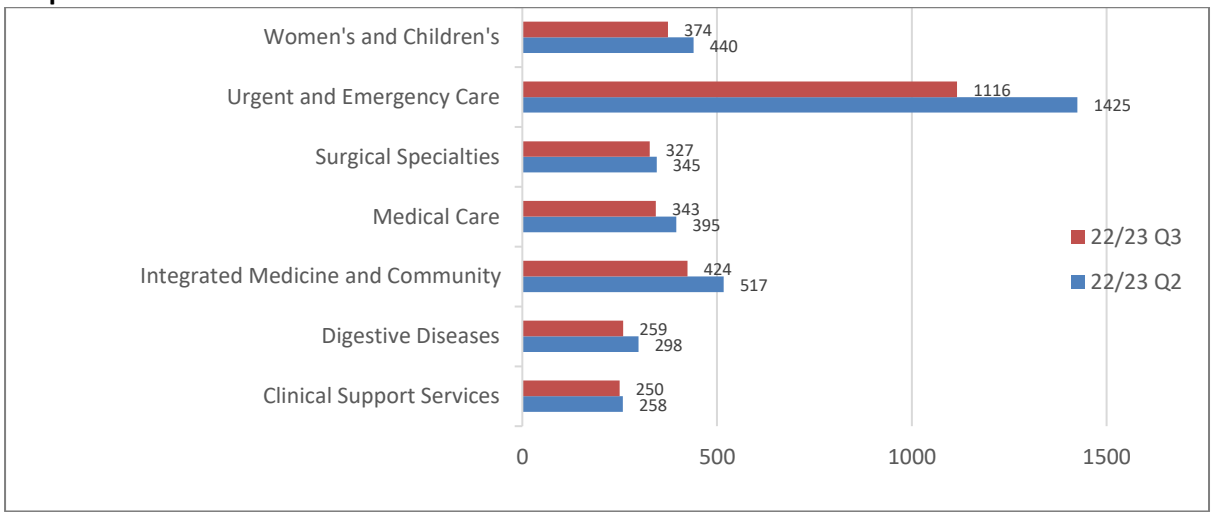


Table 1 -					
Severity	**Quarter 2**	**Quarter 3**	**% Increase**	**% Variance**	**Area**
Catastrophic	2	3	1 (50%)	⬆ 0.06%	• External • Theatre K25
Major	6	10	4 (67%)	⬆ 0.6%	1 since downgraded • Fall • Missed fracture ED • Cystoscopy delay
Moderate	44	49	5 (11%)	⬆ 0.8%	

In Quarter 3, the decrease in incident reporting mainly relates to ED as detailed in **graph 2** and has been in part contributed to by the cluster reporting of 12 hour breaches, these continue to be logged centrally as discussed with PLACE, with a 10% dip sample to provide assurance of no harms. All areas have reported a reduction in the number of incidents reported demonstrating some consistency across the Trust though this needs to be understood in broader terms in the coming weeks and months. Areas with significant reporting reduction are Urgent and Emergency Care, Integrated Medicine and Women's and Children's. This has been escalated to the Care Group and will be monitored closely through the governance structure. It is likely that reporting figures for Urgent and Emergency Care are impacted by the cluster management of 12 hour breaches, though these are centrally logged with the agreed dip sample of 10% each month for the assurance of no harm. The reviews undertaken historically confirmed and repeated themes reflecting national pressures identified including:

- High numbers of attends
- High level of acuity
- High number of super stranded patients
- Staffing challenges

Whilst there is a 21% reduction in reporting in Urgent and Emergency Care they remain the highest reporting with all reporting within statistical variation. Other themes include delay in admissions, time

to treatment and physical assaults on staff from patients. This reflects the challenges of increased activity and acuity being experienced nationally.

To promote an open and honest reporting culture and to optimise learning the governance managers review all incidents daily and liaise with all CBUs to discuss incidents. Bespoke Datix training sessions continue to be offered by the senior administrator for Datix. A weekly drop-in governance session continues to support any additional staff training needs. Whilst incident reporting remains within statistical control a rolling agenda item has been added to the CBU Governance agendas to highlight the reduction in incident reporting to those areas. The incident position across the Trust is also reported weekly to the Executive Team.

2.3 Management of Violence and Aggression toward Staff

In Quarter 3, there has been an increase in the number of Antisocial/ Abusive/ Violent Behaviour incidents reported (5%) with no increase in harm noted. In relation to the learning from physical assaults on staff from patients, Urgent and Emergency Care have been working closely alongside the Head of Security to safeguard staff and are in the process of trialling body cameras to reduce the risk of staff assault alongside training and a position of zero tolerance. An evaluation of this intervention will be reported to the Health and Safety Sub Committee where these incidents are monitored alongside compliance with Violence Prevention and Reduction Standards (19 August 2022).

2.4 Learning from Incidents and Assurance

The Associate Director of Governance and the Patient Safety Manager continue to attend the PLACE (previous CCG) meetings in order to present Serious Incidents alongside the Investigating Officer. This enables feedback and assurance in real time through broad discussion with health partners. In addition, the Director of Governance, Deputy Chief Nurse presents at the Clinical Quality Focus Group any themes and trends and offers assurance at the PLACE meeting with learning actions identified. Learning is shared within governance and speciality meetings with wider learning shared through other modalities such as safety alerts and any relevant meetings such as Nursing and Midwifery Forum, Mortality Review Group and Medical Cabinet.

Following evaluation of Root Cause Analysis (RCA) investigations, the following themes were identified, and actions implemented. In order to measure the success of the learning, complaints, PALS, incidents and risk are monitored to ensure a downward trend of the specific learning points noted below and /or timely escalation where required. Following detail of the wider themes noted below, examples of learning identified and actions taken are detailed throughout the report.

2.4.1 Inadequate Documentation

Seven of the RCAs completed in Quarter 3 found that documentation errors or omissions were root causes or direct contributory factors in the incidents. In order to address the documentation omissions identified in the Urgent and Emergency Care RCA, whereby enoxaparin was prescribed without an accurate weight there has been a drive via the Safety Brief to alert and educate staff on the need for accurate weights and equipment and checks prior to administration. This supports the monitoring of accurate weights being recorded and is further supported by improvement work around the management of VTE. There have been no other RCAs noted within the quarter relating to this trend, but this is monitored centrally via the governance team and any on-going trend will be highlighted.

2.4.2 Transfers

Three RCAs indicated learning through transfer. One example is with regard to the transfer of a child which had a direct impact upon patient care. Following a pediatric investigation report it was identified that during transfer, the vapotherm began to alarm and stopped administering oxygen to the patient. To prevent this from happening again, the team have now devised a formal process and checklist to be followed for internal transfers of a child or infant requiring vapotherm within WHH. This is now visible in the ward areas to ensure safe transfers for paediatric patients. Following this incident, a simulation for learning was undertaken which was positively evaluated. And an external review undertaken for further assurance of learning and recommendations.

2.4.3 Communication

Ten RCAs identified challenges with communication between teams. One example related to an RCA where a patient was admitted due to a paracetamol overdose, there was a delay in treatment which required the patient to be discussed with Birmingham Liver Centre. It was identified that there was a delay in the laboratory alerting the ward to abnormal blood results and a delay in requesting a review of blood tests which required urgent action. There was also insufficient clinical information provided on the I-bleep request for the review of blood results. This meant that doctors were therefore unable to establish the urgency of the clinical review. Staff have been reminded through communication on the I bleep that they must provide sufficient clinical information so that it clearly notifies clinicians to follow up requests. This will be monitored further through the incident and complaints process. Other examples include communication for escalation between mental and physical health, escalation for medical review, discharge planning and timely discussion with patients and families.

2.5 Learning from Quality Improvement

Quality Improvement (QI)- Capability Building Programme

It is widely recognised that organisations that have embedded a culture of continuous quality improvement and use a systematic framework to build improvement skills at all levels are better able to achieve high levels of performance, outcomes, and staff satisfaction in a sustainable way (AQuA 2018, Health Foundation, CQC 2018). Most of the NHS trusts in England that have an outstanding CQC rating have implemented an organisational approach to improvement. One of the signs of a 'mature quality improvement approach', identified by the CQC (2019), is a plan for building improvement skills at all levels of the organisation, ultimately supporting learning to optimise impact and sustainability. The National Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF) also recognise the value of QI methodology and will increasingly require organisations to engage in a more systematic approach to improvement.

WHH have targeted focus on ensuring that the Trust has a workforce equipped with the appropriate knowledge, skills, and confidence to deliver sustainable change aligned to strategic priorities, utilising quality improvement principles and systematic methods, to deliver the organisation's mission to be outstanding.

WHH has identified six proposed levels of QI knowledge and training, building on our existing programmes, based on the concept of 'dosing' to allow a progression of knowledge and skills, linked to the needs of different roles. Starting with an awareness of what QI is, through the ability to participate in and run QI projects, progressing to lead QI as daily business, and eventually teach and coach others in improvement.

The proposed capability building programme will sit within a broader Quality Academy Strategic Delivery Plan and will require leadership commitment, and a supporting culture and infrastructure to

ensure that staff are not only upskilled to improve but have the opportunities, support, and motivation to put those skills into action as part of their everyday work.

QI collaboratives continue (not exhaustive- some actions identified following feedback to support learning and improvement):

- Sepsis
- Medications optimisation in ED
- Ward A9 ECAT trial – recently commenced, not yet evaluated – an approach to enhance clarification of enhanced care needs.
- Pressure Ulcers and falls:
    - Reviewed phased approach for change package implementation to optimise sustainability
    - Pressure ulcer collaborative identified further review of skin integrity where orthotics in use – trauma nurse to support and directly review as part of ward round
    - Visual prompts e.g Traffic light system as visual display to support repositioning be trialled
    - Further data analysis to support improvement – in progress
    - Access to equipment, namely ED -system pressures
    - Staffing with harms for falls - explored by Deputy Chief Nurse
    - Falls and PU champions from across the organisation have been brought together for regular monthly meetings, provided as an opportunity to share learning and create efficiencies and consistency in care provision
    - Collaborative working including engaging with NHS Professionals, based on feedback from wards, regarding agency staff awareness of falls and pressure ulcer prevention supported by revised literature

Learning from evidence reviews includes:

- Evidence provided by the KES evidence specialists has contributed to an agreement with the anaesthetic team to change the previous practice of delaying hip fracture surgery for patients on Direct-Acting Oral Anticoagulants (DOACS). This will lead to an improvement in Best Practice Tarif for hip fracture care by reducing delays and will improve patient care and outcomes.

- Substance misuse Joint Strategic Needs Assessment (JSNA) – focusing on the Warrington population cohort at highest risk of accidental self-poisoning and drug related deaths, identifying any specific interventions which this group responds well to that translates into treatment recovery or drug-related death reduction. This is one of the patient safety-focused learnings from our current Provision to Warrington Public Health Team and NHS Cheshire and Mersey ICB.

2.6 Safety Alerts

WHH uses the daily safety brief to share learning on a wider scale, these are shared Trust wide via communications, and noted as pop-ups on computer screens and shared at daily staffing huddles. The

below table provides examples of Safety Alerts issued by the Trust via the daily safety brief following incidents that occurred or were investigated in Quarter 3:

Subject	Detail	Date issued
Temporary Shortage of Supplies of Intravenous Levofloxacin	There is currently a supply challenge with intravenous (IV) levofloxacin. The Trust has very limited supplies and based on current usage this supply will run out within a few days. An alternative antibiotic may need to be used for some patients until this issue is resolved. The supply issue is expected to continue intermittently until the end of December. **Action:** Oral levofloxacin therapy should be considered for any patient who is not nil-by-mouth. IV levofloxacin 500mg is bioequivalent to levofloxacin PO 500mg. If oral levofloxacin is not appropriate, in the first instance refer to the Trust's antimicrobial formulary on MicroGuide for alternative treatment options to IV levofloxacin. If IV levofloxacin is the only option specified within the formulary, or the alternative antibiotic regimen is not appropriate, please contact a Consultant Microbiologist for advice. For intra-abdominal infections where IV levofloxacin is indicated, IV ciprofloxacin 400mg BD in combination with IV metronidazole 500mg TDS should be used as an alternative. As per national Antimicrobial Stewardship guidelines, intravenous antibiotics MUST be reviewed between 24-72 hours after commencement. If antibiotics are still indicated, refer to the Trust's antimicrobial formulary on MicroGuide to determine if an IV to oral switch is appropriate. **Assurance:** We will know that this communication has had the desired impact by monitoring requisitions.	22/11/22
Examination Requested & Performed on Incorrect Patient	A CT scan of the head was recently requested and performed on the incorrect patient due to the referring clinician incorrectly ordering the examination under the wrong patient record on ICE. This error resulted in an unintended dose of radiation to the patient. **Action:** Where possible ensure ICE is launched directly from Lorenzo; where this is not possible always use the system using a unique identifier (NHS number or unit number) as opposed to the patient's name to avoid confusion over patients with similar details. Once the patient has been selected on the system, please check the demographic details sre correct before entering the order. The Society and College of Radiographers has produced a 'Pause and Check' checklist for Radiology Referrers and this includes the importance of checking details to ensure the correct patient. If a request is entered on the incorrect patient, please contact the Radiology department as soon as the error is identified	29/03/22

Subject	Detail	Date issued
	so that the examination can be cancelled if it has not already been performed and the appropriate action can be commenced if the examination has been completed. **Assurance:** We will know that this communication has had the desired impact by monitoring the number of incidents and complaints reported relating to this issue.	

2.7 Never Events from Q3

There was 1 Never Event opened in Quarter 3. This incident related to a wrong site drain insertion attempt. Urgent training was identified for the individual staff member and enacted. It is recognised that LOcSSIP training should commence at the point of entry and as such is now included at local induction for doctors.

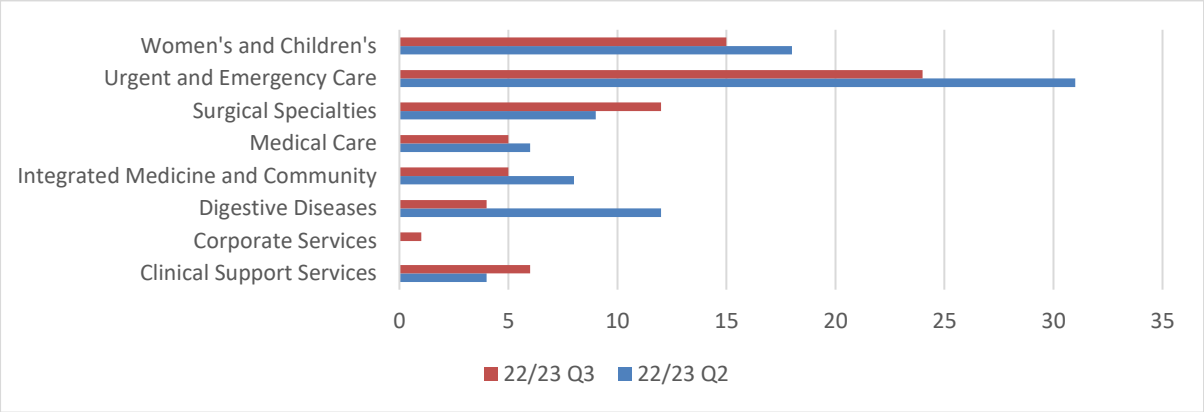
2.8 Learning from Complaints and PALS

Complaints

Complaints received

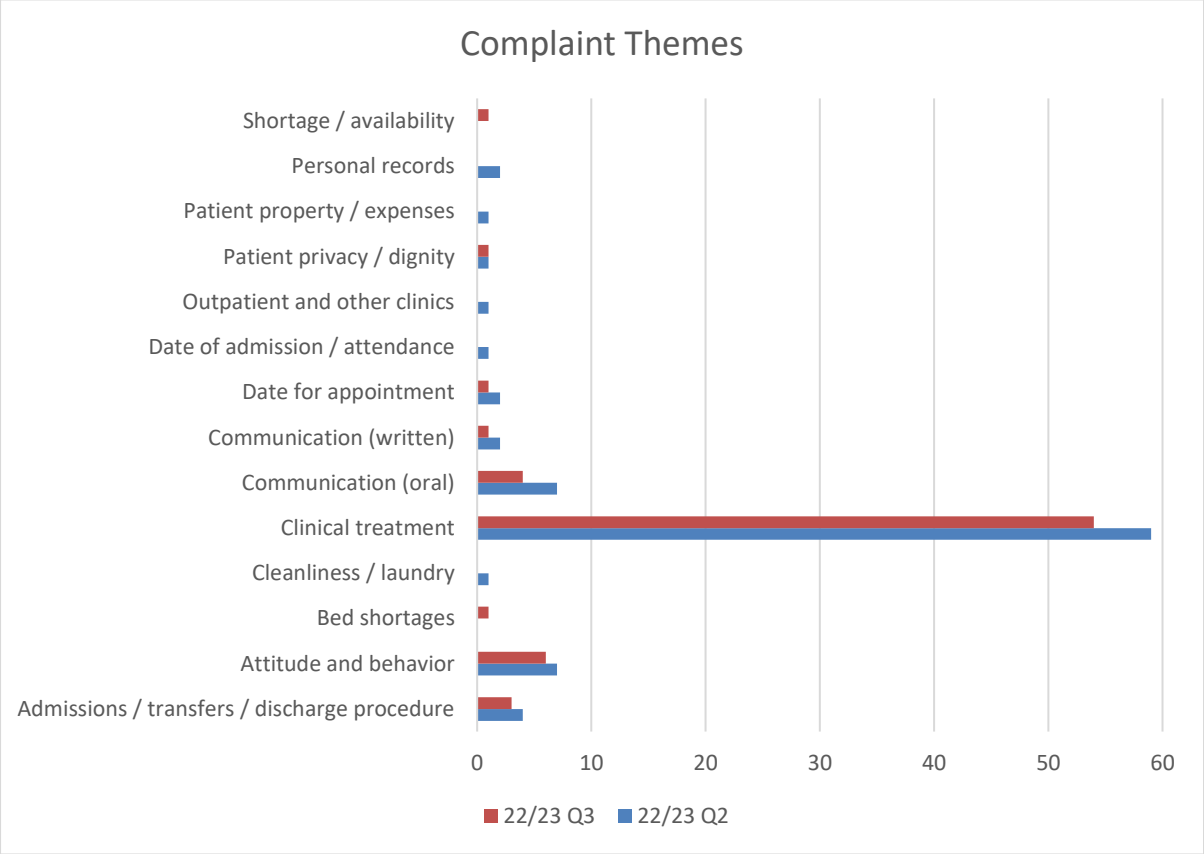
There was an 18% decrease in the number of complaints received during Q3 (72 in Q3 versus 88 in Q2). Clinical Support Services, Corporate Services and Surgical Specialties saw an increase in the number of complaints received **(graph 3**). Themes relate to co-ordination of medical treatment and waiting times. The remaining CBU's reported a decrease in the number of complaints received.

Graph 3



The themes of complaints received in Q2 compared to Q3 are outlined within **graph 4.** Clinical treatment remains the most common theme of complaints received. This category of complaints includes perceived delays in treatment, waiting times and/ or misdiagnosis. This is triangulated with the themes noted within incidents. The number of complaints relating to this theme has marginally decreased from 59 in Q2 to 54 in Q3.

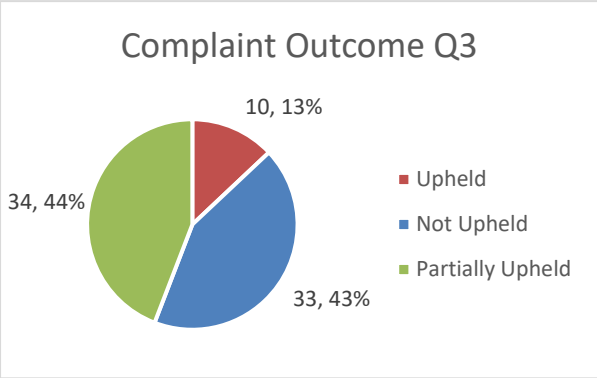
Graph 4

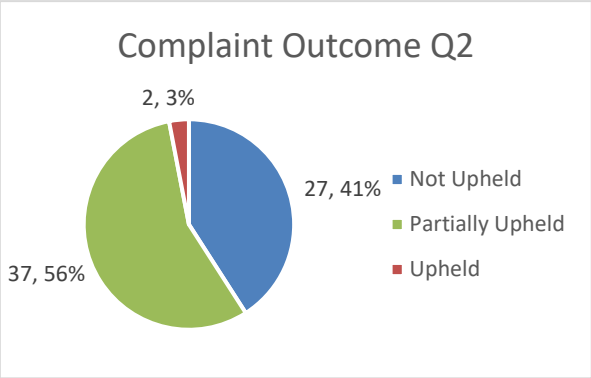


2.8.1 Complaints closed

There was an increase in the number of complaints closed in the Trust in Q3 (77 in Q3 compared to 66 in Q2) and all were closed within timeframe. The below pie charts demonstrate the outcomes for complaints closed in Q3 compared to Q2. In Q3 a greater percentage of complaints were not upheld (41 % in Q2 vs. 43 % in Q3). There has been a smaller percentage of complaints that were partially upheld (56 % in Q2 vs. 44 % in Q3). There has been a 10% increase in upheld complaints in Q3, recognising there are 11 more closed than in Q2. This data is being reviewed in more detail. The main themes relate to waiting times to be seen in the ED which has previously been covered earlier in the report and communication.

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





2.8.2 Responsiveness

All specialties have responded to complaints within the timeframe in Q3. The Trust has a target to respond to 90% of complaints on time and in Q3 the Trust continued to achieve 100%. The Trust continues to have 0 breached complaints and there are no complaints over 6 months old.

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

2.8.3 Actions resulting from Complaint investigations

The following table provides examples of complaints raised in Q3, and the actions we took to address the concerns raised and improve our processes. For further assurance, a complaints position with learning is provided quarterly to the Quality Assurance Committee. The Chairman also holds a monthly complaint meeting where a CBU or speciality will present a complaint, the lessons learnt, and actions implemented.

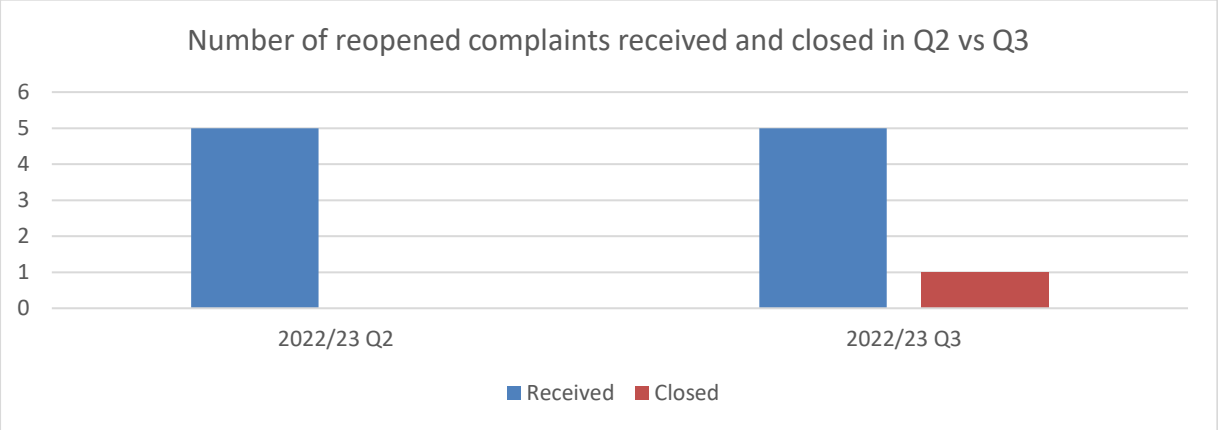
You Said….	We Did….
A patient raised concerns in relation to the seating and refreshments offered to patients attending the antenatal clinic.	The concerns were shared with the Patient Experience Team to conduct a review with the Maternity Team of the service provisions available, to improve the provision of these services. The review will also involve the Maternity Voices group, to ensure patient opinion is taken into account.
A patient raised concerns in relation to her interactions with staff members. She felt that staff did not interact with her in a compassionate way.	Apologies were offered for the patient's experience. The concerns were shared with the staff members involved and in order to encourage wider learning and reflection, the patient's experience was also developed into a learning piece and shared via the "our wise learning" leaflet within the CBU.

A patient experienced pain following failed attempts at cannulation, related to size of the patient's veins.	Although it was identified that the attempts were appropriate, this was still felt to be a useful opportunity for learning and an anonymised version of the patient's experience and importance of clear communication was shared with all applicable Radiology staff for reflection. An alert was also added to the patient's records regarding difficult veinous access in order to improve the individual patient 's journey for future attendances.

2.8.4 Reopened Complaints

The **graph 5** demonstrates the numbers of reopened complaints received and closed in this Quarter compared to the previous Quarter. The Complaints Team is continuing to work with the CBUs to improve the quality and detail of the complaint responses to reduce the number of reopened complaints. There has been no change in reopened complaints received in Q3 compared to Q2.

Graph 5



2.8.5 PHSO Complaints

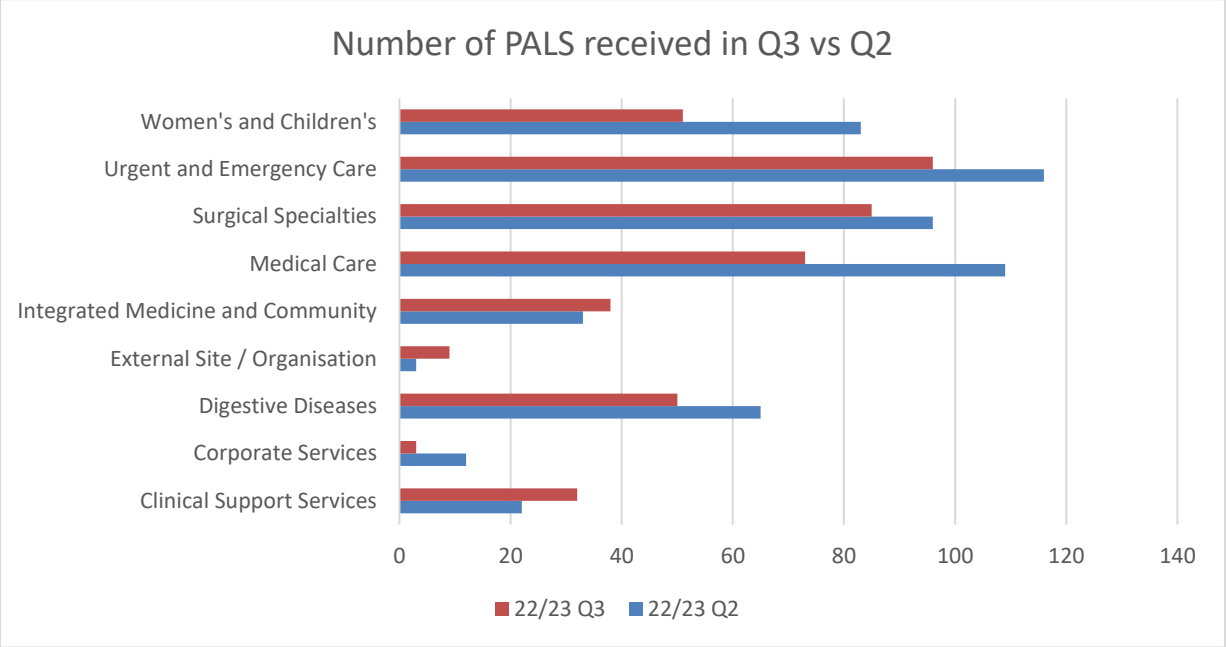
There were 4 PHSO complaints received within Q3. PHSO complaints continue to be dealt with in a timely manner. 1 PHSO complaint has been closed in Q3. All other investigations being undertaken by the PHSO have not yet concluded.

2.8.6 PALS

PALS received

There were 437 new PALS received in Q3, a decrease from the 539 received in Q2. The below chart demonstrates the breakdown of PALS received for each service. The decrease is also reflective of the complaints position **(graph 6).**

Graph 6



2.8.7 PALS closed

In Q3, 428 PALS cases were closed, compared with 536 closed in Q2. This is in line with the number of PALS opened in their respective quarters. Themes for learning identified are reflective of incident and complaints data referencing waiting times, communication and clinical treatment.

2.9 Learning from Claims

Clinical Claims

2.9.1 Clinical Claims Received

There were 26 clinical claims received in Q3. This is a slight decrease from Q2, where 27 clinical claims were received. This is a relatively static position.

2.9.2 Clinical Claims Closed

37 Ongoing Claims were closed in Q3, 8 of which were with damages (totalling £766,995.40) (excluding the costs of instructing Trust solicitors). 1 was successfully rejected and 28 were withdrawn, including closed due to lack of further correspondence from the claimant.

Specialty	Damages (Payment summary)
Radiology	£75,000.00
Radiology	£55,000.00
General Surgery	£221,298.40
ENT	£320,000.00
Trauma & Orthopaedics	£27,500.00
Urology	£60,000.00
Emergency Medicine	£1,500.00
Obstetrics	£2,500.00
Total	£762,798.40

2.9.3 Non-Clinical Claims (Employee Liability/Public Liability)

Non-Clinical Claims Received

There were 4 non-clinical claims received in Q3. This is a decrease of 2 from Q2. The learning from these will be provided once they have been closed.

Non-Clinical Claims Closed

There were 4 Employer Liability Claims closed in Quarter 3, 1 with damages paid. There was 1 Public Liability Claim with damages paid. The total damages paid for both is £38,300.00 excluding costs. All claims continue to undergo triangulation.

2.9.4 Claims Learning and Actions

Following claims investigations for claims closed in Quarter 3, the following themes were identified, and actions implemented. The clinical claims review group continues to monitor themes and trends.

Claims Learning	
Failure to note abnormality resulting in delay in diagnosing cancer	MDT and pre- MDT processes have been reviewed to ensure improvements are made. This includes working with trainees to ensure robust processes.
There was a reporting error on the MRCP from March 2021, where findings suggestive of pancreatic cancer were visible but not reported. There was a delay in performing the CT on the 8th of November 2021 due to the Covid-19 backlog (took six weeks instead of maximum of two).	Case taken for discussion at Radiology Events and Learning Meeting (REALM) to ensure learning from the error is disseminated to other Consultant Radiologists and Trainees. Personal reflection by reporting Radiologist undertaken to gain insight into cognitive processes that can lead to increased risk of errors.
Lack of communication with other service providers meant a delay in diagnosis (led to stillborn)	Develop and review contact log sheet to included risk assessment/criteria for referral to triage guide Education and reflective learning undertaken by staff involved. Case presented to department involved for education. NWAS and other hospital involved to review care provided by them – collaborative learning

3.0 Learning from Inquests Q3

13 inquests were heard in Quarter 3, all with narrative verdicts concluded. The Cheshire Coroner was satisfied with the learning implemented. There were no Regulation 28 (prevention of future deaths) concerns.

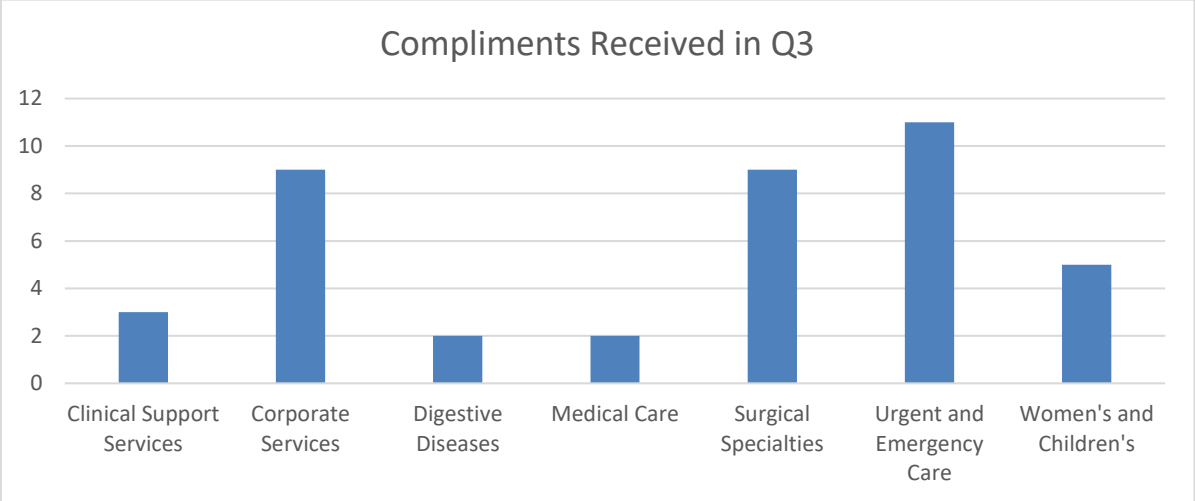
One of the inquests had legal representation. Themes identified for learning include full compliance with the observation policy and clinical escalation and review. Work is being undertaken to support learning and improvement with focus upon NEWS compliance and escalation for which there has been a significant amount of work undertaken including with the CQUIN relating to ITU and ED indicating good compliance. Other areas for learning include documentation and communication as previously referenced. Learning is shared as required through a variety of forums including governance meetings, Nursing and Midwifery forum and Medical Cabinet. Learning and preparation is also supported through the Mock Inquest process.

3.1 Mock Inquest Sessions

A mock inquest learning session took place with the support of Hill Dickinson solicitors. This included a 20-minute power point presentation presented by Hill Dickinson followed by a mock inquest session, complete with senior members of Trust staff acting as witnesses. The session was well attended by Junior Doctors from FY1 to ST4 level. The aim of the session was to introduce staff to the inquest process and learning with actions identified. Feedback from the session was that staff had found the session to be very informative. A further session is scheduled to take place across all healthcare disciplines for Q4 with over 100 attendees registered in March 2023.

4.0 Learning from Compliments

A positive safety culture is one where compliments are fed back to staff in the same way that investigations are. Compliments are a very useful tool for the Trust to be able to identify what areas are working well. In Q3 the Trust received 41 compliments which has significantly increased compared with 24 compliments received in Q2. Importantly to note for balance, whilst Urgent and Emergency care have received the highest number of complaints and PALS for Q3, they have also received the highest number of compliments.



It has been identified that compliments are often received within letters of complaint, whereby the patient or relative will take the time to acknowledge the positive impact of staff members involved in their care. The Head of Complaints has discussed the importance of logging these compliments with the Complaints and PALS staff at the 18th January 2023 team away day and will continue to monitor the logging of compliments monthly to ensure the numbers received are being accurately captured. This positive feedback is also shared with the CQC.

4.2 Learning from the CBUs

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

We learnt that….
Patient prescribed brinzolamide and timolol eye drops on TTO, however no brinzolamide eye drops supplied.
We Acted Upon …
➢ The outcome identified that a member of staff had typed Brinzolamide into the well-sky programmes and selected Brinzolamide eye drops, however the combination of Brinzolamide and timolol eye drops is not recorded on the system generically, it is on the system as its brand name Azarga. Brinzolamide eye drops were then selected from the shelf for dispensing, label attached and then it was passed for accuracy checking. ➢ The accuracy checker failed to identify that the incorrect medicine had been dispensed and it was sent to the ward. ➢ Reflective learning was issued to members of staff involved with labelling, dispensing and accuracy check.

We learnt that….

The patient was x-rayed to confirm position of NG tube but a non-radio opaque NG was used resulting in unnecessary radiation.

We acted upon …

- It was identified that the NG tube used was radio-opaque however the current stock within the trust of NG tubes was difficult to be visualised on an x-ray.
- New stock supply of NG was sourced and implemented within 24 hours of a fully radiopaque tubes
- A trust circular was shared with information on the new tubes to be used and for all old stock to be discontinued and removed from shelves – as discussed with procurement
- Radiology team supported in checking different batches of NGs as assurance
- An incidental findings of medics not completing LOCSIPS was identified – the education team are to provide additional support.

We learnt that….

A patient came to the MRI reception asking to be clinically assessed for a burst ulcer on leg. Patient stated he felt a burn when having MRI scan 09/08/22 and told the staff.

We acted upon …

- The feedback from a rapid incident review has been shared with the radiology governance team
- Discussed at RDA meeting the importance of escalation and to utilise the completion of datix' for incidents in which patients complain of burning post MRI. This will allow for the incidents to be investigated in real time and will allow for accurate monitoring of "burns" related incidents within MRI.
- Discussed with the direct line manager to arrange update training for all RDA staff to ensure awareness of processes

We learnt that ….

- Poor discharge - no referral. Continue to chase referral 6 days later. Only known to district nurses through MacMillan nurses for the administration of enemas. Lady had a RIG inserted and no referral was sent to district nurses. Balloon change was 3 weeks overdue and buttons around RIG site have been sutured. Lady discharged from hospital 27/9/22. RIG inserted 19/9/22.

We acted upon …

- Ward staff retrained in the care and maintenance of equipment
- Clear documentations of discussion and training with patients and family

- Work undertaken evidences an improved position with regard to discharge summaries Trust wide. Presented at Patient Safety and Clinical Effectiveness Sub Committee 31st January 2023.

We learnt that….

- major haemorrhage, delay in retrieving blood to theatre

We acted upon …

- To ensure that all trained staff have active login/passwords
- To train more staff to be able to collect blood products. Trajectory in place.
- To carry out simulation of activation if Major Haemorrhage exercises in Theatres and ward areas to support wider learning and facilitate broad and transparent discussion.

We learnt that….

Prescription not fully completed on EPMA

- Consultant review on the ward
- Anticoagulant prescribed on EPMA
- Pharmacy teaching session for self-administration of anticoagulant booked at the same time
- 2 days later pharmacist arrived for teaching session, noted no anticoagulation prescribed
- Patient developed a PE

We acted upon….

- Clinicians to be advised to confirm all medications are correctly prescribed before finishing the electronic prescription.
- Daily presence of a pharmacist on the wards assigned a daily pharmacist must be ensured.
- Anticoagulation counselling requests are misleading on ICE. Their purpose is to advise the Pharmacy and anticoagulation services that anticoagulants have been commenced. Pharmacy to discuss how to change this request to reflect this.
- Added to the handover that all medications are checked

We learnt that ….

Tracheostomy concern

- A surgical tracheostomy was inserted under ENT and an endoscopic PEG inserted following NG feeding throughout the stay and a failed RIG insertion.
- Patient was successfully weaned from high flow oxygen and discharged from ITU to the respiratory ward
- Regular tracheostomy care continued 2-4hrly overnight, and the tube holder strap /dressing was intact.
- The tracheostomy tube came out during a wash by 2 health care assistants

We acted upon ..

- The senior Nurse checked the patient, noticed the tracheostomy tube was fully out, no bleeding from stoma site and patient not in any distress, Sats 98-99% on room air. Obs stable. no oxygen required, continuously monitored MET Call made.
- A size 4 tracheostomy was inserted as the Size 6 shiley had come out, noted to be patent.
- staff responded well and followed the procedure as taught in their competency training
- The Tracheostomy group reviewing the possibility of training the Nursing staff to re site any tubes which come out and reiterate observations following providing cares

We learnt that ….

- Aggression / Violence towards staff
- An increase in challenging patients

We acted upon ….

- CBU senior staff aware and monitoring the issue on a regular basis
- Security to provide some support leaflets for staff
- All Incidents are reported to RIDDOR as required
- Staff report being confident in requesting support from the security department
- Staff to be reminded that the health and wellbeing department are available if any further support is required
- Staff reminded to ensure a Datix is submitted with the patient identifiers to ensure traceability
- To be monitored as part of violence and reduction standards at Health and Safety Sub Committee
- De-escalation training in place, increased accessibility and number of trainers
- Pilot in ED of bodycams – to be evaluated.

We learnt that …

Patient attended MIU with pain in left hip. X-ray taken and reported 2 days later with fracture indicated. Contacted patient but no answer. No further attempts made to contact patient. GP reviewed report 3 weeks after attendance and fracture noted. Referred back to hospital and admitted under T&O for surgery

We acted upon …

- Investigations results book to be checked daily to ensure all outstanding contacts have been made and signed when verbal contact has been made.
- Escalation to be made if unable to make contact with the patient after 2 attempts.
- Letter to be sent to GP informing them of results and inability to contact patient.

We learnt that….

A major haemorrhage and a delay in retrieving blood to theatre.

We acted upon….

- To ensure that all trained staff have active login/passwords
- To train more staff in the collection of blood products
- To carry out simulation of activation if Major Haemorrhage exercises in Theatres and ward areas

- Transfusion working group in place to continually review practices and act upon learning – reporting to Patient Safety and Clinical Effectiveness Sub Committee

We learnt that….

A community midwife attended the home address for a routine postnatal visit (Mum has autism/Tourette's but a special circumstances form was not commenced). Mum reported baby had blue / bruise like mark to both buttocks, which had been present since they were noticed at the primary visit. There was no documentation evident on Badger / Lorenzo regarding the marks. Baby was brought to hospital in parents' car for a paediatric review in view of a possible non accidental injury this was an inappropriate transfer into paediatrics. Baby was seen by the consultant who confirmed the marks were slate grey nevi, which don't always present immediately, not bruising.

We acted upon….

- Incident to be discussed at the multi-agency Safeguarding peer review meeting
- Practice guidance for SPCF to be re-issued to midwifery staff with highlighted emphasis on this incident as a case review
- Findings of baby check on primary visit to be clarified with community midwife and documentation issues to be discussed
- Clarification of process taken for transfer into hospital for suspected NAI
- Learning to be shared through CBU OWL newsletter

4.3 Learning from our Staff

Saying Thank You

The Extranet has been updated to include the "You Made a Difference" nomination form. We want to know how Team WHH has made a difference. You can nominate an individual or a team for going the extra mile. Anyone can make a nomination using our simple online form, and nominations will be taken to a panel for judging.

There will be a monthly 'You Made a Difference' award winner, and all winners of the monthly 'You Made a Difference' award will be put into the annual Thank You awards special category of "You Made a Difference Winner of the Year".

Sonnets on the Extranet

In order to encourage creativity and reflection, staff are now able to submit a sonnet to be uploaded to the Extranet. These are short poems, which staff can use to reflect their thoughts and feelings on certain topics. There are currently three sonnets, written by Trust staff, on the topic of covid. Sonnets can be submitted for uploading by emailing: whh.organisationdevelopment@nhs.net

Bright Spots

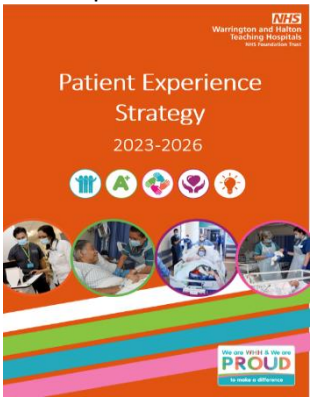
The Bright Spots section is within the daily Trust-wide Safety Brief and is an opportunity to recognise the efforts of our staff and thank them for their hard work.

4.4 Learning from Patient Experience

Continued focus on learning from patient experiences:

- Review of bereavement service systems and processes has taken place to ensure bereaved families receive all necessary documentation in a timely manner. This has included Collaborative working with Medical Examiner (ME) service
- Introduction of a digital ME summary form on ICE to ensure easily accessible to medical teams implemented by medical cabinet office and in place from 16th January 2023
- Introduction of board rounds in the bereavement office
- Introduction of daily task allocations for team to ensure accountability and focused efforts.

The Patient Experience and Inclusion Team carried out **extensive engagement** with our patients, carers, community partners and other public and third sector organisations to co produce the Trust **Patient Experience Strategy 2023 – 2026 which is currently in draft form** in readiness for approval and **launch in April 2023**. Engagement was undertaken in multiple formats to maximise opportunity which included.



- Digital surveys
- Internal engagement sessions
- Engagement with members of Patient Experience Sub Committee
- External workshops which were open to the communities, advocacy groups and local agencies within Warrington and Halton

4.5 Learning from Clinical Audit

National Audits

National Audits: Chronic Obstructive Pulmonary Disease (COPD)

Summary:

The national COPD clinical audit captures the process and clinical outcomes of treatment in patients admitted to hospital with COPD exacerbations. The inclusion criteria are patients who are 35yrs and over and have a primary diagnosis of a COPD exacerbation (ICD codes J44.0, J44.1, J44.8 and J44.9).

Results:

KPIs	Number/ Denominator	WHH Percentage	England Percentage
KPI 1 Acute treatment with NIV within 2 hours of arrival	0/17	0%	18%
KPI 2 Oxygen prescribed for the patient to a targeted saturation	75/75	100%	99%
KPI 3 Spirometry results available	104/258	40%	42%
KPI 4 Current smokers prescribed stop smoking drug and/or referred to a behavioural change intervention	67/79	85%	57%

KPI 5 Respiratory reviewed within 24 hours of admission to hospital	183/258	71%	61%
KPI 6 Key elements of a discharge bundle provided as part of discharge	209/246	85%	23%

WHH results for the KPI 1 Acute treatment with NIV within 2 hours of arrival and KPI 3 Spirometry results available are lower than the national average. KPI 1 was not obtained for any cases. Nationally this figure is 18%. The remaining KPIs are higher than the national average.

KPI 1. The patients that are considered in this audit do not always require Acute NIV on arrival to hospital but deteriorate and this is the treatment that they are escalated to, this could be a reason why WHH are not achieving KPI 1. This is being reviewed further. There is a pathway for COPD patients attending ED with exacerbations which stipulates to obtain an ABG. This audit has highlighted a training need to ensure ABG/VBG are taken in a timely manner from patients' arrival to hospital and acted upon appropriately. This is being actioned.

KPI 3. An issue has been logged with the IT department as it is no longer possible to view spirometry result via medicorr. It has only been possible to view Spirometry results that have been entered as a clinical note on Lorenzo.
Action plan for improvement: Training to be rolled out on ABG/VBG to be taken in timely manner and acted upon appropriately

Local Audits

Local Audits: Re-audit of Visual Processing Difficulties

Summary: This was a re-audit following the last audit in 2020 to ensure that we are still following the guidelines. The aim was to ensure that the change to guidelines during the last audit is relevant and effective and to ensure that the outcomes of the service are meeting the targeted improvements at which they are aimed. The objective was to review of notes of patients discharged to ensure that we are following the correct procedure in that:

- Are patients receiving the right care?
- Are the patients being referred appropriately?
- Are patients receiving written information?
- Have previous actions been fully implemented?

no.	Standard	Comparison from previous year	2016/17	2019/20	2022
1	Post treatment of saccadic initiation difficulties Improvement	↑	100%	100%	100%
2	Post treatment of saccadic accuracy improvement	↑	100%	98%	100%
3	Post treatment of both saccadic accuracy and initiation	↑	100%	100%	100%
4	Did the developmental eye movement test reflect the problems pre-treatment?	↑	84%	100%	100%
5	Did the developmental eye movement test reflect the problems post-treatment	↑	84%	100%	100%
6	Improvement in binocular vision difficulties after treatment	↑	77%	92%	100%
7	Improvement in reading with the overlay using the Wilkins rate of reading test	↑	75%	98%	100%
8	Average improvement in score with the test of visual perception skills		90%	93%	84%

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

Key findings:

Aim of audit was to show:

1. Improvement of Orthoptic problems such as convergence insufficiency (CI)
2. Improvement in Reading speed with Wilkins Rate of Reading Test
3. Improvement in Ratio with Developmental Eye Movement (DEM)Test
4. Improvement in score with Test of Visual Perception Skills

The re-audit showed:

1. 100% improvement in Orthoptic problems such as CI following treatment
2. 100% improvement in reading speed with Wilkins Rate of Reading Test following use of overlay
3. 100% improvement in Ratio with Developmental Eye Movement Test following exercises
4. 84% average improvement overall in score with Test of Visual Perception Skills in all areas following exercises

Recommendation:

- Continue to use DEM for those patients who struggle with saccades (a rapid movement of the eye between fixation points) only and for those patients who are inconclusive during assessment
- Continue to match the symptoms of the patient with visual perception skill thereby performing the most relevant perception tests soonest
- No longer bring patients back to reassess improvements in saccades

Action plan: to re-audit in 2024.

Assurance rating (using Trust assurance rating matrix):

High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied.

4.6 Quarterly Learning Section

Mental 'Elf' Day

The Mental 'Elf' Day was held at Halton on Tuesday 13th December and Friday 16th December 2022. Elf Day is where people across the UK will dress up as elves to raise money and awareness of Dementia for the Alzheimer's Society. As always this was a very important date in our WHH festive calendar. This gave an opportunity for staff to meet and learn about Dementia from the Mental Wellbeing Team and the Staff Engagement Team along with lots of goodies and information about Dementia including details about their very own WHH Charity. Jo Drewett, Staff Engagement and Wellbeing Manager shared a Good Morning Message (GMM) which focused on the support provided to staff at our Trust.

4.6 Welcome Booklet

The Patient Experience Team are in the process of redesigning the Trust's "Welcome to our Hospitals" booklet. This booklet provides information for patients, relatives, and carers on what to expect from their hospital stay, from admission to discharge. It provides key details around topics including mealtimes, visiting and infection control. The booklet is being redesigned in collaboration with the Digital Communications Team, Complaints & PALS Team and Clinical Teams from each of the CBUs. The booklet seeks to address questions commonly asked by patients and relatives.

4.7 Staff involved in incidents – Survey

This workstream has progressed in Quarter 3 and the questions for the questionnaire will shortly be sent out to staff. The survey is expected to be rolled out to a sample group of staff in Quarter 4 to gain initial feedback on the survey itself. The findings of this survey will assist the Governance Team in the delivery of training for RCA investigators and will also help us to better support staff involved in incidents and the implementation of the patient Safety Incident Response Framework.

4.8 Junior Doctor Incident Training

The patient safety manager has been completing junior doctor training to support the understating of governance and how incidents are managed and progressed. During these sessions a selection of incidents are chosen to focus and discuss the learning outcomes. On occasions the junior doctors have selected incident scenarios and completed a presentation for discussion. The feedback received from these sessions is that they are informative and bring about positive discussion identifying workstreams where they can learn and work together to improve patient care. These sessions will continue in Quarter 4 2022/2023.

4.9 Learning from Research and Development

5.0 HARMONIE HCRU Study

Clinical trials play a key role in helping WHH improve healthcare and develop life-saving treatments. Here at WHH we are participating in the HARMONIE study, and we are looking to further assess the impact with more babies involved. "The study is critical and parents across the UK are being urged to support a new respiratory virus study looking into the UK's leading cause of infant hospitalisation.

Respiratory Syncytial Virus (RSV) is one of the leading causes of hospitalisation in all infants worldwide and affects 90% of children before the age of two. RSV often causes only mild illnesses, like a cold. However, for some babies, it leads to more severe lung problems such as bronchiolitis and pneumonia.In recent months, there has been a resurgence of RSV following the easing of COVID-19 public health measures. The HARMONIE study is looking at how strongly babies can be protected from

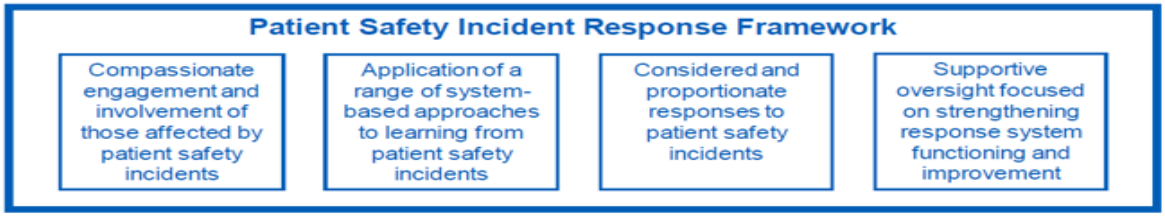
serious illness due to RSV infection, by giving them a single dose of nirsevimab, a monoclonal antibody immunisation.The study, which is a collaboration between Sanofi, its partner AstraZeneca, and the National Institute for Health and Care Research (NIHR), will evaluate the efficacy of nirsevimab. The antibody has recently been approved by both the Medicines and Healthcare products Regulatory Agency (MHRA) and the European Medicines Agency (EMA).

The HARMONIE study is open to newborn babies, and babies who are up to 12 months old at the time of participation. The study will last approximately 12 months and includes a single in person visit, with entirely virtual follow up visits

PI Dr Christopher Bedford, supported by Dr Delyth Webb are leading on the clinical trial. The region have set a target of 600 babies. WHH have recruited the 100th patient in the region on 19 January 2023. There is the possibility of an extension to recruitment until March 2023. An additional update will be provided regarding the outcomes and further learning from this study. Other studies and opportunities to support future learning include but are not limited to:
Sanofi Ulcerative Colitis
Moderna
Primary Care collaboration – being scoped
Opportunity to broaden academic research being scoped- Edge Hill, John Moores University.

6.0 Patient Safety Incident Response Framework (PSIRF) - learning and improving patient safety

- PSIRF is not an investigation framework, it aims to drive culture change
- PSIRF does not mandate investigations as the only method of learning from patient safety incidents or prescribe what to investigate
- PSIRF aims to move us away from perverse incentives that styme learning
- PSIRF supports the development and maintenance of an effective patient safety incident response system with four main aims:



Bi-weekly meetings have been arranged to support the implementation of PSIRF with expanding core group members for wider learning and discussion. The Patient Safety Manager will be attending CBU meetings to start circulating information about PSIRF and the various tools and types of investigations and reviews that can be used for learning and improving patient safety as detailed below:

- **Patient Safety Incident Investigation (PSII)** – in-depth review of a single or cluster of incidents to understand what happened and how
- **Multidisciplinary Team Review** – aims to through open discussion to agree the key contributory factors and system gaps that impact on safe patient care
- **Swarm Huddle** – initiated as soon as possible after an event and involves and MDT discussion. Staff 'swarm' to the site to gather information about what happened and why and decide what needs to be done to reduce reoccurrence
- **After Action Review (ARR)** – structured facilitated discussion of an event, based around four questions
    1. What was expected to happen?
    2. What actually happened?

3. What was the difference between the expected outcome and the event?
4. What is the learning?

3.0 RECOMMENDATIONS

The Quality Assurance Committee is asked to note the report.

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/23/02/35**
SUBJECT:	**Infection Prevention and Control Report Quarter 3**
DATE OF MEETING:	7 February 2023
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3: We will ... Work in partnership with others to achieve social and economic wellbeing in our communities.
EXECUTIVE SUMMARY	This report provides a summary of infection prevention and control activity for Quarter 3 (Q3) of the 2022/23 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. Healthcare Associated Infection (HCAI) cases in Q3 were: - • C. difficile 14 cases: YTD = 42 against annual threshold of 37 • MRSA bacteraemia 0 cases: YTD = 3 against zero tolerance threshold • MSSA bacteraemia 7 cases: YTD = 19 no threshold • E. coli bacteraemia 23 cases: YTD = 56 against annual threshold of 57 • Klebsiella Spp. bacteraemia 7 cases: YTD = 20 against annual threshold of 19 • P. aeruginosa bacteraemia 1 case: YTD = 2 against annual threshold of 6 Inpatient Covid-19 cases for Q1 -Q3 are : - • 809 (0-2 days) • 221 (3-7 days) • 189 (8-14 days – probable healthcare associated) • 256 (15+ days – definite healthcare associated)

<table>
<tr><td></td><td colspan="4">Inpatient Covid-19 outbreaks in Q3 :
• 8 Covid ward outbreaks, 5 of which were mixed patient and staff outbreaks and 3, patient only outbreaks were reported. Outbreak Control Groups were established to manage the Covid-19 outbreaks with the Planned and Unplanned Care Groups.

Good progress is being made against the policy and guideline recovery schedule and the objectives in the Infection Prevention Strategy.

To promote antimicrobial stewardship, positive messages of thanks for good practice were shared using social media.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Quality Assurance Committee is asked to receive and note the report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Infection Control Sub Committee</td></tr>
<tr><td rowspan="3"></td><td colspan="2">Agenda Ref.</td><td colspan="2">ICSC/23/01/254</td></tr>
<tr><td colspan="2">Date of meeting</td><td colspan="2">19 January 2023</td></tr>
<tr><td colspan="2">Summary of Outcome</td><td colspan="2">Submit to Quality Assurance Committee</td></tr>
<tr><td>NEXT STEPS:
State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="4">Choose an item.</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="4">Choose an item.</td></tr>
</table>

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QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control Report Quarter 3	AGENDA REF:	QAC/23/02/35

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 3 (Q3) of the 2022/23 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) thresholds, response to the ongoing Covid-19 Pandemic and progress against the Infection Prevention Strategy.

NHS England/Improvement (NHSE) use Clostridioides (Clostridium) difficile (C. difficile) infection rates to assess Trust performance. All Trust apportioned cases are considered for regulatory purposes.

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

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

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

Table 1: HCAI Thresholds for 2022/2023

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

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

- 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 guidance.

2. KEY ELEMENTS

Healthcare Associated Infection Surveillance Data

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

Table 2 Surveillance Data

Indicator	Threshold	A	M	J	J	A	S	O	N	D	Total	Position in year
C. difficile	≤ 37	4	5	0	8	4	7	3	2	9	42	Over threshold
MRSA bacteraemia	Zero tolerance	0	0	1	1	0	1	0	0	0	3	Over threshold
MSSA bacteraemia	No target	0	3	3	0	4	2	1	3	3	19	No threshold
E. coli bacteraemia	≤ 57	6	6	5	4	5	7	10	7	6	56	Over trajectory
Klebsiella spp. bacteraemia	≤ 19	1	3	0	5	1	3	2	3	2	20	Over threshold
P. aeruginosa bacteraemia	≤ 6	0	0	0	1	0	0	0	0	1	2	On trajectory

C. difficile: Increase in cases across the Northwest. Ribotyping of Trust apportioned cases has ruled out links. Root cause analysis investigation continues, and themes include, missed sampling opportunities and isolation on suspicion of infection. Next steps include: -

- Continue RCA investigation & review meetings
- Align approach to PSIRF to identify system learning
- Embed SIGHT mnemonic https://youtu.be/f4RRUVSKwvk
- Review approach to hand hygiene auditing

WHH STAFF C.DIFF TRAINING VIDEO
SCAN TO VIEW

MRSA Bacteraemia: Post Infection Reviews for the 3 MRSA bacteraemia cases identified: -

Case 1 - Learning including: missed blood culture sampling opportunities and delay in commencing MRSA suppression treatment. This case was considered avoidable.

Case 2 - Likely unavoidable, household contact a carrier of MRSA. This case was considered unavoidable.

Case 3 – Nil learning identified, Likely unavoidable.

Next steps include: -

- Awaiting meeting date for discussion of cases 2 and 3 with ICB/CCG
- Drive compliance with ANTT training
- Audit compliance with MRSA screening policy for assurance

GNBSI: E. coli cases are just below the annual threshold and P. aeruginosa cases are on trajectory. Klebsiella spp. cases have exceeded the threshold. The GNBSI prevention plan has been revised. Next steps include: -

- Audit hepatobiliary cases
- Revise GNBSI RCA template
- Reintroduce RCA to identify additional learning
- Align to PSIRF framework to identify system learning
- Nurse led protocol for urinary catheter removal in progress
- Focus support to wards with higher number of UTI associated cases

- Align to (nutrition) and hydration strategy

Trauma and Orthopaedic Surgical Site Infection

UKHSA identified WHH as an outlier with an increase in arthroplasty (hip and knee replacement) surgical site infections (0.9%). Action was taken to assess the situation and action taken including: -

- Establishing a T&O oversight group to review SSI suspected cases and agree cases for reporting
- Root Cause Analysis identified patient factor risk associated with high body mass index
- Captain Sir Tom Moore ward redesign with Estates completed January 2023
- Separation of surgical speciality lists
- Implementation of MSSA pre-operative screening and suppression treatment

Policy/Guideline/SOP Updates

The Infection Prevention and Control Team continue to ensure all policies are reviewed, updated, and renewed and the following documents have been updated in Q3 and approved by the Infection Prevention and Control Sub-Committee: -

- Deceased Patient Infection Control Guidelines
- Ward/Department Closure Guidelines
- Healthcare Associated Infections – Local Surveillance Guidelines
- Hospital Onset Covid-19 Infection (HOCI) Assurance Checklist
- Standard Precautions Personal Protective Equipment Audit Tool
- Mattress inspection and cleaning SOP
- SOP for Non-elective Patient Respiratory Virus Testing, Placement, and Infection Control Precautions v16
- Assessing infection risks when admitting, transferring, or discharging patients' guidelines
- Specimen collection guidelines
- Blood Culture Policy
- MDRO Guidelines
- Scabies Guidelines
- SOP for Non-elective Patient Respiratory Virus Testing, Placement, and Infection Control Precautions v17

Audit

Ten infection prevention and control audits were completed in Q3 with overall scores as detailed in Table 3 and full audit scores included at appendix 2.

Table 3 IPC Policies Audit Data

AMU	B14	B12	C21	A4	A10	AED	A9	B10+B11	C20
91%	96%	98%	96%	100%	97%	94%	96%	97%	98%

Ward environment score was lower that minimum standard in one area (AMU = 66%) and ward kitchens in 3 areas (AMU = 75%, ED =76% and A9 = 82%). Action was taken at the time of auditing to address environmental cleanliness. Audits are repeated if scores are low or in response to concerns about HCAI cases. The audit programme is being reviewed to increase audit activity.

Antimicrobial Stewardship

The Trust participated in world antibiotic awareness week in November 2022 using social media including Twitter and positive desk top messages to promote the campaign .

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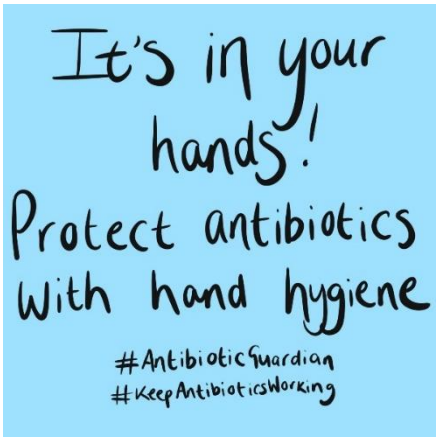
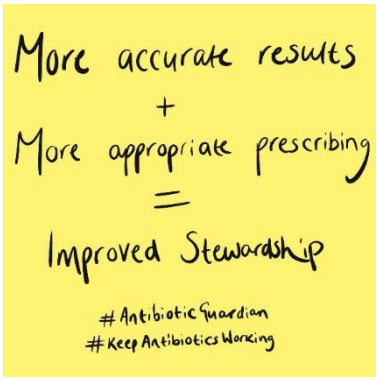
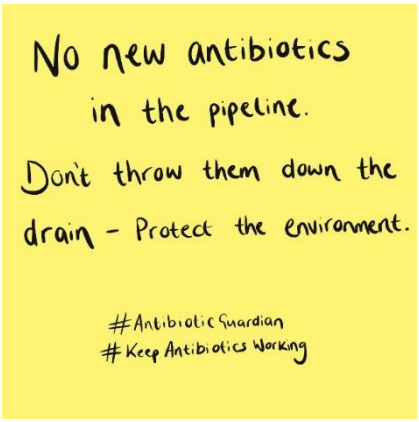






Education and Training

Overall compliance with infection control mandatory training was 86% at the end of December. Mandatory training is available via eLearning and 2 taught sessions are provided each week.

Table 4 Mandatory training Compliance

Infection Control Mandatory Training	A	M	J	J	A	S	O	N	D
Level 1 – Non-Clinical	88%	90%	90%	90%	89%	89%	90%	91%	91%
Level 2 - Clinical	78%	78%	79%	81%	81%	81%	81%	80%	80%
Overall % of staff trained	**83%**	**84%**	**85%**	**85%**	**85%**	**85%**	**86%**	**86%**	**8**6%

The Infection Prevention and Control Team have offered additional sessions to support compliance improvements, including evening training sessions. The training package is being shared with Practice Based Educators for local delivery. All CBUs have been asked to set trajectories to improve and progress will be tracked at Infection Control Sub-Committee meetings.

Environmental Hygiene

The revised national cleanliness standards have been fully implemented. Reporting with star ratings is in place with timescales of 2-4 hours to rectify concerns in function risk 1 (highest risk areas) and functional risk 2 categories. All areas are scoring 4 – 5-star ratings (out of a 5-star rating). Star ratings are displayed alongside the Commitment to cleanliness charter.

Incidents

Covid-19

Covid-19 continued to impact the Trust with details of all cases as shown in Table 5. Asymptomatic Covid-19 admission screening and day 3 and day 5 testing remains paused, and cases are being tested positive later their admission episode.

Table 5 Covid-19 Cases

Month	0 to 2 days	3 to 7 days	8 to 14 days	15+ days	Grand Total
Apr	217	53	22	27	319
May	109	12	5	14	140
Jun	92	17	14	38	161
Jul	142	35	36	41	254
Aug	84	12	10	18	124
Sep	46	25	41	40	152
Oct	45	24	22	28	119
Nov	30	21	16	29	96
Dec	44	22	23	21	110
Total	**809**	**221**	**189**	**256**	**1475**

Covid-19 Outbreaks

Eight Covid outbreaks were reported in Q3 five of which affected both patients and staff. Outbreak Control Groups were established to manage the Covid-19 outbreaks with the Planned and Unplanned Care Groups.

Additional Activity

Influenza

Additional challenges for IPC included an increase in patient admissions with influenza. The escalation plan for managing influenza admissions was enacted and a cohort ward was established. Support from the digital team was used to manage operational flow of recovered patients and placement of new influenza patient cases.

S. Pyogenes (Group A Streptococcus)

Further challenges associated with an increase in patient admissions with S. pyogenes, (Group A Streptococcus) including invasive disease. Good collaboration was in place with the DIPC, IPC Team, Paediatric Department, Pharmacy, and the Microbiology Laboratory. Rapid testing for S. pyogenes was introduced to support safe management of available antibiotics (national shortage) and effective treatment of patients presenting with suspected infections.

RSV

An increase in paediatric admissions associated with respiratory syncytial virus (RSV) was jointly managed by close working between the paediatric and IPC Teams. At times of surge cohort bays were established to care for paediatric admissions with bronchiolitis.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Infection prevention and control policies recovery plan
- Delivery of the Infection Prevention Strategy

- Provision of infection prevention and control expert advice to colleagues
- Review of escalations in infections jointly with the associated Care Group

4. IMPACT ON QPS?

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

5. MEASUREMENTS/EVALUATIONS

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

6. TRAJECTORIES/OBJECTIVES AGREED

IP Strategy Objectives

- Prevention of healthcare associated infections

Table 6

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

- Strengthening Antimicrobial Stewardship
- Improving standards of environmental cleanliness

7. MONITORING/REPORTING ROUTES

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

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

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

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

The Director of Infection Prevention and Control Report is submitted to Trust Board annually and published on the Trust website.

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

8. TIMELINES

2022 – 2023 Financial Year

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

The Infection Prevention and Control Team has continued to work well to meet the increase in workload. The continued challenge associated with Covid-19 patient admissions and outbreaks has been efficiently managed alongside additional challenges from influenza, Group A Streptococcus and RSV. Other activity continues to proactively prevent C. difficile and bloodstream infections from MRSA/MSSA and GNBSI.

The policy/guideline recovery plan has gathered pace alongside frequent updates to Covid-19 testing procedures in line with national guidance.

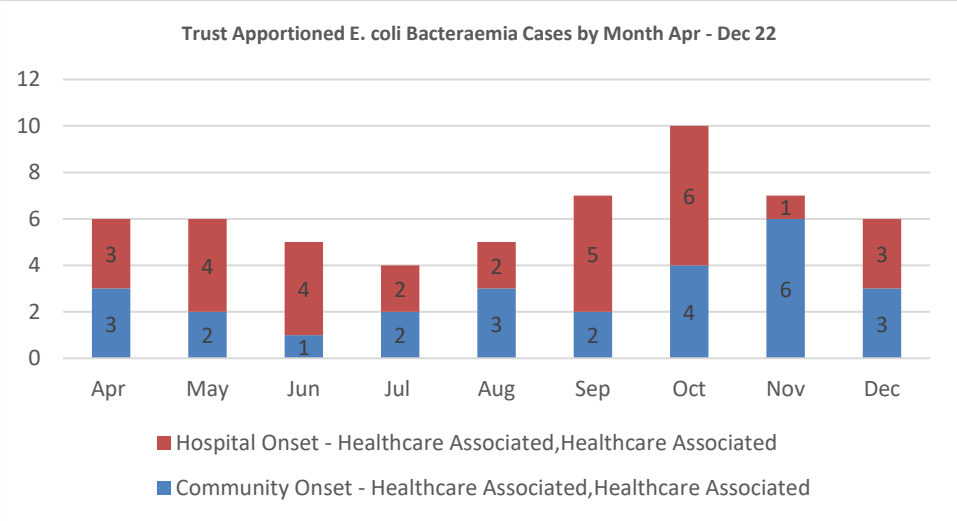
Discussion has commenced to review and update the annual objectives in the IPC Strategy for 2023/24.

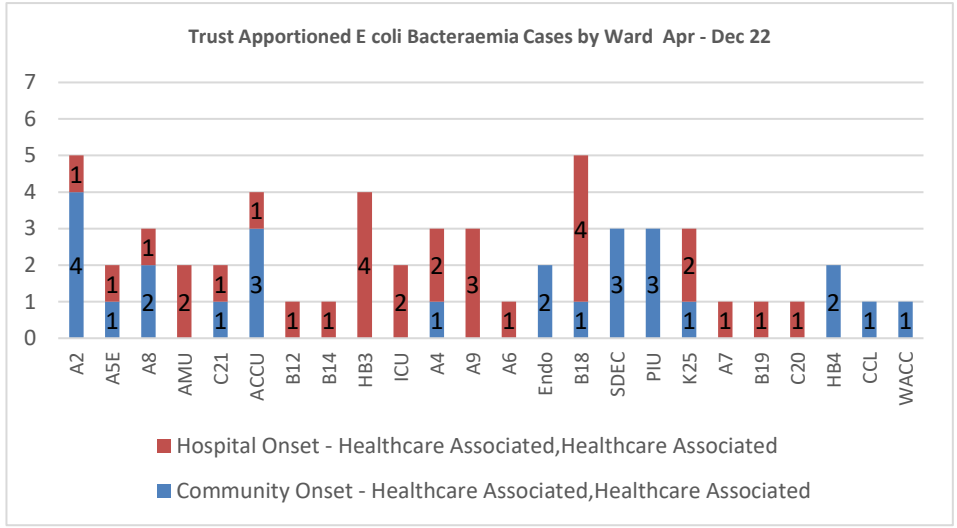
The Quality Assurance Committee is asked to receive the report, note the exceptions reported and amount of good progress made.

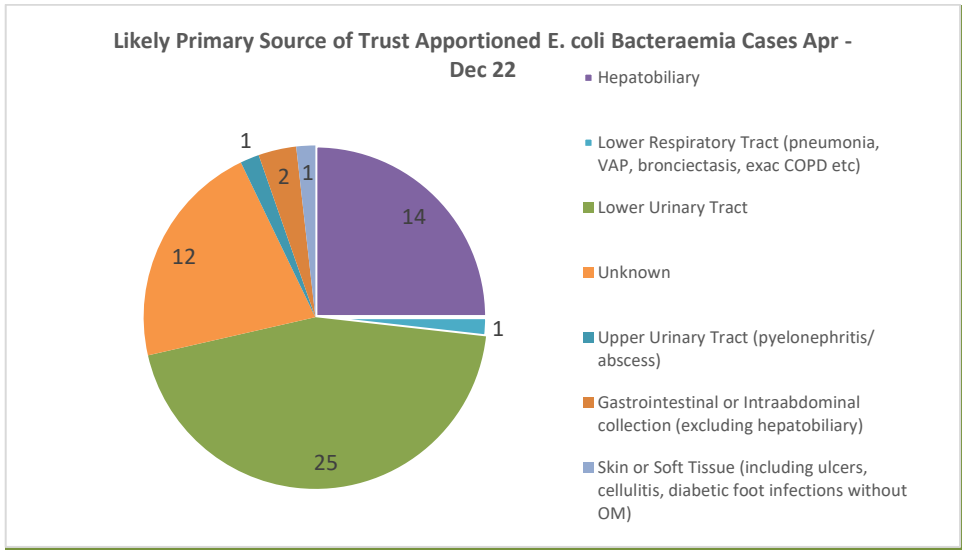
Threshold	57
YTD Total	56

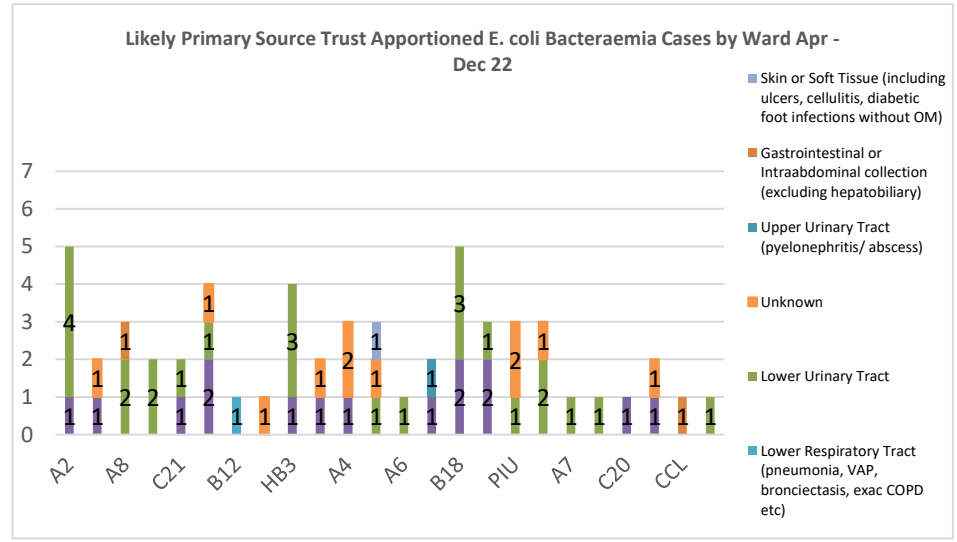
Appendix 1 HCAI Surveillance Data Apr – Dec 2022

Gram Negative Bloodstream Infection: E. coli Apr – Dec 2022



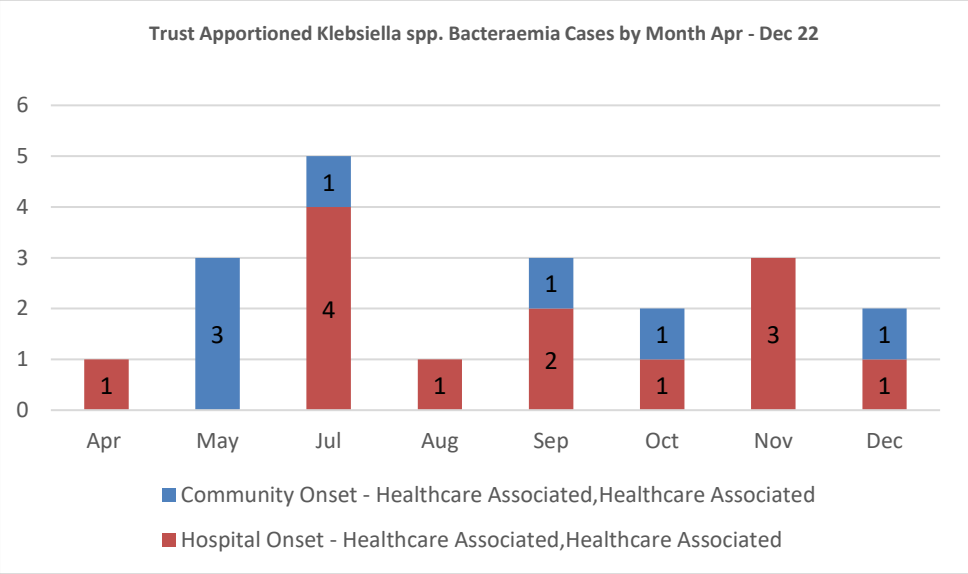


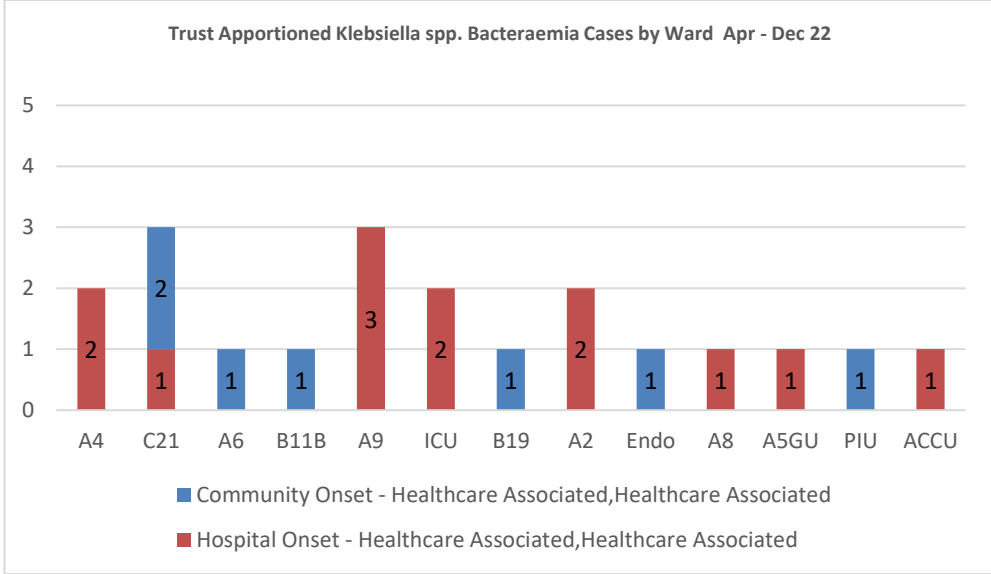


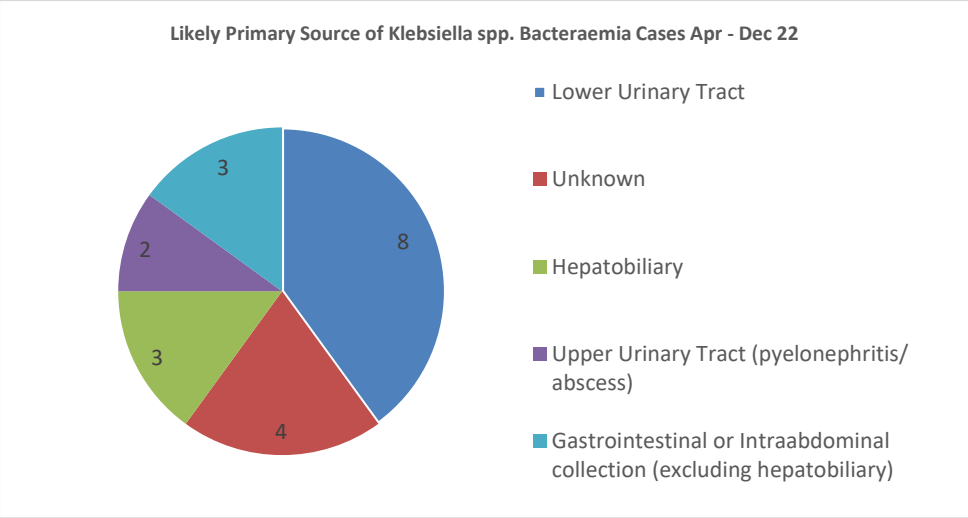


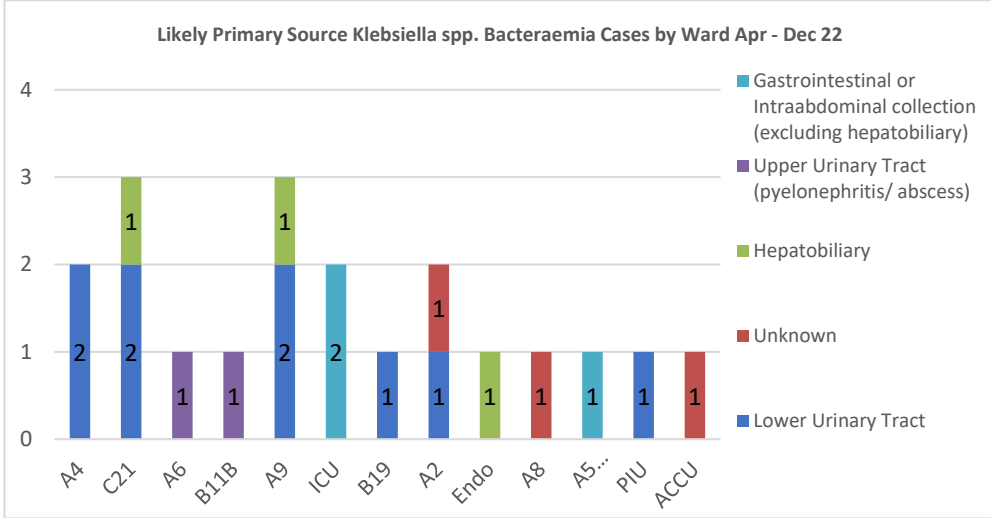
Threshold	19
YTD Total	20

Gram Negative Bloodstream Infection: Klebsiella spp. Apr – Dec 2022



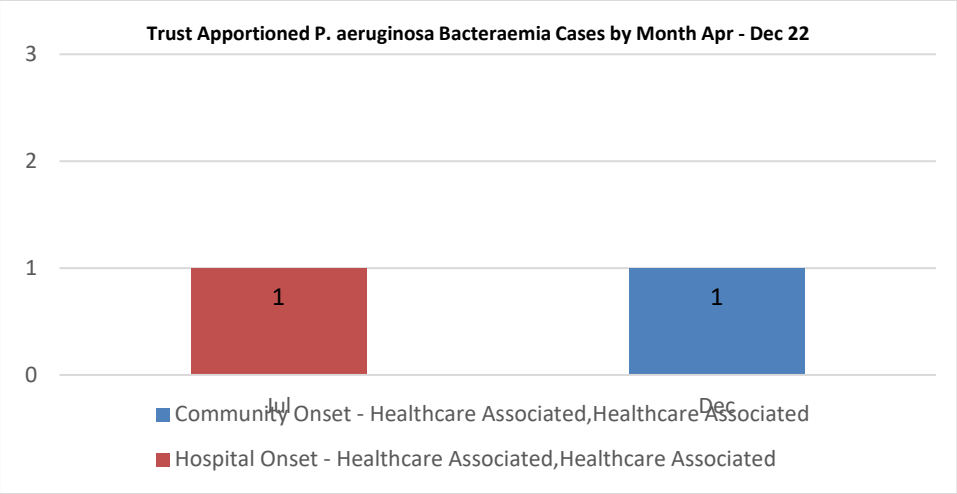


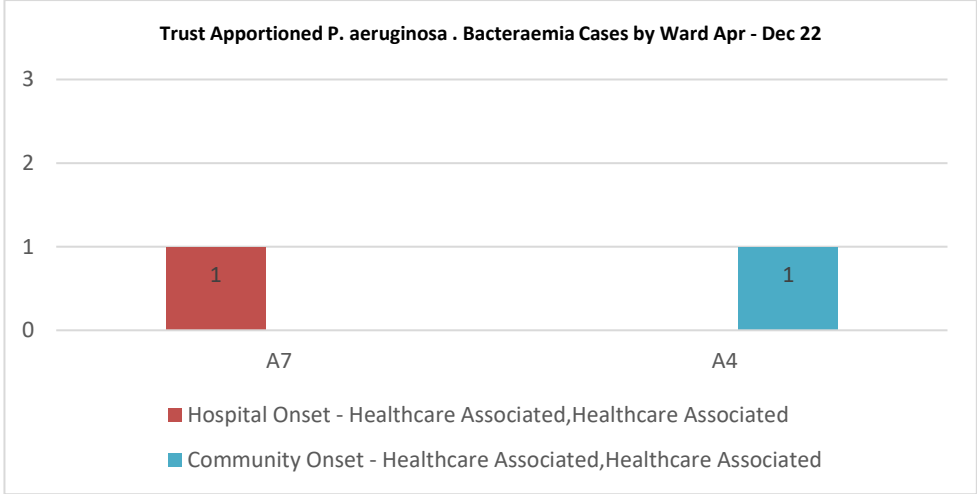


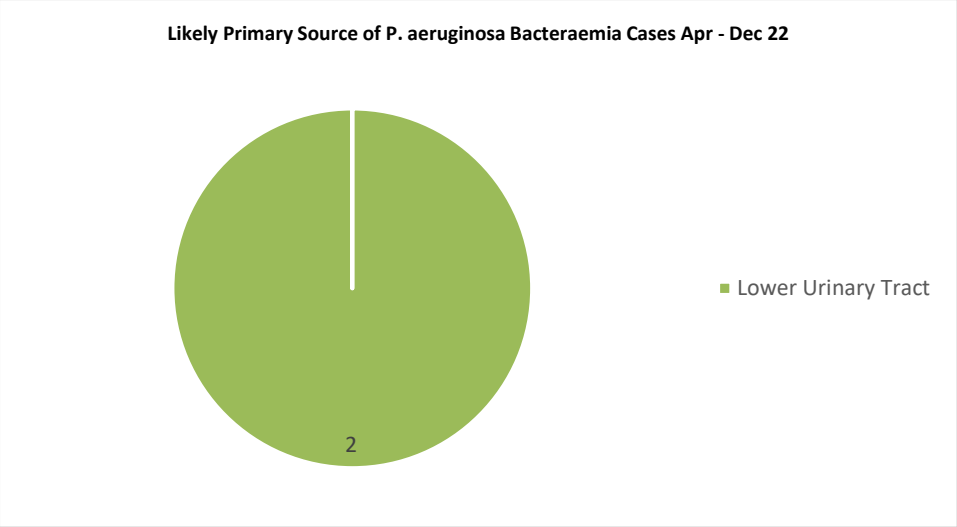


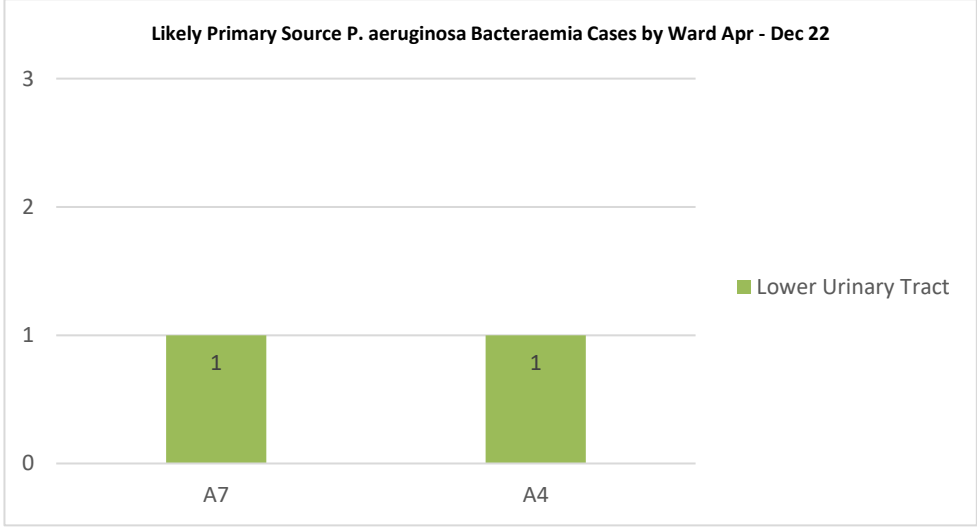
Threshold	6
YTD Total	2

Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa) Apr – Dec 2022



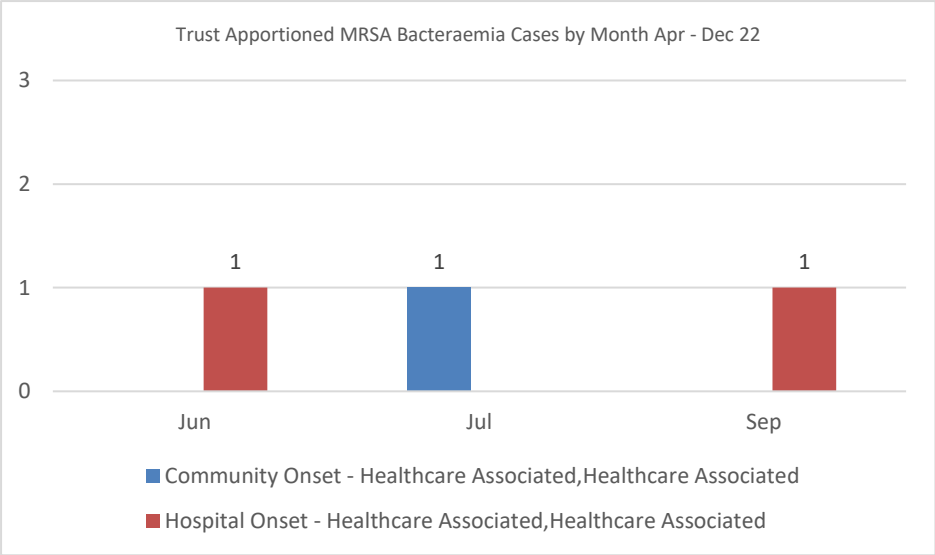


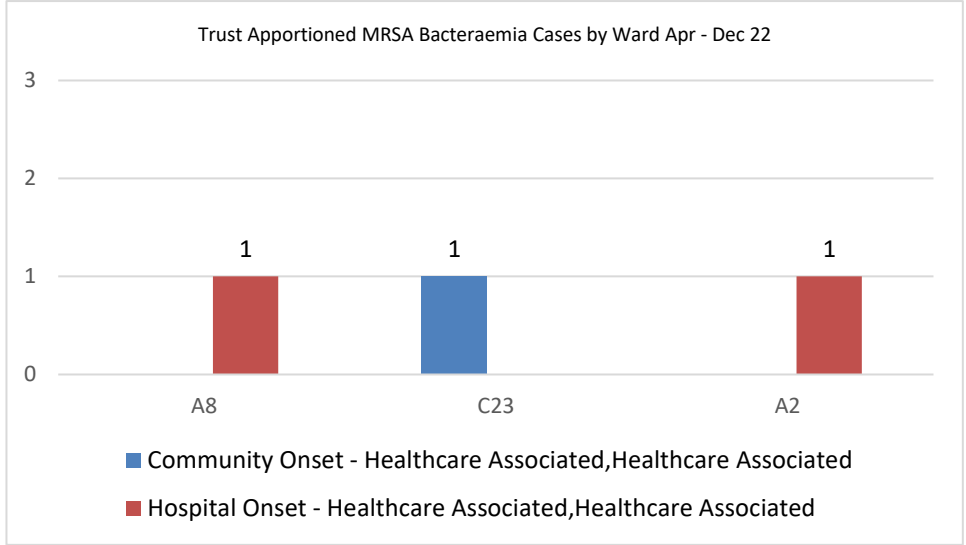


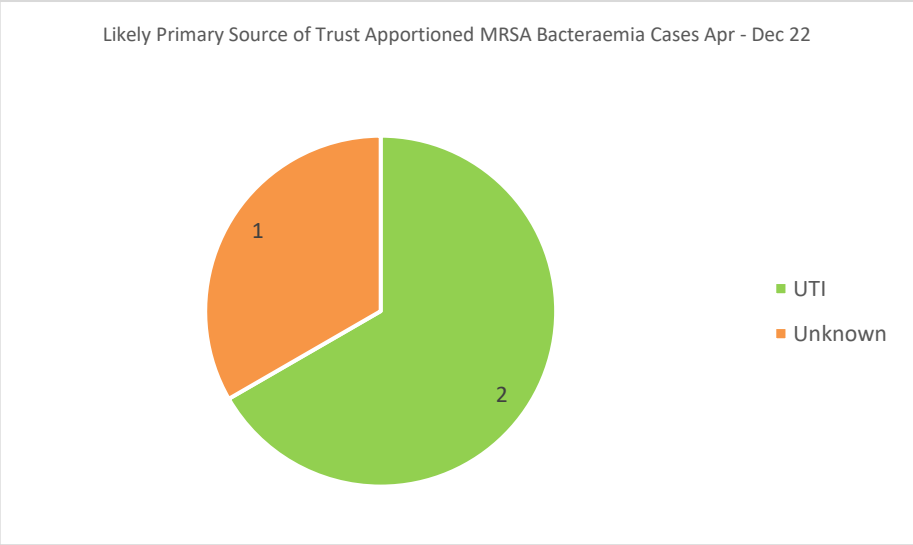


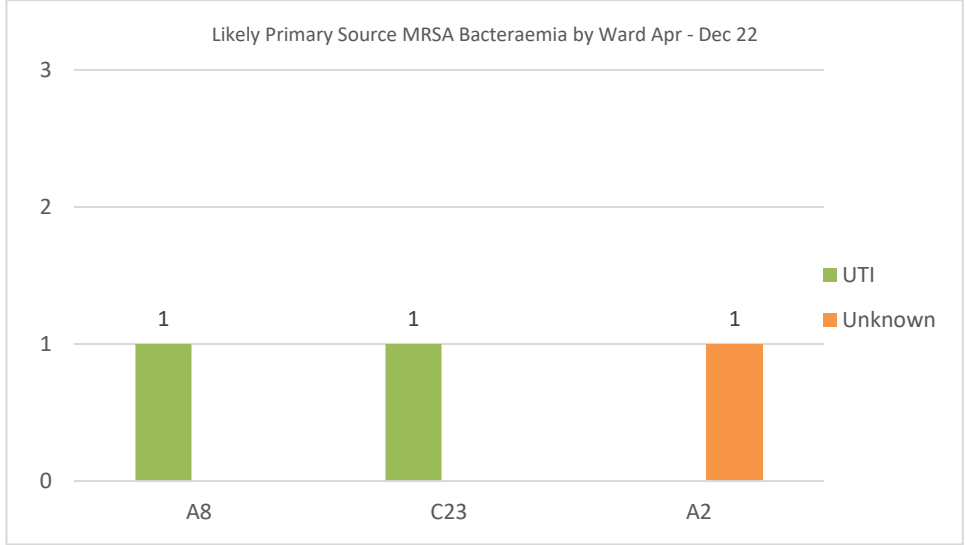
Threshold	0
YTD Total	3

Gram Positive Bloodstream Infection: Meticillin-resistant Staphylococcus aureus Apr – Dec 2022



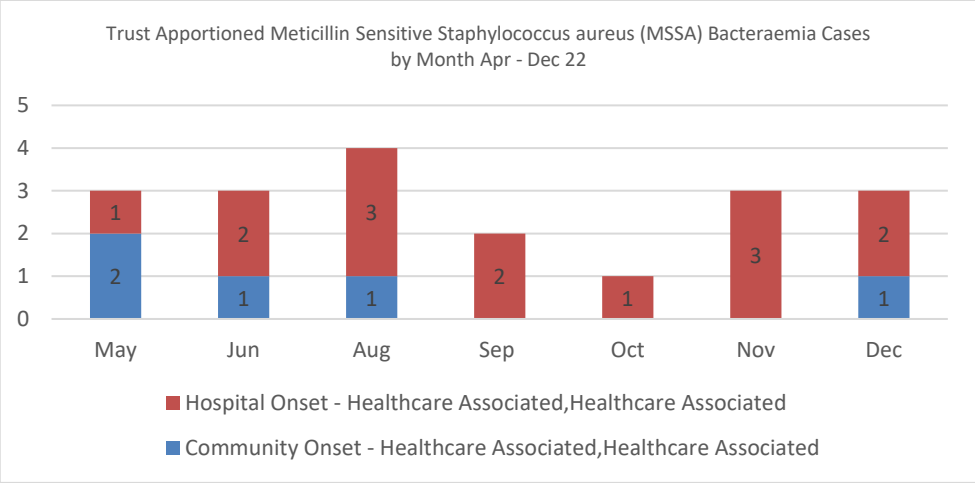


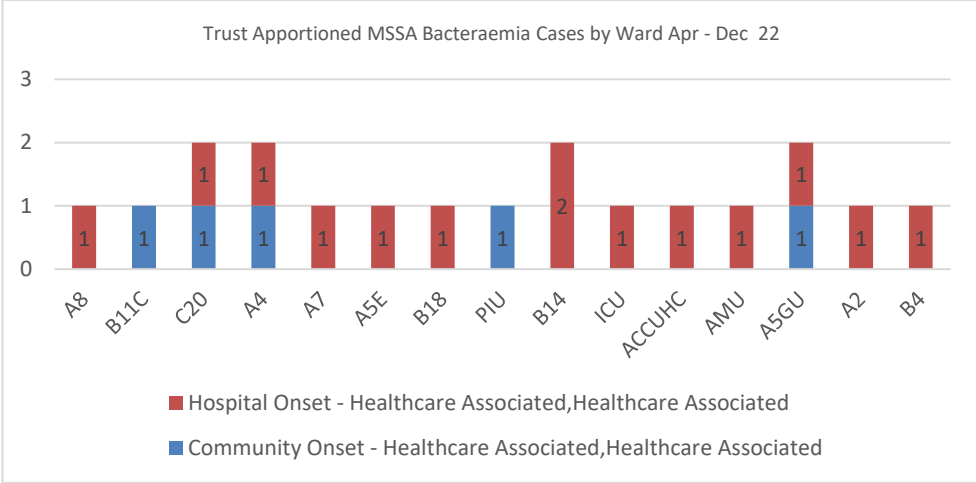


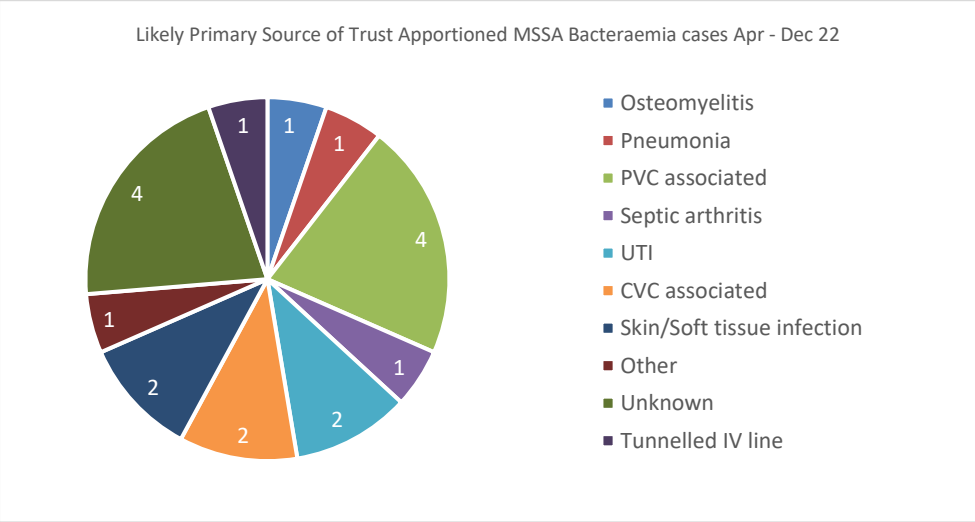


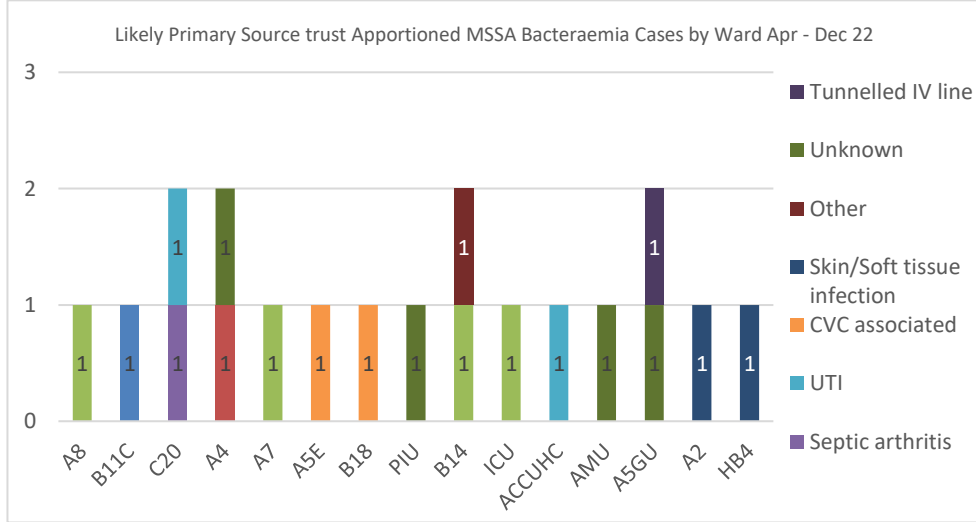
No Threshold	
YTD Total	19

Gram Positive Bloodstream Infection: Staphylococcus aureus Apr – Dec 2022



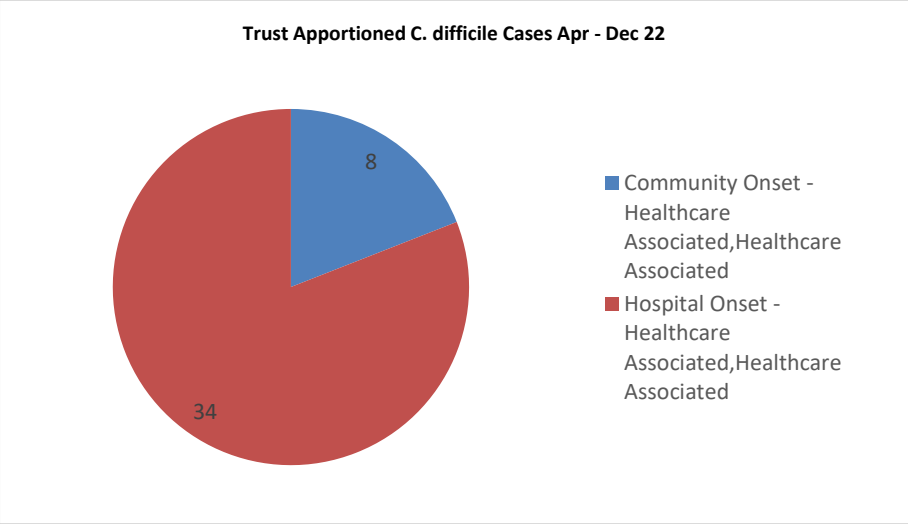


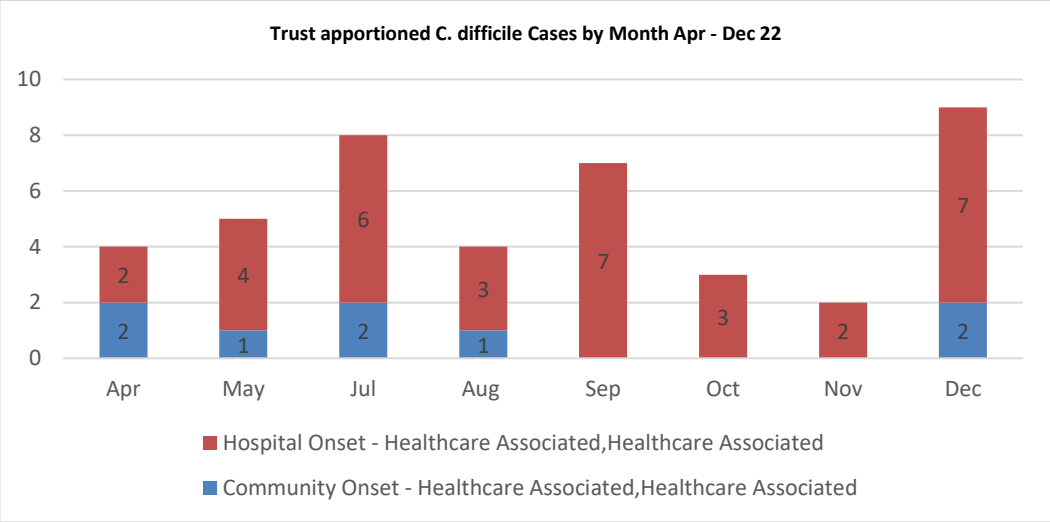


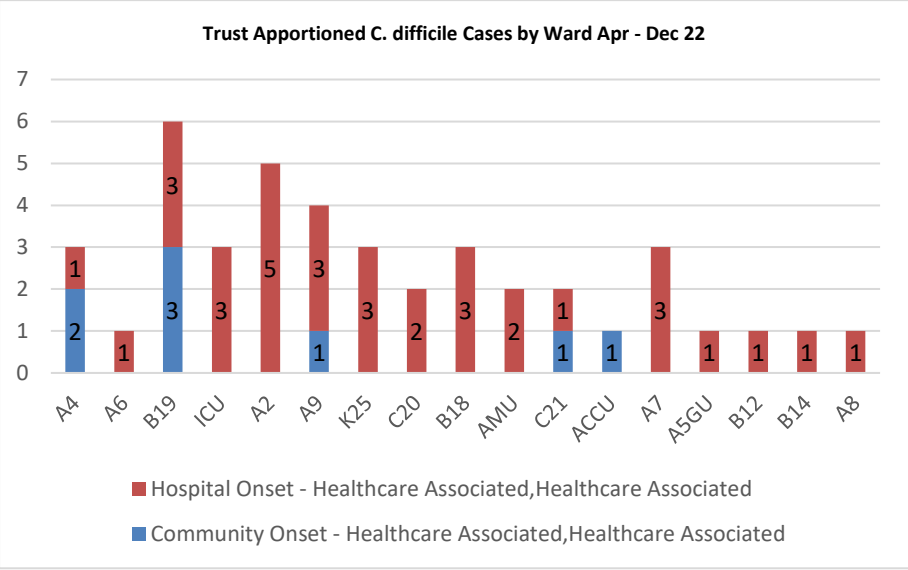


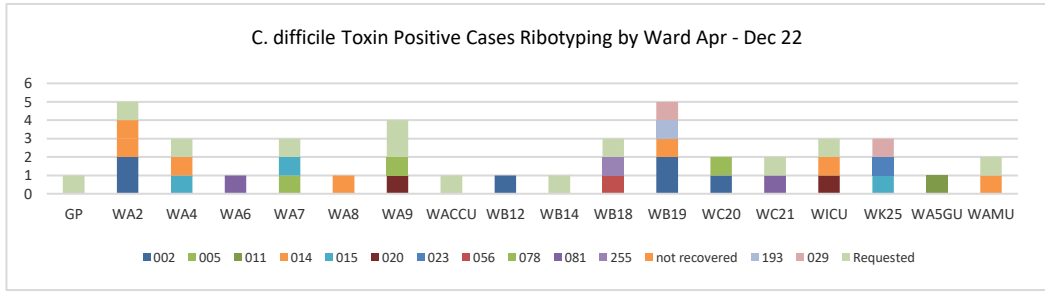
Threshold	37
YTD Total	42

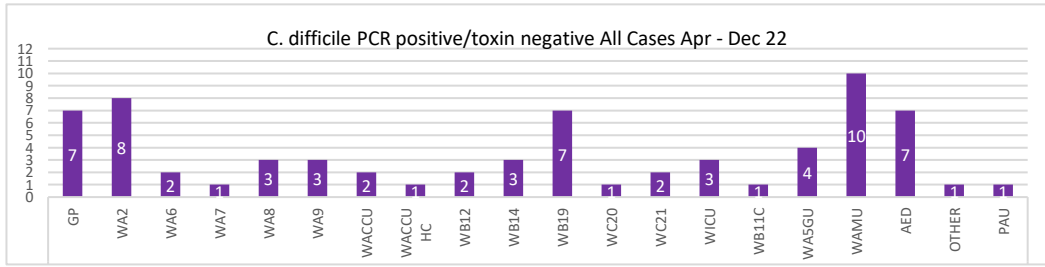
Clostridioides difficile (C. difficile) Toxin Apr – Dec 2022



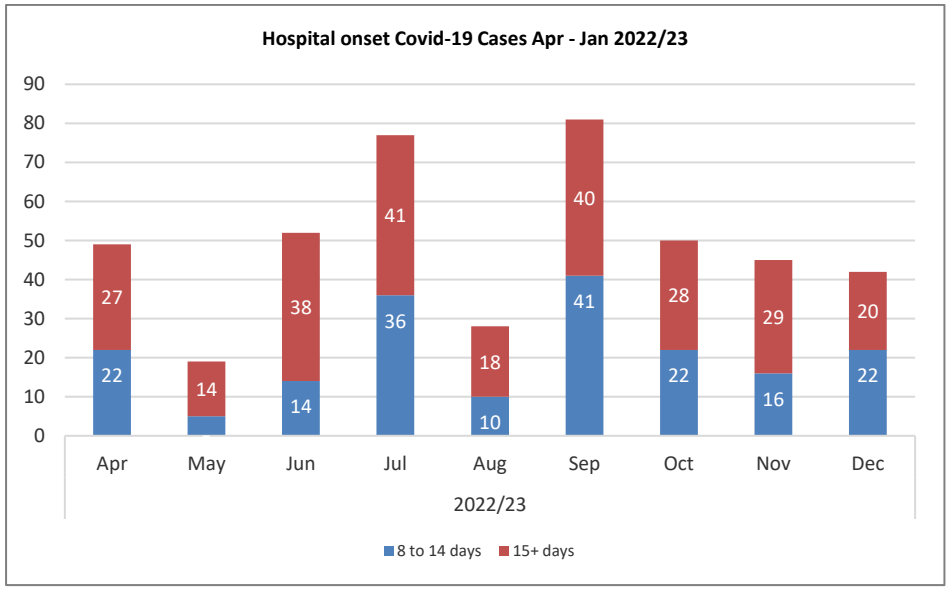


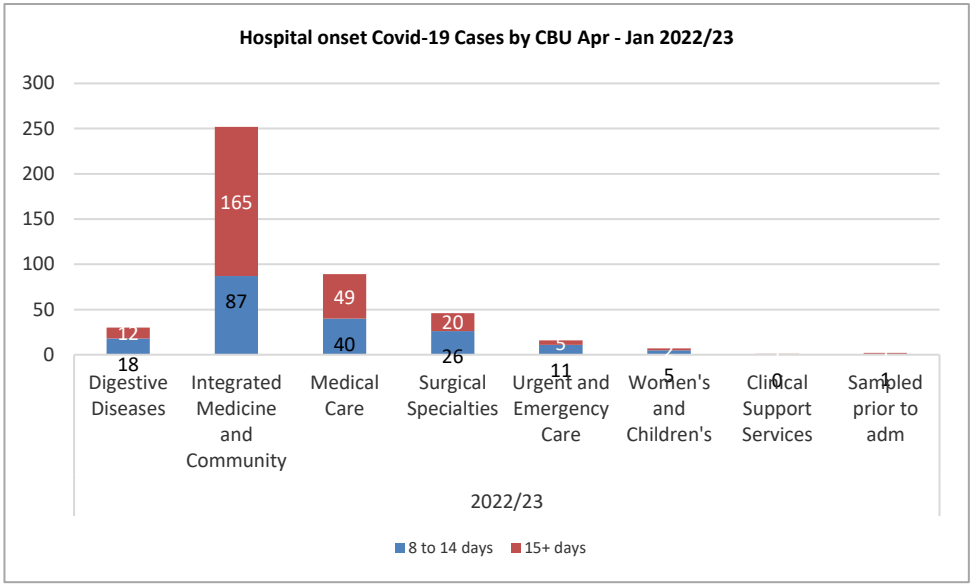


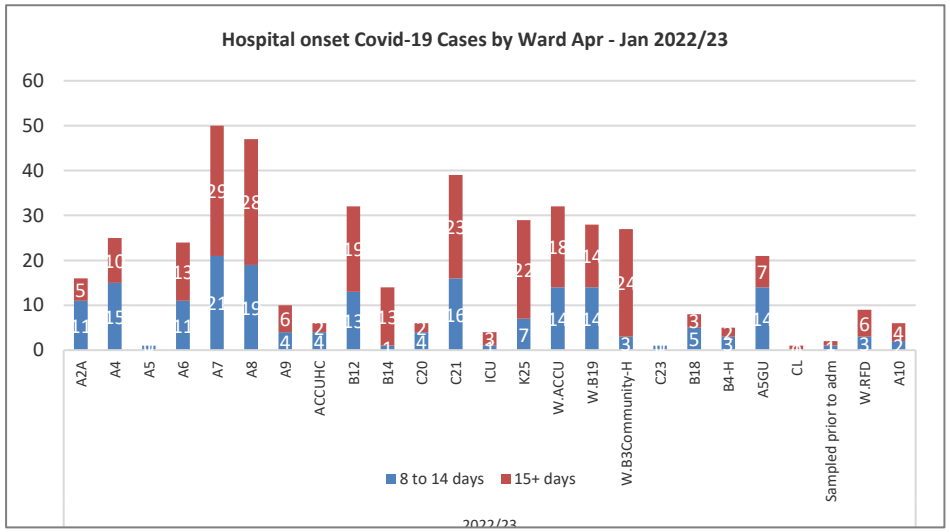


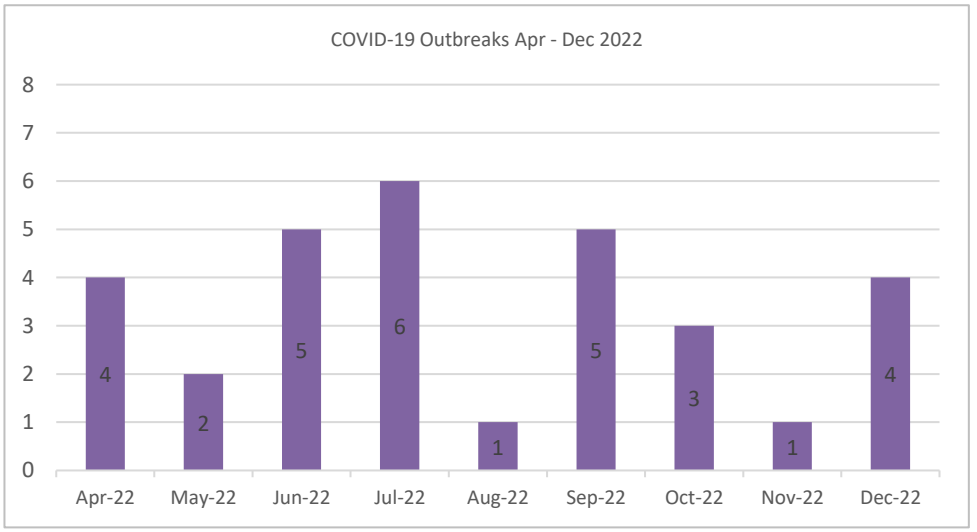


Covid-19 Surveillance Data Apr – Dec 2022









Appendix 2 IPC Audit Results

Ward	AMU	B14	B12	C21	A4	A10	AED	A9	B10+B11	C20
Environment	66%	85%	91%	92%	98%	86%	85%	90%	85%	95%
Ward Kitchens	75%	100%	100%	96%	100%	92%	76%	82%	96%	96%
Handling/Disposal of Linen	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%
Departmental Waste	86%	100%	94%	92%	100%	94%	100%	82%	100%	100%
Safe Handling Disposal of Sharps	88%	95%	96%	94%	100%	100%	88%	96%	96%	92%
Patient Equipment (General)	87%	82%	100%	90%	100%	100%	93%	100%	94%	100%
Patient Equipment (Specialist)	100%	100%	N/A	NA	N/A	100%	N/A	100%	100%	100%
Personal Protective Equipment	100%	100%	100%	100%	100%	100%	100%	100%	100%	93%
Short Term Catheter Management	100%	100%	100%	100%	100%	N/A	100%	100%	N/A	100%
Enteral Feeding	100%	N/A	N/A	NA	N/A	100%	N/A	100%	100%	100%
Care of Peripheral Intravenous Lines	100%	N/A	100%	NA	100%	N/A	100%	N/A	N/A	100%
Non-Tunnelled Central Venous Catheters	N/A	N/A	N/A	NA	N/A	N/A	N/A	N/A	N/A	N/A
Isolation Precautions	100%	93%	100%	100%	100%	N/A	100%	N/A	N/A	100%
Hand Hygiene	94%	100%	96%	100%	100%	93%	97%	100%	100%	100%
Overall Compliance	91%	96%	98%	96%	100%	97%	94%	96%	97%	98%
CBU	UEC	IMC	IMC	MC	MC	IMC	UEC	IMC	WC	WC

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/22/02/33**
SUBJECT:	**Safe Staffing Report; 6 Monthly Acuity Review, November 2022.**
DATE OF MEETING:	7th February 2023
AUTHOR(S):	Ali Kennah, Deputy Chief Nurse
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.
EXECUTIVE SUMMARY	This paper details the bi-annual review of nurse staffing (data up to November 2022), in line with the commitment requested by the National Quality Board in 2016 and more recently in the Improvement Resource for Adult Inpatient Wards in Acute Hospitals January 2018. The previous paper (June 2022 Data) was presented to Quality Committee (QAC) and Trust Board in August 2022. Since the last paper, a further Safer Nursing Care Tool (SNCT) data collection took place in November 2022 which enabled the June and November data to be reviewed and analysed against current establishment alongside the existing Allocate Safer Care acuity tool which is completed twice daily. The SNCT data collection does not include Intensive Care Unit (ITU) who align to the Guidelines for the Provision of Intensive Care Services (GPICS) staffing recommendations and Maternity who align their guidelines to Birth Rate Plus staffing recommendations and are therefore not included. Emergency Department data collection will be repeated in February 2023 as capacity issues impacted on the ability to collect accurate data in November. In accordance with the data collection for November **(Fig.10)**, the recommended Safer Nursing Care establishment figures compared to the number of staff in post, show there is a deficit of 103.72 (WTE) On analysis of the data there are 4 areas that show significant differences in SNCT recommendations and funded establishment, therefore an adjustment of the recommendations from SNCT has been included in this paper (**Fig 11**).

	The 4 areas for adjustment are: **CSTM:** SNCT recommends 8 WTE staff are required, actual funded establishment is 31.28 which is accurate, these results are unreliable due to estates work for IPC precautions at the time of the data collection, therefore less activity on the ward. **B12**: The ward has a layout of 3 bays and 4 cubicles, this means staff need to be allocated into bays and cubicles to support the patients, who are living with dementia to maintains safety. Therefore, more staff are required than recommended as SNCT data does not consider the practice environment, which is seen as one of its limitations (BMJ 2020). SNCT recommends 35 WTE, the actual establishment is 47 WTE which is correct. **B18:** This ward was refurbished and designed to accommodate patients with higher acuity, patients who require closer nursing (level 2 patients). The layout of the ward is significant in consideration of staffing establishments, these are unmeasured influences on demand that could have a substantial influence on the staffing requirements. SNCT recommends 35.8 WTE actual is 56.8 WTE. **B3:** SNCT data recommends a figure of 53.9 WTE against a funded establishment of 16.51 WTE. This is due to escalated beds in operation and the type of patients in those beds who breach the criteria for medically optimised. On analysis the senior clinical team can confirm that when B3 is functioning as it was intended to do, the current establishment is correct. This must be considered in line with the increased acuity and dependency of patients at WHH The limitations of SNCT such as the lack of consideration for activity, ward layout and speciality must be recognised when considering the results as part of reviewing staffing establishments. Professional Judgement, which is recommended within the SNCT process, must always be applied, seen as the ‘ gold standard' when determining safe staffing levels BMJ (2020) Across both the June 2022 and November 2022 data collection there are similar differences in the deficit between what SNCT recommends and what the establishment figures are for wards A2, A7, A8, A9. Across these 4 wards in November 2022 the total deficit in WTE funded establishment compared to

recommendations from the SNCT data collection is 28.25 WTE. These wards require an establishment review with a recommendation to increase funded establishments in line with the increases recommended as consistent reports of higher dependency, enhanced care and increased harms are escalated regularly to the senior nursing team.

Another area of concern in relation to funded establishment is AMU, national guidelines recommend 1:6 Nursing ratio's instead of 1: 8, Local evidence of the growing demand on this ward illustrates the requirement for an establishment review.

The report also provides an overview of the current nursing/midwifery staffing workforce data, which shows latest (November 2022) vacancy data in whole time equivalent (WTE) for the following:

Areas where WTE vacancies have reduced

- Health Care Support Workers (HCSW): A reduction of 10 (WTE) vacancies from 80 in June 2022 to 70 in November 2022 equates to 12%
- Theatres: A reduction of 6 (WTE) Registered Nurse (RN) vacancies from 18 in June 2022 to 12 in November 2022 this equates to 33%

Areas where WTE vacancies have increased

- Registered Nurses (all bands): An increase of 53 WTE from 95 in June 2022 to 148 in November 2022 equates to 35%
- Registered Midwives: an increase of 8 WTE from 20 in June 2022 to 28 in November 2022
- Turnover has **increased** month on month since January 2022 reporting at 14.95% in June 2022 with an increase to 16.97% in November 2022.

Overall Position

Increased nursing vacancies, increased acuity and dependency on the wards and the continuing number of patients with 'no right to reside' significantly impacts on the ability of the senior nursing teams to ensure there are enough nurses to provide the standards of care expected. Daily oversight and mitigation of this continues to be the main priority for the senior nursing teams and temporary staff are deployed as necessary. Recruitment and retention planning is in place and expert external support from Just R (engagement and recruitment

<table>
<tr><td></td><td colspan="4">specialists) is utilised. WHH have seen positive increases is HCSW staff and Theatres, Maternity show higher vacancies for November data and have positively closed this gap in December. Proactive recruitment continues.

The report gives an overview of the current workforce position for the Planned, Unplanned and Clinical Support Services Care Groups and a Maternity Services and Allied Health Professional (AHP) update, demonstrates processes and mitigation to ensure safe levels of care and outlines recruitment and retention plans.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
X</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">It is recommended that the Quality Assurance Committee discuss and note the contents of the report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Not Applicable</td></tr>
<tr><td rowspan="3"></td><td colspan="2">Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td colspan="2">Date of meeting</td><td colspan="2"></td></tr>
<tr><td colspan="2">Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>NEXT STEPS:
State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="4">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(If relevant)</td><td colspan="4">Choose an item.</td></tr>
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QUALITY ASSURANCE COMMITTEE

SUBJECT	**Safe Staffing Report 6 Monthly Acuity Review, November 2022**	**AGENDA REF:**	**QAC/22/02/33**

1. INTRODUCTION

1.1. This paper provides the bi-annual comprehensive report to the Quality Assurance Committee on Nursing, Midwifery and Allied Health Professional staffing. This report details the six-monthly review of nurse and midwifery staffing in line with the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016), and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018. The guidance recommends that the Board of Directors receive a biannual report on staffing to comply with the CQC fundamental standards on staffing and compliance outlined in the well-led framework.

1.2. A triangulated approach to nurse workforce establishment planning is utilised at WHH in line with NQB recommendations. This includes:

- Twice-yearly review of nursing establishments using an evidence-based decision matrix, the Safer Nursing Care Tool (SNCT)
- Daily analysis of Safe Care results
- Annual Chief Nurse led evaluation of staffing establishments
- Monthly analysis of Care Hours per Patient Day (CHPPD)
- Daily monitoring of staffing capacity versus demand with a review of harm data and the relationship to staffing

1.3. As per the NQB guidance, this bi-annual report will provide the results from the first and second SNCT data collection for 2022, completed in June 2022 and November 2022. The report also includes the current Trust nursing and midwifery workforce position from month 8 of the PWR data. A summary workforce position for the Care Groups and Allied Health Professions (AHP) workforce is also detailed.

2. NATIONAL/LOCAL CONTEXT

2.1. Nursing and midwifery workforce supply continues to be a significant challenge nationally with the shortfall in registered nurses well-documented across all NHS organisations and oversight bodies. According to NHS workforce statistics, the total number of vacancies in the medical and nursing sectors of the NHS has increased. The latest NHS Digital vacancy data, published January 2023 for September 2022, shows a vacancy rate of 9.7% equal to 133,446 vacancies.

2.2. In September 2021, the National University and Colleges Admission Services (UCAS) received unprecedent interest in healthcare programmes commencing in September 2021. This translated into an increase in students commencing on Nursing, Midwifery and AHP programmes over 2022 with The Nursing and Midwifery Council also reporting an increase in the number of nurses on the permanent registration by 5,949 which is a 0.9% increase.

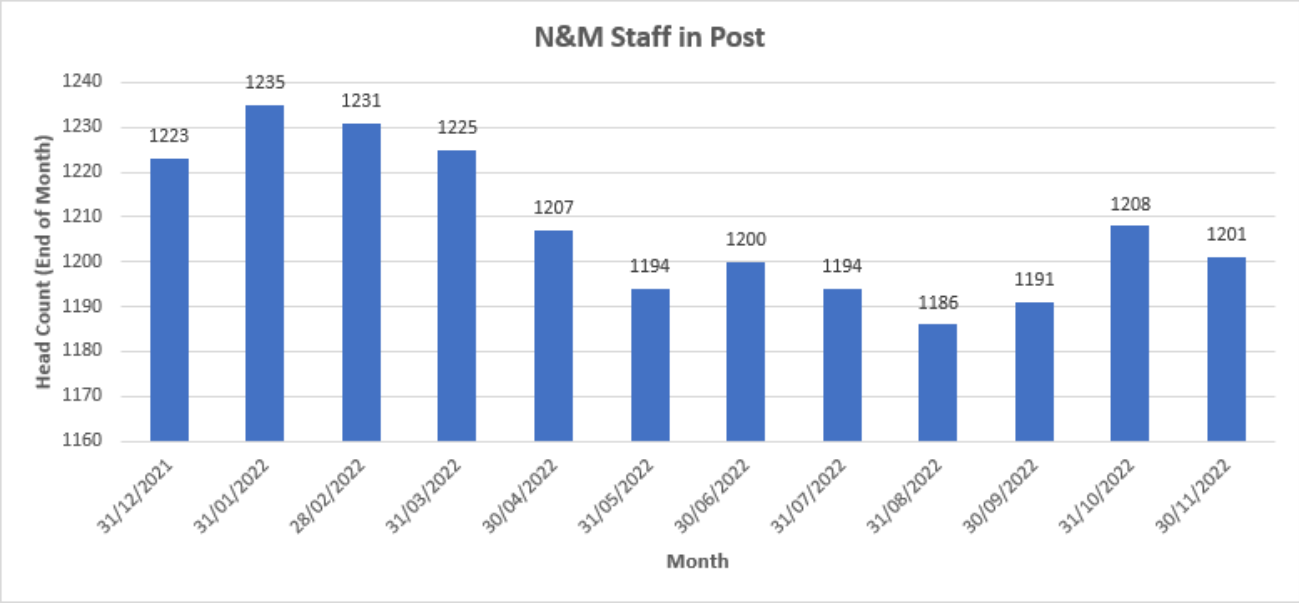
2.3. More recently, the Royal College of Nursing (RCN) has published concerns of falling numbers of applications into nursing during 2022, particularly from mature students. This is significant for WHH as Chester University, the main Higher Education Institute (HEI) provider for WHH, receives the majority of applications into nursing from mature students. Work is underway with Chester University and WHH Nursing and Midwifery Workforce Team to address this. WHH do receive students from Liverpool John Moores and Edge Hill University, these numbers are smaller due to WHH geographical location.

2.4. The demand on services continues as higher levels of patient acuity and dependency are experienced across all the clinical areas at WHH, which mirrors the national picture, as published in NHS providers report, NHS Reality Check; The financial and performance ask for Trusts on 2022/2023. Furthermore, the Care Quality Commission (CQC) State of Care report (May 2022) and Jivraj et al (2020) a higher dependence amongst older people because of the pandemic which is reflected in the WHH continuing increased numbers of patients with 'no right to reside'.

2.5. There is clear evidence to shows that nurse staffing levels make a very significant and positive difference to patient outcomes (mortality and adverse events) patient experience, quality of care and the efficiency of care delivery. Short staffing compromises care and recurrent short staffing results in increased stress and reduced staff wellbeing, leading to higher sickness and a higher turnover rate.

3. TRUST WORKFORCE POSITION

Fig. 1 Nursing and Midwifery Staff in Post



3.1. Historically 'staff in post' data follows a trend of increase in Q3/4 due to students who qualify in September and gain registration across October and November and then a rising number of vacancies in Q1/Q2, due to increased turnover rates. The trend shown in the table above is showing a decrease in staff in post for November, out with WHH natural familiar yearly pattern, in line in what national statistics are showing. An increase in turnover is noted from 16.09% in September 2022 to 16.97% in November 2022, above the national turnover rate of 13.6% and the Trust target of 13%. Recruitment and retention planning is fundamental to ensure this downward trajectory does not increase. Further information for WHH recruitment and retention planning is described in section 3.6.

3.2. WHH turnover rate for HCSW's in September was 19.56% and has shown as significant decrease in November to 16.87%. WHH continues to commit to the NHSE/I National Programme to further reduce HCSW vacancies and reduce turnover.

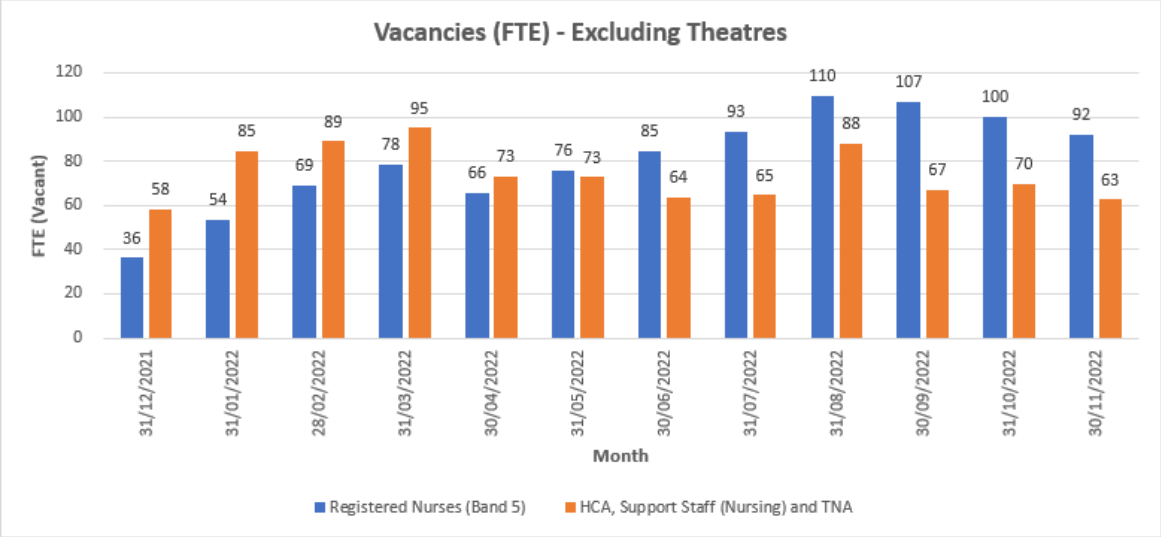
3.3. Vacancy Position

3.3.1. To provide clarity with the vacancy data presented, WHH externally report Provider Workforce Return (PWR) data each month to NHS Digital- this data is driven by the number of staff paid in month so whilst the PWR data shows whole time equivalent (WTE) vacancies, a number of these may have already been assigned and therefore are not truly vacant posts.

3.3.2. Monthly meetings are held between the Finance Department, Human Resource Workforce Team, and Trust Workforce Lead to compare data and ensure correct reporting. A narrative explaining the number of staff within the recruitment pipeline accompanies the tables below.

3.3.3. The chart below identifies the number of band 5 Registered Nurse (RN) and band 2 Health Care Support Worker (HCSW) vacancies up to the end of November 2022, this is based on the funded establishments, against the number of staff in post.

Fig. 2 Registered Nurse band 5 and Health Care Support Worker Vacancies (excluding theatres)



N.B. Theatre staff are excluded due to the job titles of their staff in post- they are demonstrated separately below in Fig 2

3.3.4 A reduction in band 5 RN and HCSW vacancies is demonstrated for November 2022. Positive recruitment continues and this is demonstrated with the continuing reduction of both RN and HCSW during October and November 2022.

3.3.5 The above data demonstrates band 5 RN vacancies only, total RN vacancies across the Trust (all bands) are 148 WTE. Of these, 54 have 'no name assigned', 56 are international nurses who will be working as band 5 nurses in September 2022 and 28 current 3rd year students who qualify in September 2022. Therefore whilst 84 of these vacancies are assigned, those staff will not be in post as band 5 nurses until

September 2022. This leaves a continuing shortfall in staff of approximately 44%. A recruitment event is planned in February 2023 and WHH are working with Just R, an expert team to improve employee attraction engagement and retention. Particularly focussed on hard to recruit to areas such as ED, Maternity and Pharmacy, the specialist input provided includes proactive campaigns to target interest. Ward B18 is highlighted as an area with increased shortfall of staff with 14 RN vacancies equating to a 32% % vacancy factor. Plans for that area to be included in the Just R recruitment campaign are underway.

Fig 2 Band 5 vacancies by Care Group Split (Planned Care includes Maternity)

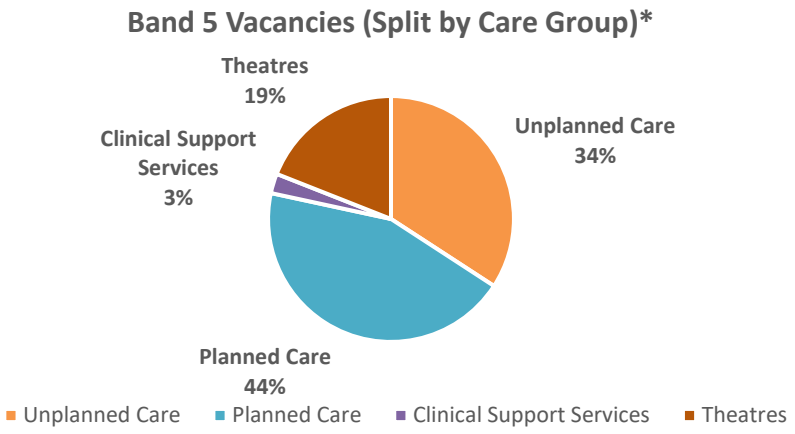
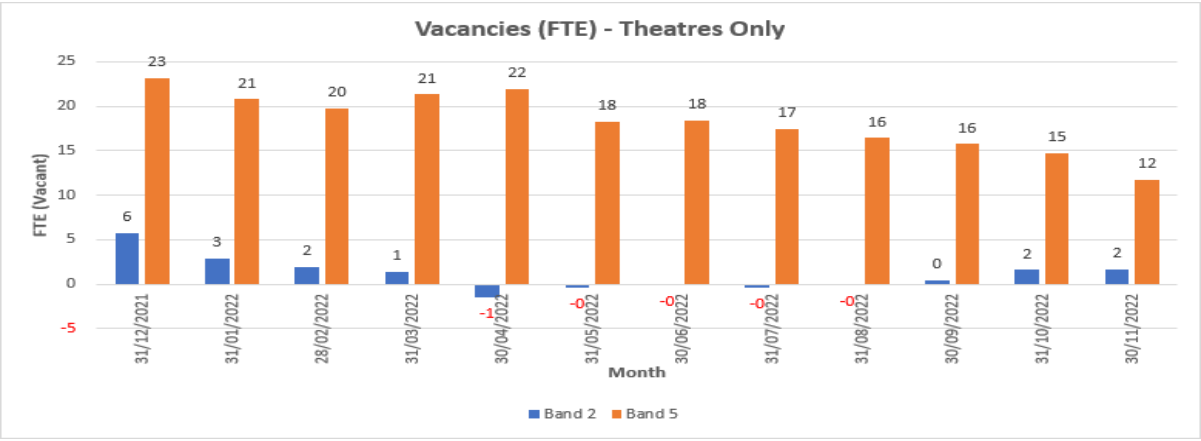
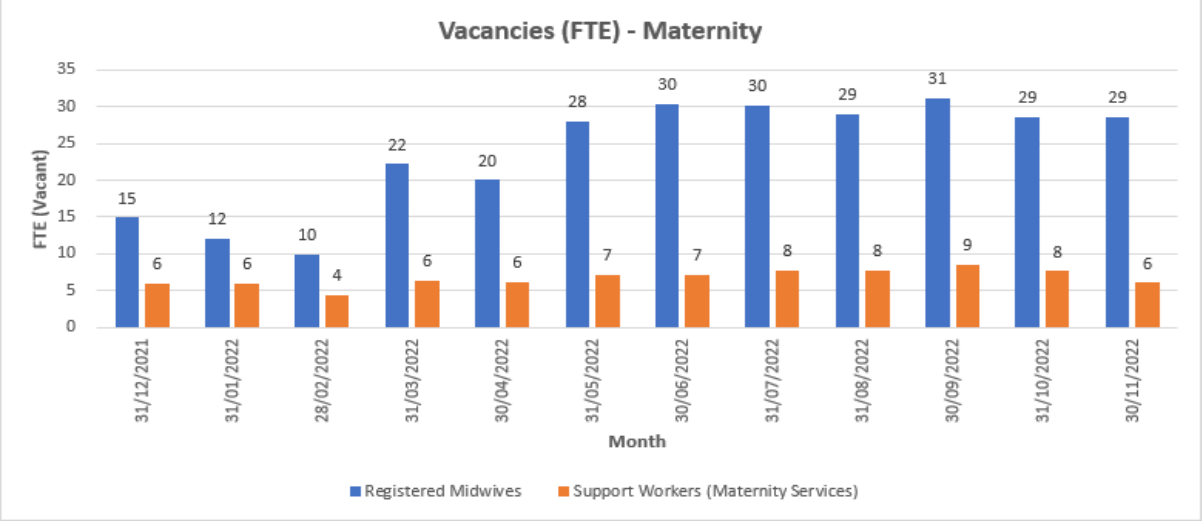


Fig. 3 Theatres Band 5 and Band 2 Vacancies



3.3.6 A positive reduction in vacancies is shown for November with theatre vacancies on a downward trajectory. The Digestive Diseases CBU Team have worked hard with the Theatre Team to review establishments and explore different ways of working. Agency usage data for December 2022, shows nil agency used during December, which is a significant improvement for this team, as a result of the improving vacancy picture.

Fig.4 Midwives and Maternity Support Workers vacancies



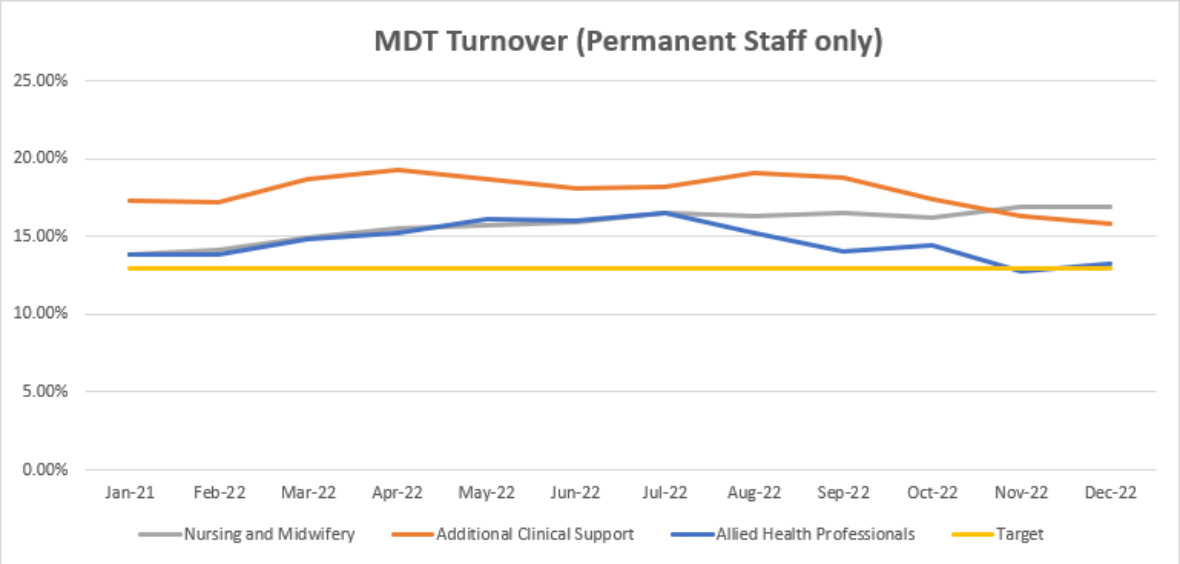
3.3.7 Local data for maternity in December 2022 shows a reduction to 20.34 vacancies down from the 29 WTE shown above. Of this, 14.44 WTE have been recruited to and are at various stages of the recruitment pipeline. This is an improving picture, following the development and implementation of a workforce staffing action plan. This leaves a total of 5.9 WTE vacancies at this time with a plan to continue to work with Just R.

3.3.8 Midwifery team leaders have collaborated with Trust recruitment events and a bespoke Midwifery Open Day was held on 27th November 2022, successfully recruiting 2.54 WTE midwives and connecting with a number of students who have since applied via the Just R recruitment campaign. In 2023 Maternity is included in a Trust led recruitment initiative.

3.3.9 All Band 7 Specialist and Ward Manager roles are now recruited into alongside two Matron posts, one of which has been vacant since May 2022. There are no band 3 Maternity Support vacancies.

3.4. Staff Turnover:

Fig 5. Registered Nurse and Midwifery, Health Care Support Workers and AHP Turnover.



3.4.1. The table above illustrates a continued increase in nursing and midwifery turnover from 16.09% in September 2022 to 16.97% in November 2022, against a national average of 13.6%, and Trust target of 13%.

3.4.2. The main reasons staff cite for registered nurses and midwives leaving the Trust is captured as an overall reason within the Trust Workforce Dashboard. Reasons for leaving over the last 12 months are:

- Voluntary resignation (unknown), this reason is cited for the greatest number of leavers
- Voluntary resignation (work life balance) Flexible working offers are promoted before staff leave for example a member of staff currently working in the Trust who has requested 9-5 hours, this is being worked through by the clinical team.
- Retirement age
- Flexible retirement

3.4.3. Monthly turnover updates for care groups are provided to the Trust Workforce Review Group chaired by the Deputy Chief Nurse. Trends for leaver data are pulled from the updates, with the Emergency Department as a hotspot for increased leavers in 2022. Staff cited reasons for leaving as work life balance, with many staff leaving to work for agencies to avoid working within an Emergency Department setting. The peak absence being mid-December with 38% of RN positions (band 5-7) vacant. More recently in early January a positive response to specialised recruitment for the Emergency Department via Just R has been reported with over 40 people interested in posts, this is being closely managed. No further resignations have been received for the Emergency Department in January and recent appointments of the Ward Manager and Lead Nurse have a positive impact on the department.

3.4.4. The HCA specific leaver data is monitored and reported to NHSEI on a weekly basis. The themes for leaver reasons from this data are:

- Flexible retirement
- Work/Life balance

The current piece of work reviewing B2 and B3 job roles, in line with Cheshire and Merseyside (C&M) Workforce Leads is due to complete in February 2023. WHH is one of the final Trusts across C&M to move ofrward with this. Acknowledging the value that the HCSW workforce contributes will have a positive impact on recruitment and retention of this workforce.

3.5. Sickness

Fig.6 Sickness Absence

Month	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22
N&M	7.69%	8.86%	6.28%	5.64%	6.24%	5.80%	7.12%
Band 2	8.69%	9.75%	9.21%	8.87%	9.32%	8.065	11.11%

3.5.1 Sickness absence levels for registered nurses and HCSW's has been consistently above the Trust target of 4.2% as demonstrated above, which impacts on the overall staffing available in the Trust, significantly increasing in December 22 for both registered staff and HCSWs.

3.5.2 The impact of the increase in sickness in December triggered the start of the NHSP Incentive Scheme, 1 week early from 22nd December to continue until end of January 2023, and the use of off framework agency workers, via approval from the Chief Nurse, Deputy Chief Executive. Anxiety and stress cited in December for absence where peak occurred.

3.5.3 Any shortfalls in staffing are reviewed and managed twice daily at the operational staffing meetings chaired by a Lead Nurse to ensure all wards and departments have sufficient staff to meet the acuity and activity needs of the wards.

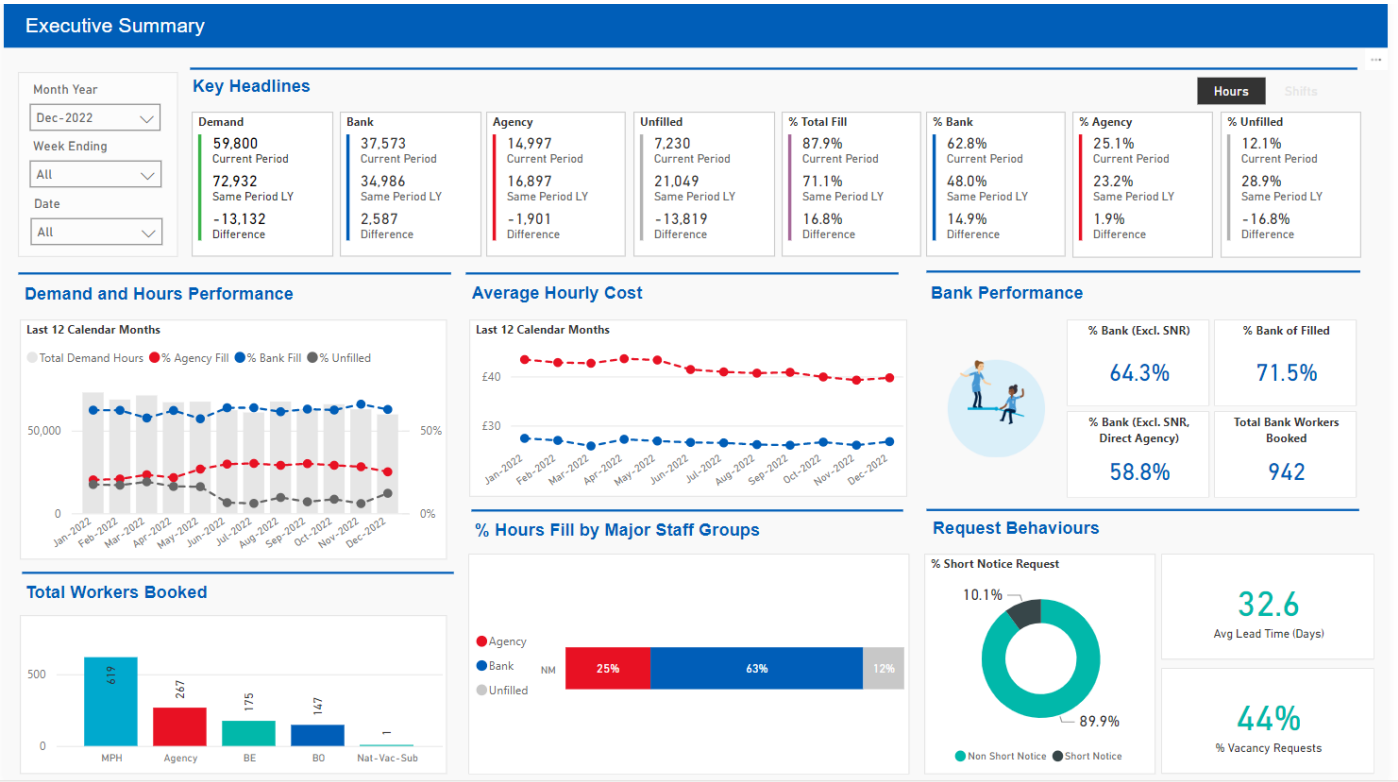
3.6. Temporary Staffing

3.6.1 WHH are contracted to work with NHS Professional NHSP for the provision of temporary bank and agency staff. Systems are in place to monitor usage and work is ongoing to reduce the use of agency staff. Monthly meetings are held with NHSP colleagues to review key performance indicators.

3.6.2 WHH have agreed NHSP rates in line with the agenda for change and have recently paid NHSP staff their uplift dating back to April 2022.

3.6.3 A 'winter incentive scheme' was approved for staff working additional hours via NHSP, this commenced 22nd December 2022 to end 31st January 2023. The aim of this incentive was to improve fill rates within the Trust via substantive staff who are members of NHSP and reduce agency usage. A review of staffing utilisation across the Christmas and New Year period shows a positive 22% increase in shift fill by NHSP from 57% to 79%, as a result of the incentive scheme. Agency usage was not reduced due to the unexpected need to utilise off framework agency workers across Christmas and New Year, usage increased by 165 hours.

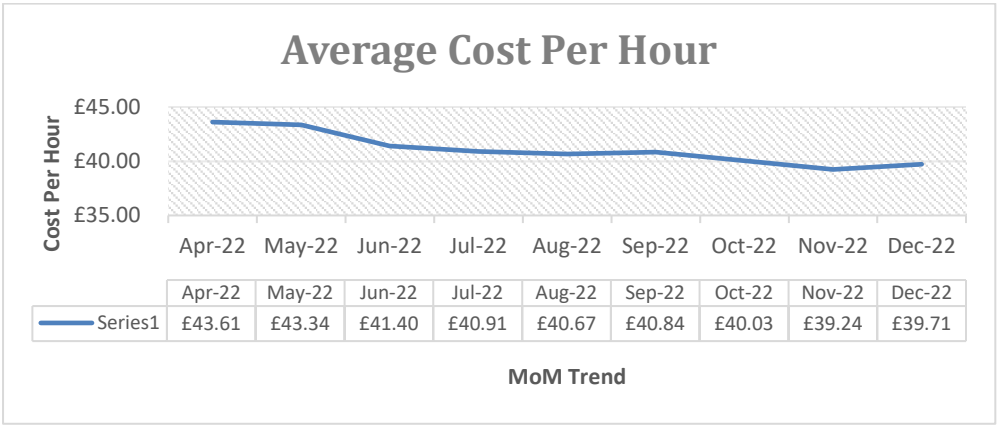
Fig. 6 Summary of NHSP bank and agency usage for December 2022



3.6.4 The table above demonstrates improved total fill rates compared to the same period the year before, a reduction in hours filled by agency workers, and marked reduction in unfilled shifts. The figure also demonstrates the reduction in average hourly cost for agency staff. This diagram also highlights the lead time for booking shifts. For December 2022, WHH were the best performing Trust in C&M at 32 days and outperformed other Trusts in C&M contracted with NHSP, for booking NHSP shifts automatically from rosters rather than direct, this demonstrates good roster management.

3.6.5 The table below demonstrates the reducing cost of agency workers based on savings of £2.12 per hour that totals a cost avoidance of £342k since the introduction of Centrally Agency Managed Service (CAMS) via NHSP.

Fig.7 Average Cost of Agency Per Hour since April 2022



3.6.6 During December 2022, due to significant increase in sickness, higher numbers of open escalation beds (up to 62), accelerated transfers of care for prolonged periods and ongoing vacancy figures, off framework agencies, Greenstaff and Thornbury were utilised from 19th Dec into the new year, the latter being for increased beds and associated acuity in ITU. Off Framework agencies can only be approved by CN/Dept CEO after comprehensive site review of the staffing position and all other alternatives explored. No further use of off framework agencies since 18th January 2023.

3.7 WHH Recruitment and Retention:

3.7.1 A Trust Recruitment and Retention Action Plan is in place, monitored via the Workforce Review Group. Retention planning is supported by the Cheshire and Merseyside HEE Retention lead, work continues with Trust Workforce Lead and the Clinical Education Department to ensure progress with this workstream is moving forward. A number of initiatives are in place listed below:

3.7.2 **Rolling recruitment programme:** Regular advertising for both RN and HCSW with bi-weekly shortlisting and ongoing interviews. Larger recruitment events are planned every 3 months and held off site with the next event February 2023. WHH is a member of the NHSEI Retention Programme of work sharing good practice across C&M to support system working.

3.7.3 **Specialist Areas Recruitment:** 'Just Recruit' (Just R) have been commissioned to support ED, Maternity and Pharmacy in filling their vacancies and weekly meetings are in place to monitor progress. Increased interest in posts within the Emergency Department has been seen with over 40 expressions of interest currently being monitored.

3.7.4 **Transfer Window:** The 'Transfer Window' supports registered nurses to move to a different ward/ area without going through the formal interview process. This is subject to the clinical requirement and WTE vacancy on the receiving ward and requires senior nurse approval. This process continues to be utilised within WHH. Between August 2022 and December 2022, there have been 3 band 5 and 4 HCSW transfer requests, 2 band 5's have transferred to date, 1 HCSW resolved locally with flexible working, remining in progress or staying on original ward.

3.7.5 **Legacy Mentoring:** Successfully bid for and awarded 12 months funding from HEE for a Legacy Mentor role to focus attention on nursing and midwifery staff within the first 24 months of their working life in the NHS with the intention of improving their experience and reducing attrition.

3.7.6 **International Recruitment:** 31 more nurses from overseas joined their allocated areas in HCSW posts in December 2022 which will take our total cohort of international nurses to 122. WHH continue to work with C&M Recruitment Teams and have committed to a further 56 international nurses who will join WHH between January and March 2023. A celebration event for the international recruits is being planned for summer 2023.

3.7.7 **HCSW development with NHSP:** A continuous programme is in place to recruit HCSW's through the nurse bank NHS Professionals (NHSP), a 6-month programme during which they work towards achieving their Care Certificate in an allocated area. There are currently 28 staff members working in the Trust due to complete their training in February and April 2023. Since January 2021 there have been 88 members of staff who have completed the programme with 10 members receiving substantive positions within WHH in the last 12 months.

3.7.8 **The WHH** Support, Transition, Education and Progress (to Preceptorship), S**TEPP Programme:** A programme designed to track every student from their first year first placement at WHH outlining our

commitment of a guaranteed interview through a conditional offer letter from the Chief Nurse Deputy Chief Executive, personally given to students at induction to the Trust.

3.7.9 **WHH Home Grown Student Programme:** The aim of this programme is to talent spot pre-registration nursing students from three local HEIs and provide them with a bespoke training package which leads to employment at the Trust. Nine students are currently within this programme from HEI's in Liverpool that usually do not provide WHH with high numbers of students

3.7.10 **HCSW Buddy Programme:** continues to support new HCSW commencing employment at WHH particularly those new to care. Between July to December 2022 71 new starter HCSW's were contacted by an existing HCSW through the Buddy Programme, % have stayed working at the Trust.

3.7.11 **Nursing Associates:** A recurrent process of supporting 8 HCSW staff to develop their skills into Nursing Associates is in place annually. The next Registered Nursing Associate apprenticeship programme is due to commence in March 2023, with 8 HCSW staff from within WHH.

3.7.12 **Professional Nurse Advocates (PNA):** The PNA model focusses on supporting the wellbeing of nurses through restorative supervision, supporting retention, WHH have 7 PNA's currently with plans to expand the cohort.

3.7.13 **Over recruitment** – agreed by the Trust Executive Team in December 2022 greater flexibility for areas to over recruit where necessary. This process is already underway within the Theatre Department.

3.7.14 **Celebration days –** WHH continue to celebrate national events for staff with the last one being the Nursing Support Workers Day in November 2022.

3.7.15 **Ward of the Month**: The Trust introduced Ward of the month in September 2022. A ward is celebrated for a month with gifts and well-being services for staff with a communication celebrating the good things about that area and team shared Trust wide. The wards are chosen by the Associate Chief Nurses supported by the Interim Lead Nurse for Workforce, B19 being the winner for January 2023.

One of the most successful initiatives is the overseas recruitment programme, with 180 nurses having joined WHH to date. A review of the next round of overseas recruitment is underway. The HCSW development through NHSP programme has been successful in recruiting and training ????? HCSW's. A number of the other initiatives are in the early stages but have positive indications such as the Buddy Programme and the STEPP programme.

4. SAFER NURSING CARE TOOL DATA COLLECTION

4.1. The Safer Nursing Care Tool (SNCT):

4.1.1. In line with NQB recommendations, the Safer Nursing Care Tool (SNCT) was developed to ensure the right staff, with the right skills are in place to support safe patient care. Originally developed by The Shelford Group and utilised for adult inpatient wards, it has recently been adapted nationally for the assessment of patients in the Emergency Department (ED). Recommended to be undertaken twice yearly, the first of these data collections, since prior to the onset of Covid-19 pandemic, was completed in June 2022 for both ED and adult inpatient areas with the second data collection taking place in November 2022. This has enabled the two data collections to be analysed and compared with current establishment, a full review of the data results and professional judgement will be completed with the Chief Nurse, Deputy Chief Executive, Deputy Chief Nurse and senior nursing team in February 2023.

4.1.2. The twice daily data collection is entered into to the SNCT calculator which indicates the number of staff required for patient care based on acuity and dependency.

4.1.3. The Safer Nursing Care Tool (SNCT) is one method that can be used to assist senior nurses to ensure optimal nurse staffing levels. Nursing workload and the ability to provide safe care is influenced by many variables including patient acuity and dependency, as evidence has shown that low staffing levels and skill mix ratios have an adverse effect on patient outcomes. Triangulating data from Nurse Sensitive Indicators (NSIs) such as infection rates, complaints, pressure ulcers and falls is essential in determining staffing levels. Additionally, when reviewing staffing levels and NSIs competence, leadership, morale, and compliance needs to be considered. Professional Judgement must also be applied in addition to measurement tools.

4.1.4 The table below demonstrates the staff required calculated from the November 2022 SNCT data collection against those already within the budgeted establishment, ED, ITU and Maternity are not included. The data does not include ITU who align to the Guidelines for the Provision of Intensive Care Services (GPICS) staffing recommendations. Maternity aligns their guidelines to Birth Rate Plus staffing recommendations and are therefore not included.

4.1.5 ED data was not fully captured due to their staffing levels and number of patients in the department at the time. The data collection is rescheduled for February with support from outside the department to ensure all data is captured. A full staffing review alongside the SNCT will be completed in February 2023.Key

+/- Funded	This means more or less staff in the funded establishment than identified in the SNCT data results
+/- In post	This means more or less staff in post than the SNCT data results indicate

Fig.7 SNCT November data collection

	SafeCare Required WTE Nurses vs Nurses in Post November 2022				
Ward	**SafeCare Required WTE**	**Funded Nursing Staff WTE**	**+/- Funded**	**Nursing Staff in Post WTE**	**+/- in-post**
AMU	45.2	59.66	14.46	45.45	0.25
A2	44.7	37.17	-7.53	31.57	-13.13
A4	46.6	40.89	-5.71	36.65	-9.95
A5 G	26.5	30.3	3.8	25.59	-0.91
A5 E	15.7	22.29	6.59	19.76	4.06
A6	43.7	48.77	5.07	40.97	-2.73
A7	48.4	42.46	-5.94	30.41	-17.99
A8	50.7	42.46	-8.24	38.04	-12.66
A9	50	43.46	-6.54	41.8	-8.2
B3	53.9	16.51	-37.39	21.9	-32
B12 FMN	35.8	47.12	11.32	38.83	3.03
B14	37.4	35.48	-1.92	30.88	-6.52
B18	35.8	56.78	20.98	40.07	4.27
B19	36.3	38.14	1.84	29.54	-6.76
C20	16.3	21.18	4.88	15.98	-0.32

A3/ACCU	41.6	48.71	7.11	45.69	4.09
C21	42.3	38.31	-3.99	28.27	-14.03
K25	32.4	28.5	-3.9	22.99	-9.41
CSTM	8.8	31.28	22.48	23.99	15.19
Total	712.1	729.47	17.37	608.38	-103.72

4.2 Analysis and Next Steps

In accordance with the data collection for November **(Fig.10)**, the recommended Safer Nursing Care establishment figures compared to the number of staff in post, shows a deficit of **103.72** (WTE)

Analysis of the data shows there are 5 areas with significant differences in SNCT recommendations and funded establishment, 4 of those areas B12, B18, B3 and CSTM are considered to have the correct funded establishment therefore an adjustment of the recommendations from SNCT (Fig ?) , based on assurance of safe staffing establishment figures from the Associate Chief Nurses and Interim Lead Nurse for Workforce, has been included in this section, with the associated narrative outlined below.

AMU is the exception to this and from a professional judgement point of view requires a funded establishment review due to continuing increases in activity.

AMU: For the purpose of the amended SNCT data table AMU SNCT results have been adjusted to match the funded establishment figure, whilst the establishment figures need a review, they are closer to an accurate portrayal of the numbers required. SNCT doesn't reflect the functionality of the unit as an assessment area. With high volume of patient turnover, discharges, and transfers, alongside attendance to diagnostics; the SNCT solely focuses on acuity and not activity. Therefore, the significant number of nursing care hours spent doing these tasks is not reflected in the SNCT dataset. Additionally, given the high volume of activity, there is the requirement to have a senior nurse co-ordinator on every shift, which is not considered within the SNCT results.

The functionality of the ward as Medical Assessment Unit and therefore has a key role in supporting flow for the Trust, at pace. Recent review of activity on AMU showed that in the month of October 2022, there were 579 admissions, in comparison to A2 at 152 and A6/7/8/9 which admitted between 80-90 patients. This illustrates the need to consider an increase to the establishment to ensure that safety and quality in relation to patient care, including safe and efficient transfers/discharges/flow.

The guidance from the Society of Acute Medicine and the "Getting it right first time" document released in April 2022 informs us that the required ratio for an Acute Medical Unit (considering acuity and activity) is 1 RN:6 patients in the day and 1 RN:7 patients overnight. The current ratio is 1:8 on a long day and on a night shift. Therefore, the recommendation is that an establishment review is undertaken

B12: The ward has a layout of 3 bays and 4 cubicles, this means staff need to be allocated into bays and cubicles to support the patients, who are living with dementia, to maintains safety. Therefore, more staff are required than recommended as SNCT data does not consider the practice environment, which is seen as one of its limitations (BMJ 2020). SNCT recommends 35 WTE, the actual establishment is 47 WTE which is correct.

B18: This ward was refurbished and designed to accommodate patients with higher acuity, patients who require closer nursing (level 2 patients). The layout of the ward is significant in consideration of staffing

establishments, these are unmeasured influences on demand that could have a substantial influence on the staffing requirements. SNCT recommends 35.8 WTE actual is 56.8 WTE.

B3: SNCT data recommends a figure of 53.9 WTE against a funded establishment of 16.51 WTE. This is due to escalated beds in operation and the type of patients in those beds who breach the criteria for medically optimised. On analysis the senior clinical team can confirm that when B3 is functioning as it was intended to, the current establishment figure is correct. This may need to be reconsidered in line with the increased acuity and dependency of patients at WHH and the difficulty in identifying medically optimised patients at WHH.

CSTM: SNCT recommends 8 WTE staff are required, actual funded establishment is 31.28 which is accurate, these results are unreliable due to estates work for IPC precautions at the time of the data collection, therefore less activity on the ward.

The table below shows the adjusted SNCT data as outlined above

Fig.7 SNCT Adjusted November data collection

	SafeCare Required WTE Nurses vs Nurses in Post November 2022				
Ward	**SafeCare Required WTE**	**Funded Nursing Staff WTE**	**+/- Funded**	**Nursing Staff in Post WTE**	**+/- in-post**
AMU	59.66	59.66	-	45.45	0.25
A2	44.7	37.17	-7.53	31.57	-13.13
A4	46.6	40.89	-5.71	36.65	-9.95
A5 G	26.5	30.3	3.8	25.59	-0.91
A5 E	15.7	22.29	6.59	19.76	4.06
A6	43.7	48.77	5.07	40.97	-2.73
A7	48.4	42.46	-5.94	30.41	-17.99
A8	50.7	42.46	-8.24	38.04	-12.66
A9	50	43.46	-6.54	41.8	-8.2
B3	16.51	16.51	-	21.9	-32
B12 FMN	47.12	47.12	-	38.83	3.03
B14	37.4	35.48	-1.92	30.88	-6.52
B18	56.78	56.78	-	40.07	4.27
B19	36.3	38.14	1.84	29.54	-6.76
C20	16.3	21.18	4.88	15.98	-0.32
A3/ACCU	41.6	48.71	7.11	45.69	4.09
C21	42.3	38.31	-3.99	28.27	-14.03
K25	32.4	28.5	-3.9	22.99	-9.41
CSTM	31.28	31.28	-	23.99	15.19
Total	758.86	729.47	-14.48	608.38	-150.48

The adjusted data shows a deficit of **150.48** WTE, this is comparable with our band 5 and band 2 vacancy data which currently sits at 155 WTE. SNCT does not differentiate between qualified and unqualified groups of staff and as such it requires a very good understanding of patient groups and nursing requirements, hence the

requirement to overlay the SNCT data with professional judgement, as factors such as ward layout, turnover and speciality are not directly considered in the patient classifications yet may influence the outcome. Therefore, SNCT must be used in conjunction with a professional judgement model, seen as the 'gold standard' in determining safe staffing requirements (BMJ 2020).

The data shows differences in some areas of planned care, A5E and A4, work was undertaken for both these wards to review their staffing requirements in October 2022 and adjustments were made to their funded establishments from within the planned care budget to respond to clinical need across those areas. The funded establishment figures for these areas need to be amended to reflect but overall are correct.

Further analysis of the data using the SNCT and professional judgement modelling shows that for both June 2022 and November 2022 data collection, there are similar differences in the deficit between what SNCT recommends and what the establishment figures are for wards A2, A7, A8, A9. Concerns regarding higher dependency on those wards have been highlighted in bi-monthly staffing updates to Trust Board through 2022, particularly A7, A8, A9. Across these 4 wards in November 2022 the total deficit in WTE funded establishment compared to recommendations from the SNCT data collection is **28.25** WTE. Applying professional judgement confirms these wards do require a higher staff to patient ratio than allows in the current funded establishment. These wards require an establishment review in line with the increases recommended as consistent reports of higher dependency, enhanced care requirements and increased harms are escalated regularly to the senior nursing team. When considering the data based on the wards included in the SNCT and professional judgment, the required uplift in funded establishments 28.25 WTE, outlined in the table below.

The table below demonstrates the differences in SNCT for wards A2, A7, A8, A9, funded establishment and professional judgement

	SNCT	**Funded Establishment**	**Difference between SNCT and staff in post**
November collection	712.1	729.47	103. 72
Adjusted Collection	758.86	729.47	150.48
Professional Judgement & SNCT Uplift to funded establishment required: A2/A7/A8/A9	758.86	757.72	178.73

What must be acknowledged is that ED data is not included in the SNCT census but is included in the vacancy data, therefore a more accurate picture of deficit between SNCT data compared to Trust vacancies will be provided following the ED SNCT data collection in February.

Each CBU Lead Nurse and Associate Chief Nurses will meet with the Chief Nurse, Deputy Chief Executive and the Deputy Chief Nurse in February to undertake final analysis and review the findings further.

In summary, the SNCT does provide a measure of nursing workload and in the data collected this can be demonstrated across several wards, however as highlighted earlier it is an adjunct to professional judgement and using this methodology has highlighted the requirement to uplift the funded establishment by 28.25 WTE.

Further review of AMU will be undertaken with a strong possibility of the requirement to increase establishment to support the activity and national recommendations for safe staffing within that department

5. EVIDENCE BASED STRATEGIC WORKFORCE PLANNING

5.1. SafeCare

5.1.1. The Trust operationally utilises the SafeCare function within the Allocate E-Rostering system to collect acuity and dependency data twice daily for all wards. SafeCare uses the same dependency scoring as the Safer Nursing Care Tool (SNCT). The data is inputted twice daily.

5.1.2. The senior nursing team review the data twice daily to ensure appropriate escalation plans are in place to support staffing decisions to meet the needs of the operational demands so that high quality care can be provided on inpatient wards. Any potential care issues associated with staffing are also recorded here using the Red Flag system. Red flags remain open until resolved during the staffing meetings and reports are sent to Lead Nurses and Matrons on a weekly basis to allow them to review their trends and themes.

5.1.3. A monthly report is also shared with the senior nurses that triangulates staffing incidents, staffing red status, red flags and patient harms. In relation to red flags the table below demonstrates the gradual increase across the last 12 months demonstrating increased potential harms to patients. This report will be reviewed and amended with the support of the QI team to ensure the report triangulates all issues related to staffing and safety.

Fig. 8: Staff Red Flags Data for 2021/22 – 2022/23

Time Period	Q2 2021/22	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23
No. Red Flags opened	377	810	857	976	1340	1180

5.1.4. The above table demonstrates an increasing trajectory in Red Flags opened by senior nursing teams related to staffing capacity versus demand. A contributory factor for this is the higher number of patients with 'no right to reside,' very often these patients have increased dependency therefore require more staff, red flags are opened when the demand outweighs capacity .This continues to be monitored daily with staff moved across departments to support areas of greater need. Staffing numbers also form part of our serious incident reporting to ensure triangulation of harm in relation to staffing has continued oversight and actions to address.

5.2. Care Hours Per Patient Day (CHHP)

5.2.1. Care Hours per Patient Day (CHPPD) was developed and adopted to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatients wards. CHPPD monitoring and tracking can be facilitated alongside E-Rostering systems and supports the daily assessment of operational staffing requirements. CHPPD are monitored monthly via the Trust IPR and reported via the bi-monthly Trust Board Staffing Paper Across WHH performance consistently fell below the National target of 7.9, averaging between 6.5 and 7.5 which means patients do not receive the recommended number of hours of care. This is due to, the number of vacancies, sickness, dependency of patients and increased number of escalated beds opened.

6. CARE GROUP AND SERVICE WORKFORCE UPDATE POSITIO

6.1. Planned Care Group

6.1.1 Ward B3 was made substantive in September 2022. Excellent progress has been made with recruitment to all posts with a trajectory to be fully established by the end of January 2023.

6.1.2 As part of Trust winter escalation plan, Ward B4 has been escalated with non-elective patients in December 2022/ January 2023 and is currently in the process of being de-escalated to complete end of January 2023 in line with the Trust commitment to the elective programme.

6.1.3 The Halton Matron post has now been made substantive and provides senior oversight and leadership for the Halton site.

6.1.4 The estates work within CSTM ward are now complete to enhance the cohorting of orthopaedic arthroplasty patients, with the appropriate staffing model within the current establishment.

6.1.5 Nurse-led clinics have commenced in the Urology Investigation Unit (UIU). Work continues within Surgical Specialties CBU to identify the funding required to extend the range of nursing services needed. the funding for the remaining RN establishment.

6.1.6 Senior staff in theatre are working hard to reduce their vacancies- with good effect, the CBU clinical team have worked to look at vacant posts to determine whether alternative ways of working can be introduced. In December nil agency usage was reported within the Theatre Department, this is an improvement.

6.2. Unplanned Care Groups

6.2.1 Due to the increased number of vacancies within the ED a bespoke ED workforce plan was put in place, including recruitment and retention plans. This has included block bookings of agency staff, development reviews for all current staff, recruitment events, a dedicated training week for all new ED starters with the Practice Educator Facilitator and initiation of a recruitment campaign with an external company.

6.2.2 Given the increased operational pressures and acuity, and change in profile of the Emergency Department, a review of ED staffing will be overseen by the Deputy Chief Nurse.

6.2.3 B18 has seen an increase in vacancies at Band 5 level, with 14.92 vacancies as of January 2023. A workforce plan has been developed with the Lead Nurse and matron, with oversight from the Associate Chief of Nursing (ACON), including an open day and recruitment events. This position is being monitored weekly by the ACoN for Unplanned Care Group.

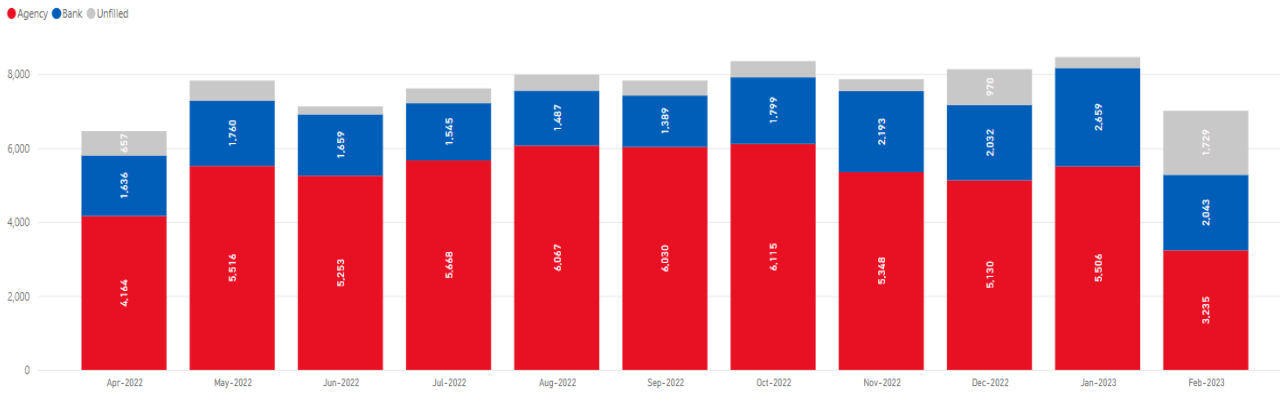
6.2.4 Business cases for K25, C21 and B19 were supported in 2022 and recruitment in these areas has been successful, with minimal vacancies remaining.

Spend on agency staff in ED and occasionally on ITU is monitored closely and will remain a source of supply to fill shifts in ED until staffing numbers improve. This is managed through the Comprehensive Agency Managed Service CAMS.

Table below shows agency fill for ED Registered Nurse

Blue- NHSP bank

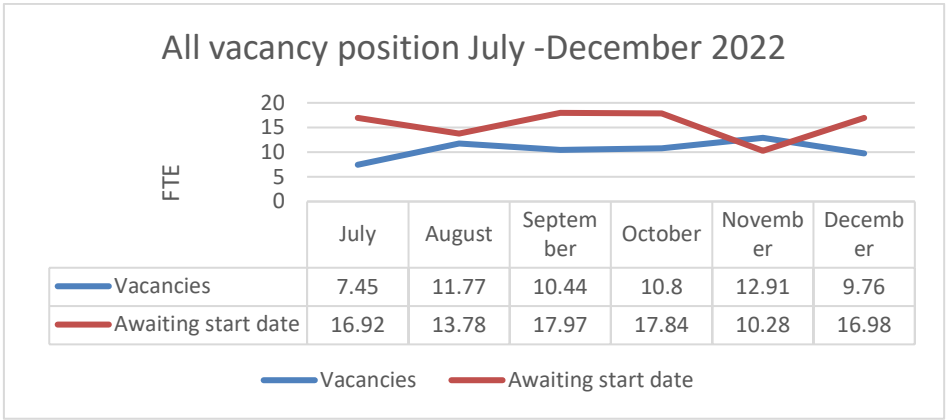
Red-Agency



6.3. Maternity Services

6.3.1 The calculated total workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust is 116.70 WTE, which includes an additional 10% for non-clinical roles. The comparative current funded establishment is 122.22 WTE which means that there is a positive variance of 5.52 WTE registered midwives which helped sustain the high achievement of the current rostered model for Continuity of Carer. Following the removal of national targets in relation to Continuity of Carer a review is underway in relation to staffing models across the service.

6.3.2 The overall ratio for Warrington & Halton Teaching Hospitals NHS Foundation Trust of 24.6 births to WTE in line with NICE guidelines.



	July	August	September	October	November	December
Vacancies	7.45	11.77	10.44	10.8	12.91	9.76
Awaiting start date	16.92	13.78	17.97	17.84	10.28	16.98

6.3.3 Retention of midwives has required focussed work. A retention midwife commenced in post in May 2022 who has implemented an action plan. This has shown some success as all newly qualified midwives who joined the organisation in 2021 and 2022 remain working for WHH. This work will continue to ensure those joining as newly qualified in 2023 remain at WHH.

6.3.4 Sickness rates for Maternity Services (all staff) were 8.7% for November 2022, this is an improvement from November 2021 when the rate was 12.29%. A similar improvement can be seen in registered staff, 13.14% in November 2021 compared to 5.97%.

6.4 Clinical Support Services Update

6.4.1 The area for concern for CSS is the high number of vacancies within the Pharmacy department with a 40% vacancy rate. This is reflective of the national picture. Part of the focussed work with Just R, a recruitment and engagement campaign started in November 2022 and runs until May 2023, the ongoing impact of shortages within the pharmacy department has a negative impact on the wards, delays in medicine reconciliation can cause harm to patients and in turn impact on staffing capacity.

6.5 Allied Health Professional (AHP) Update

6.5.1 **Vacancy position**

Vacancy data for November 2022 indicates that there are 54.7 whole time equivalent (WTE) AHP posts vacant, of which 46.15 WTE are registered AHPs. Occupational Therapy and Diagnostic Radiography (ultrasound and mammography) recruitment remains a challenge. This is consistent with the national picture for these professions, all posts continue to be advertised repeatedly via NHS jobs and at recruitment events. The impact on wards and departments this has are delays in therapy that may contribute to longer lengths of stay, this can in turn expose the patients to more harm and impact on the capacity on the nursing workforce.

6.5.2 The majority of vacancies are at band 6 level. There are 10.4 WTE are at various stages of the recruitment process leaving a total of 35.75 WTE registered AHP vacancies and 8.55 WTE clinical support worker vacancies.

6.5.3 **Staff Turnover**

In November 2022, the turnover rate for registered AHP staff was at 12.78%, the lowest since December 2020 and remains below the Trust target of 13%. Stabilisation of the AHP workforce and retention of its staff is one of the main objectives for the AHP Workforce. The highest turnover remains in therapies at 16.60%. This largely attributable to the band 5 rotational staff turnover and consistent with the national picture for this banding (last 12-month data shows 9.80 WTE leavers and 17.00 WTE starters).

6.5.4 **Sickness Absence**

Sickness absent levels for registered AHPs in November 2022 stands below the Trust target of 4.2 %, at 3.65 %. The CSW absence level stands at 14.08%, with a spike in short term sickness and a higher long term sickness rate. The overall sickness rate was primarily caused by chest and respiratory infections, followed by anxiety/stress/depression.

Registered AHP welcome back conversations stand at 91.30% and 100% for CSWs in November 2022, an improvement over the last 6 months.

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6.5.5 **Recruitment and Retention Planning**

The AHP Strategic workforce plan was ratified in July 2022, with the main objective being the stabilisation of the AHP workforce, including proactive recruitment to support staff retention.

- **Appointment of AHP Workforce lead**
- **Monthly vacancy report:** AHP vacancy data is collated each month and reported to the Trust Workforce Review Group. Therapies and ODP services have established vacancy trackers with work underway for Diagnostic Radiography.
- **International Recruitment:** Plan in place to recruit 3 international Occupational Therapists after the successful approval of a business case.
- **ACP roles:** developed to provide expert clinical support through extended roles to the patients and staff across WHH.
- **Recruitment events**
- **Preceptorship:** All newly qualified AHPs are now accessing the Trust Preceptorship programme and preceptors have received ongoing training.
- **Return to practice:** An AHP policy in development to support individuals wanting to return to clinical practice and regain HCPC registration.
- **AHP Clinical Support worker development:** Career conversations have commenced for those are aspiring to complete apprenticeships. Several ODP and OT staff are at various stages of their apprenticeships. The HCA forum also includes AHP CSWs.
- **Careers activity:** In September 2022, the AHP Career Promotion work stream was launched, to promote AHP careers in local schools, colleges and universities.
- **Northwest Placement reform activity:** The Northwest AHP Student Placement Reform programme requires organisations to provide placements proportionate to the number of staff in post. We are working closely with universities on allocation of placements for physiotherapy, dietetics and speech and language therapy degrees. OTs at the Trust have also offered role emerging/non-traditional placements to increase their placement capacity.
- **Staff engagement**: Events on AHP Day in October 2022 focussed on well-being and self-care. Nominated colleagues were awarded certificates for acts of kindness. Radiology share via a weekly Radiology team brief, which includes engagement, training and CPD opportunities. Radiology, Orthoptics are taking part in the 'Your future, Your way' training to support staff who identify as BME. Expressions of Interest have been invited for the NW BME Strategic Advisory Group.
- **Links with the C&M ICS:** WHH AHPs are closely linked to the Cheshire and Merseyside AHP Council and Faculty with WHH representation into both these steering groups and work streams. Information from all these groups is disseminated via the Trust Allied Professions Advisory Group (APAG).
- The AHP teams have seen some positive impact from the recruitment and retention plans in place such as overseas recruitment and the development of training roles to support the shortfalls. Work continues, however the national context in relation to AHP shortages is Mirrored at WHH.

7. OVERALL SUMMARY

7.1 Recruitment remains a challenge across all staff groups mirrored by the national picture and more significantly by the political landscape. Considerable work is underway to address this with recruitment and retention planning. The senior teams continue to monitor staffing levels and the relationship to safety several times daily and continuous planning is in place. There have been some improvements noted across Maternity with recently reduced vacancies and successful retention work. Theatre Department is also showing an improving picture.

7.2 Staffing capacity and the impact on safe care is recorded on the Board Assurance Framework, with a current high-risk rating of 20. The Interim Lead Nurse for Workforce continues to work with the care group and CBU nursing leads to support the recruitment and retention plans in place overseen by the Deputy Chief Nurse and monitored via the Trust Workforce Review Group.

7.3 A robust ward staffing establishment review was undertaken using a mixed methodology of approaches in line with the recommendations from the NQB, NICE guidance and the RCN Nursing Workforce Standards.

7.4 Overall, the staffing establishments remain appropriate and within recommended guidelines, there are some key exceptions where acuity and dependency levels and growing demand continue to overtake the nursing ratios. Recommendations for uplifts are highlighted within the paper and will be considered at the review meeting with the Chief Nurse, Deputy Chief Executive in February 2023.

7.5 Safe staffing and staffing escalation is monitored and utilised and is always a priority for the clinical teams. These processes remain in place to support staff and protect the safety of patients at WHH.

8. RECOMMENDATIONS

8.1 It is recommended that the Quality Assurance Committee members discuss and note the progress to date and the contents of the report.

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/22/03/56**
SUBJECT:	Learning from Deaths Report Q3 2023
DATE OF MEETING:	7 March 2023
AUTHOR(S):	Dr. Lalitha Chinnappan, Trust-wide Lead for Mortality Dr. Judith Raper, Deputy lead for Mortality Emily Barnett, Clinical Effectiveness Manager
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivery safe and effective care and an excellent patient experience.
EXECUTIVE SUMMARY	This paper summarises 'Learning from Deaths' for Q3 2022, for noting and scrutiny, in compliance with National Guidance requirements on Learning from Deaths. **Key points to note are:** • During Q3 2022, 408 deaths occurred within the Trust. • Of these, 105 met the criteria to be subject to a Structured Judgement Review (SJR). • 101 SJRs have been completed in Q3. • In Q3, 2 serious incident investigations have been reported where the patient has died. • The latest HSMR (Hospital Standardised Mortality Ratio) based on 12 months data up to October 2022 is 92.38. This result is a low value outlier. • The latest HES SHMI (Summary Hospital-level Mortality Indicator based on Hospital Episode Statistics) for the 12-month period up to October 2022 is 99.20. This result is not an outlier. • Attached as an appendix is the MRG theme of the month following December's MRG **(Appendix 1)**

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

RECOMMENDATIONS:	Quality Assurance Committee is asked to note the contents of the paper.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**	

QUALITY ASSURANCE COMMITTE

SUBJECT	Learning from Deaths report Q3 2022/2023	AGENDA REF:	QAC/22/03/56

1. BACKGROUND/CONTEXT

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

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

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

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

2. KEY ELEMENTS

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

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

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

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

3. MEASUREMENTS/EVALUATIONS

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

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

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

MRG – Forward planning

1) **SJR backlog**- During Quarter 3 there were between 38– 45 deaths per month that were flagged as required an SJR to be completed. Therefore, the average deaths requiring a SJR per month are around 40 (often with increase over winter months). Currently we have 8 Mortality reviewers, with 7 of them being allocated 5 cases per month and 1 being allocated 6 per month, leaving a total monthly allocation of 41 SJRs which will change to 40 from July/23. With the current backlog in mind, and taking into account the above figures, we will still be in a backlog position of approximately 60+ SJRs by the end of the financial year**.** To address this the number of SJR reviewers would need to be increased to ensure the supply meets the demand. We started this quarter with a more than 50 SJR's exceeding the 8 week completion from allocation and after all the efforts to address this issue currently we have only 24 SJR's which are pending over the 8 weeks. Additional support has been offered to the existing reviewers and individual email remainders are being sent regularly to re-enforce timely SJR reviews. Pending SJR list is also a regular agenda item in MRG meeting for discussion including measures to address any delays to keep up the progress made.
2) **Smartening of SJR criteria** - taskforce meeting discussion to assess and improve existing SJR criteria to maximise learning and efficiency. This will also help address the SJR demand and reduce backlog. The outcome of the meeting was discussed in MRG and the following minor changes to the existing criteria agreed.
   a)To ensure that DoLS SJR's are allocated accurately and the correct patients are being picked up, Governance and Safeguarding will cross reference their data. There is ongoing discussion to assess

what DOLS reviews are mandated via SJR to assess whether all standard DOLS should be escalated to SJR & only a sample of urgent DOLS and further update will follow soon regarding the outcome.

b)ITU patients who trigger a SJR for NO DNACPR criteria alone will no longer be sent for review. This is because these are often patients who are palliated / care is withdrawn. ITU deaths which trigger for any other criteria – for example post-op deaths, DOLS etc will continue to be escalated to full SJR.

c)OOH cardiac arrest patients who die in A&E and trigger for NO DNACPR criteria alone will no longer be sent for review unless they have had a recent discharge in the past 4 weeks. This is because an SJR review does not provide any learning given it covers only the brief ED resus attempt. All such cases undergo a ME review and if any concerns are identified, the ME service will refer to Governance. If a patient has had a recent discharge, these will remain for SJR to ensure there were no missed opportunities during that stay.

3)**Thematic review and related work-streams-** have been created to enable SJR's with common themes to be accumulated. The workstreams created are: DNACPR, Patient Transfers, Specialty Input, DoLS/ Capacity and Good practice. SJR's which identify issues relevant to these work streams are added and where required discussed in the MRG meeting. This will then enable MRG to integrate with relevant work stream leads to address the issues identified with the aim to bring about clinical changes and positively impact both patient care and trust mortality.

3) **Departmental M&M**- These have now been commenced from Feb/ 2022 in liaison with department governance leads. All speciality governance agendas now have a designated M&M section comprising following items:

a) List of all department mortality with additional information regarding death certificate cause of death, escalation to SJR's etc. This will enable specialities to review department deaths and where further deep dive needed escalate to MRG for further review.

b) MRG monthly newsletter covering current mortality related learnings

c) Any SJR's relevant to speciality & discussed in MRG where good practise or learning for speciality identified attached with feedback from MRG lead regarding relevant issues.

3.1 Mortality Review Data Q3 2022/2023

- During Quarter 3, 105 deaths met the criteria to be subject to a Structured Judgement Review (SJR).
- During Quarter 3, 81 deaths were allocated to a review for a Structured Judgement review.
- 101 SJRs have been completed in Q3, an increase of 1 from Q2.
- Of the 101 SJRs completed, 41 were allocated in Q2 and 60 were allocated in previous quarters.
- The completed percentage has increased by 19% compared to Q1.

Fig. 1 – Key Mortality Data

Total deaths in Q3	Total LD Deaths	SI investigations commenced in Q3 relating to patient deaths	Those meeting SJR criteria	Number of SJR reviews completed in Q3	Number of SJR Reviews that were allocated in Q3 and completed compared to Q2

408	10	2	105	101	Q2 Total SJR completed – 100 SJRs were completed on 53 out of 115 assigned in Q2 46 %	Q3 Total SJR completed – 101 SJRs were completed on 41 out of the 81 assigned in Q3 65% ↑

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

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

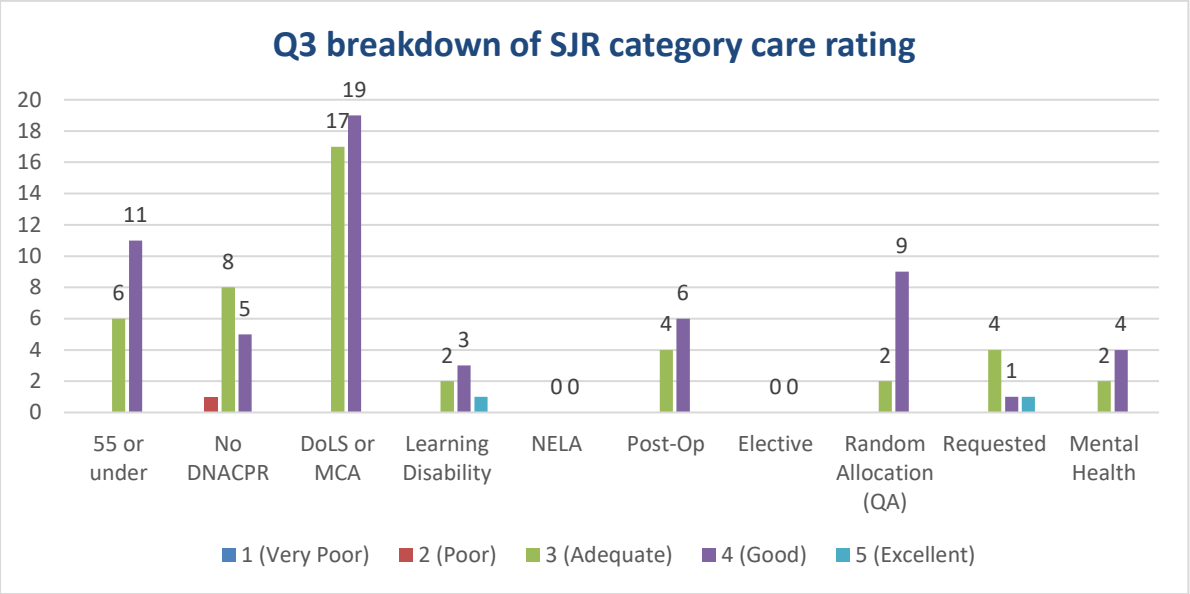
Cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Specialty Governance meetings, a sample of these are also brought to MRG to highlight good care.

Fig. 2 – Shows the overall and phase of care ratings of the 101 SJRs completed in Quarter 3

Phase of Care *	N/A	Very Poor	Poor	Adequate	Good	Excellent
First 24 hours/admission	14	0	1	18	64	4
Ongoing care	24	0	4	28	42	3
Care during procedure	86	0	0	0	14	1
End of life care	47	0	2	16	34	2
Patient records/documentation	16	0	2	33	49	1
Overall care	**16**	**0**	**1**	**34**	**49**	**1**

- In SJRs completed within Quarter 2, there has been no very poor care at any stage of admission and 1 instance of poor care at the 'end of life care' stage leading to an overall care rating of poor. This case was discussed in September MRG and related to a failed transfer to a nursing home. This has been referred for review by the Safety Officer from Halton and Warrington CCG and feedback will be given to MRG when this action is complete.
- All phases of care and documentation records including overall care had a majority of 'good' ratings.

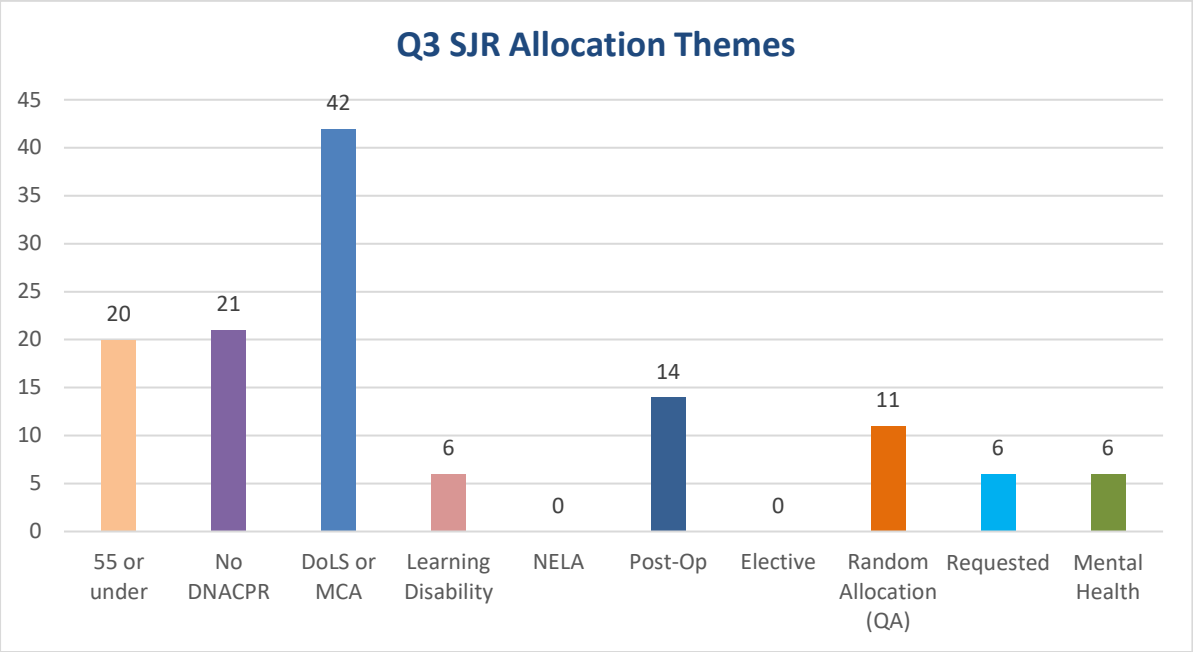
Fig 3 - Shows the breakdown of care ratings in each SJR category in Quarter 2



- All categories except for ME Request and Random Allocation patients are predominantly receiving good care.
- ME Requested patients have received equal ratings of adequate and good care. This evidences that the ME service is working positively to identify and highlight to MRG patients with potential issues in care.
- Random Allocation patients received significantly more adequate than good care. Random allocations are used by the Clinical Effectiveness Coordinator when screening deaths where they feel there could be an issue in care, but the patient does not fall into an SJR category.
- Patients who have died with a severe mental health disorder have received all good care ratings.

NB Some care ratings are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

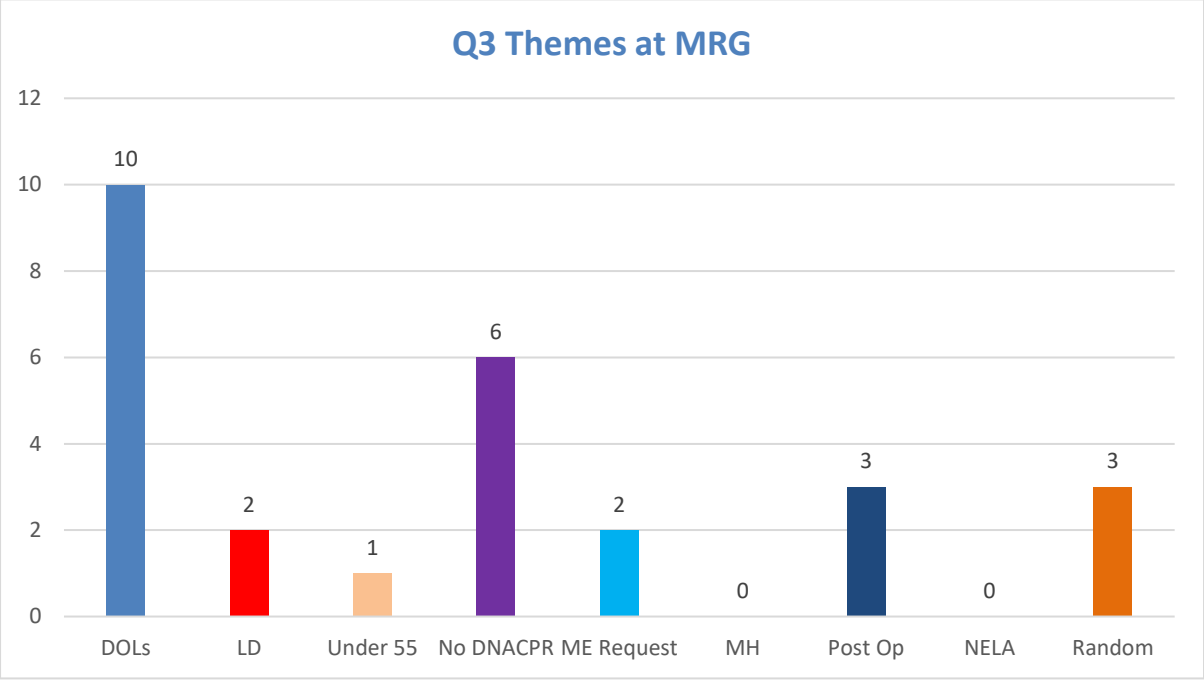
Fig 4 - Shows the frequency of each SJR category allocated to reviewers in Quarter 3



- DOLS were the most frequently allocated category to reviewers in Q3.

NB Some allocations are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

Fig 5 - Shows the frequency of each SJR category presented at MRG in Quarter 3



- The category with the highest number of SJR's requiring further discussion at MRG in Q2 is patients with DOLS. This corresponds to the number that are allocated. There is input and representation at MRG from the Safeguarding Team which facilitates learning and development of improvement plans.
- No DNACPR has the second highest number of SJR's requiring further discussion at MRG. There is DNACPR workstream within MRG to collate this learning for the Trust's DNACPR lead.
- ME Requested SJR's remain one of the most frequently presented at MRG. This highlights the good triangulation between the ME Service and MRG.

3.2 Learning from deaths

The below provides a sample of the learning following recent deaths and the actions taken.

Learning	**Action**
Group agreed that this SJR would be good to discuss with Clatterbridge regarding DNAR.	SJR to be sent to Palliative care lead for discussion with Clatterbridge.
Group had concerns about whether this patient was fit for discharge as came back to hospital the same day.	SJR to be referred to Governance incident team.
It was noted that this review had learning regarding timely CPR discussions and is an example of an SJR that should feed into the DNACPR workstream.	SJR to be taken to the ITU M&M meeting regarding proper escalation to ITU.
Themes **Appendix 1** – Explains what MRG is. Newsletters are included on CBU and Specialty Governance agendas each month.	

3.3 Learning from Serious Incident investigations:

Incident	Outcome
ID 172656: This patient was recommended for electrophysiology referral for consideration of an ICD in 2021. There is documentation that the patient contacted our service to chase up what he felt was a lost referral. He was advised to chase this up with LHCH directly. I cannot see evidence on Lorenzo or the summary care record that the patient was referred and a decision made on eligibility for ICD. This requires investigation since if he were eligible for an ICD, this may have prevented his death.	Investigation is in progress with a due date of 01/03/2023
ID 174778: Patient was recommenced on furosemide after her AKI resolved. Nursing staff had been omitting it due to low BP and not escalated it to the doctor looking after her. Had this been escalated it would have been documented to give as long as BP above 90. The patient now has a new o2 demand due to pulmonary oedema.	Investigation is in progress with a due date of 21/03/2023

4.0 Mortality Indicators

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

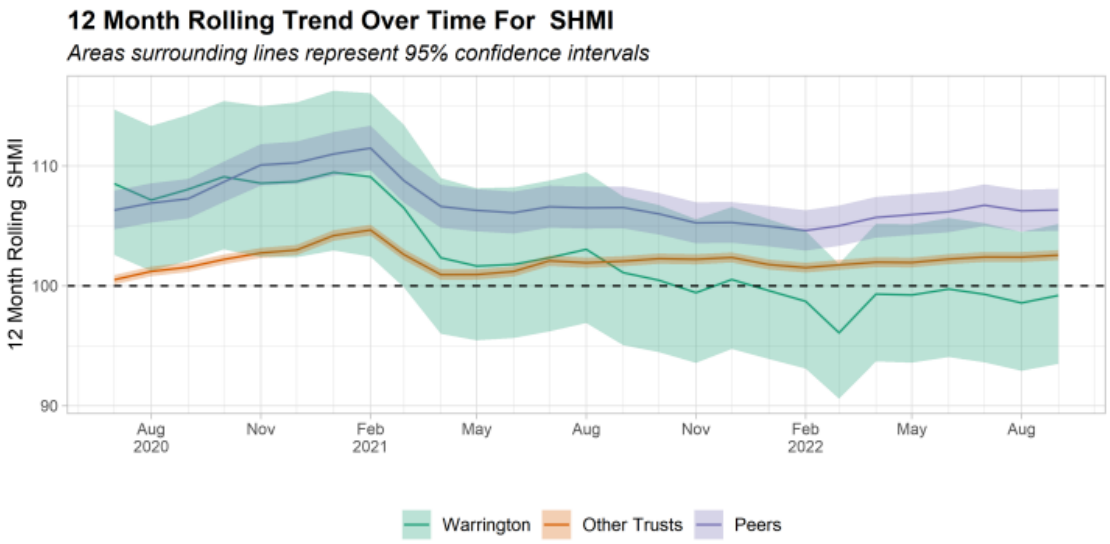
To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

The SHMI data is the ratio between the actual number of patients who die within 30 days following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of patients treated there.
The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected'

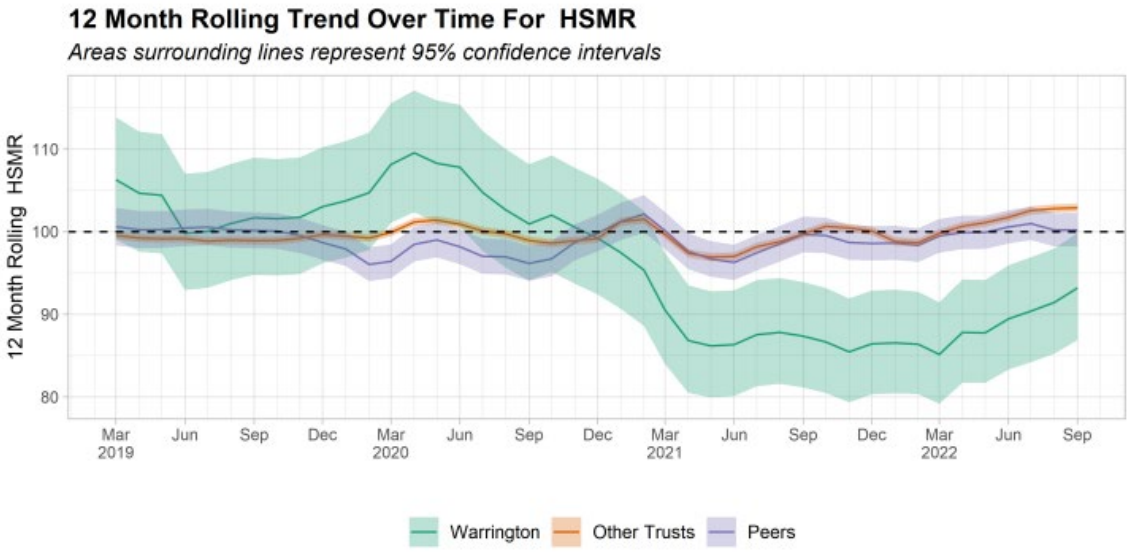
(SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.
HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents, and complaints data.

4.1 HSMR and SHMI indicators

Month	HSMR	SHMI	Total Deaths
October 2022	89.17	98.1	121
November 2022	89.87	98.48	122
December 2022	92.42	97.86	165



HES SHMI (which is based on 12 months data up to and including August 2022) is 99.20 This result is not an outlier using an over-dispersed funnel plot and is not an outlier based on the stricter Poisson method.



Standard 56 CCS group HSMR (which is based on 12 months data up to and including September 2022) is 93.20 for Warrington. This result is a low value outlier based on the 95% Poisson method.

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

There are no SHMI diagnosis groups which are outliers for the latest 12 months using an over dispersed Poisson (95% limit).

4. MONITORING/REPORTING ROUTES

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

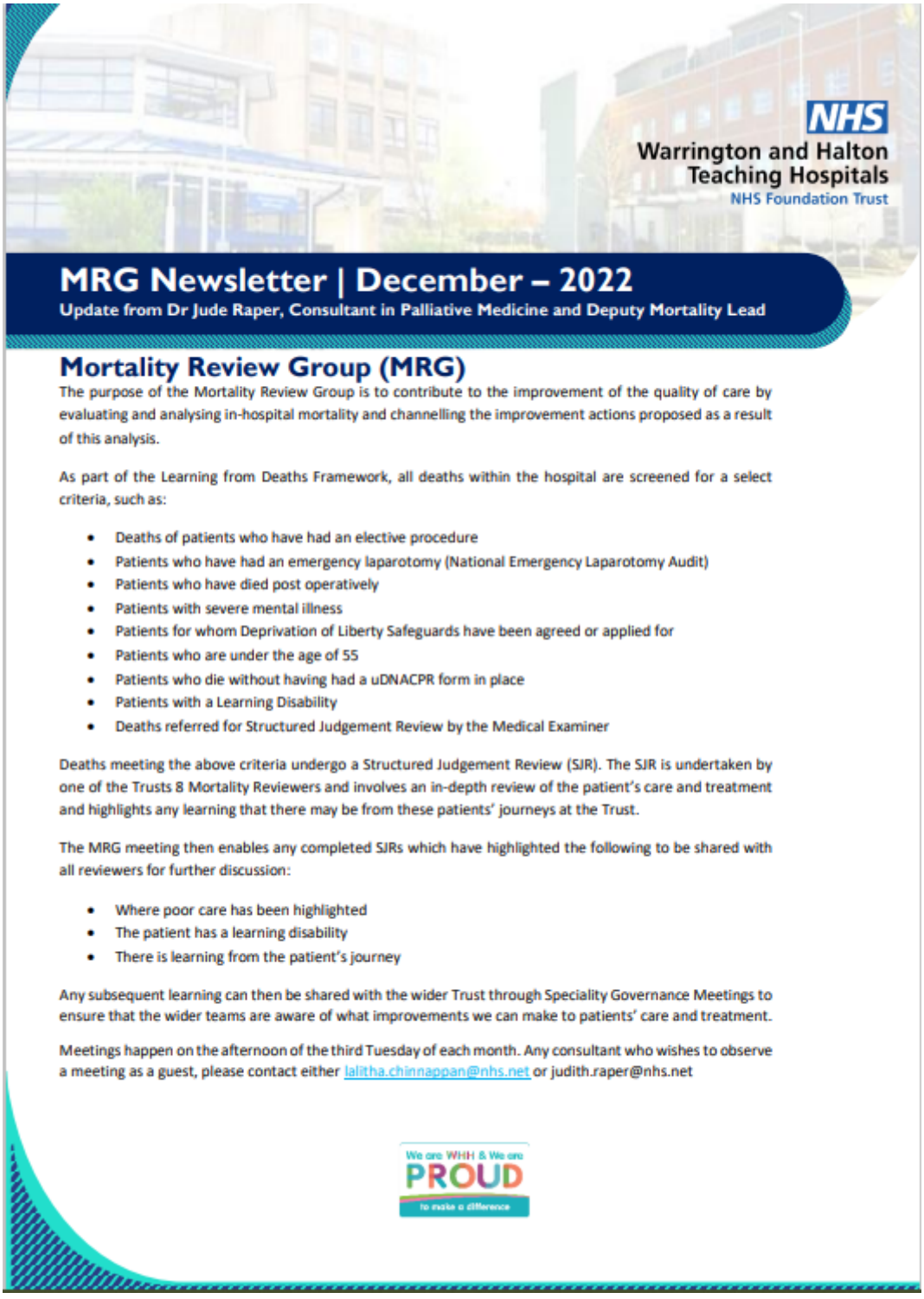
5. TIMELINES

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

6. RECOMMENDATIONS

The Quality Assurance Committee are asked to note this report.

Appendix 1:



NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

MRG Newsletter | December – 2022

Update from Dr Jude Raper, Consultant in Palliative Medicine and Deputy Mortality Lead

Mortality Review Group (MRG)

The purpose of the Mortality Review Group is to contribute to the improvement of the quality of care by evaluating and analysing in-hospital mortality and channelling the improvement actions proposed as a result of this analysis.

As part of the Learning from Deaths Framework, all deaths within the hospital are screened for a select criteria, such as:

- Deaths of patients who have had an elective procedure
- Patients who have had an emergency laparotomy (National Emergency Laparotomy Audit)
- Patients who have died post operatively
- Patients with severe mental illness
- Patients for whom Deprivation of Liberty Safeguards have been agreed or applied for
- Patients who are under the age of 55
- Patients who die without having had a uDNACPR form in place
- Patients with a Learning Disability
- Deaths referred for Structured Judgement Review by the Medical Examiner

Deaths meeting the above criteria undergo a Structured Judgement Review (SJR). The SJR is undertaken by one of the Trusts 8 Mortality Reviewers and involves an in-depth review of the patient's care and treatment and highlights any learning that there may be from these patients' journeys at the Trust.

The MRG meeting then enables any completed SJRs which have highlighted the following to be shared with all reviewers for further discussion:

- Where poor care has been highlighted
- The patient has a learning disability
- There is learning from the patient's journey

Any subsequent learning can then be shared with the wider Trust through Speciality Governance Meetings to ensure that the wider teams are aware of what improvements we can make to patients' care and treatment.

Meetings happen on the afternoon of the third Tuesday of each month. Any consultant who wishes to observe a meeting as a guest, please contact either lalitha.chinnappan@nhs.net or judith.raper@nhs.net

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

GMC Enhanced Monitoring Status Update

Dr Paul Fitzsimmons

Medical Director

GMC Enhanced Monitoring

- General Medical Council licences and regulates UK Medical Education
- Medical Education at WHH was placed into GMC Enhanced Monitoring in 2015 following National Training Survey and trainee concerns
- Initial concerns regarding quality of medical training Emergency Medicine and Acute and General Medicine
- Subsequent concerns in Obstetrics & Gynaecology
- Concerns published on GMC website
- Medical Education at Trust subject to
  - Increased frequency of HEE Quality Visits
  - Enhanced quality surveillance submissions to HEE
  - Enhanced scrutiny of GMC National Training Survey results

Progress and Improvement

- Extensive improvement plan
- Investment in Educational Supervisors
- Improved educational governance and approach to managing issues
- Delivered benefits for trainees and patients
- Progressive improvement in NTS results and Quality Visit outcomes
- Winter 2021 – Agreed gateway process for leaving enhance monitoring
- Summer 2022 - HEE monitoring stepped down to internal quality assurance overseen by Local Associate Postgraduate Dean
- Feb 2023 – recommendation from HEE NW to step down enhanced monitoring accepted by GMC

What this means for WHH

- “Be the best place to work with a diverse, engaged workforce that is for for the future”
- Assurance around improvements in the quality of medical education and care delivered at WHH
- Opens potential to have more higher trainees in key specialities
- Important milestone towards University Teaching Hospital status
- Vital for recruitment and retention – already seeing impact on Consultant recruitment
- Recognition of a huge amount of work by Medical Education team and speciality clinicians